September 2023

Utah Department of Health & Human Services
Integrated Healthcare

MEDICAID INFORMATION BULLETIN

Medicaid Information: 1-800-662-9651 | medicaid.utah.gov

23-60 Provider Enrollment Contracts

With the end of the Public Health Emergency (PHE) on May 11, 2023, Provider Enrollment will restart the auto-closure process in January of 2024 that was previously waived per 1135(b)(1)(B).

Per Utah Administrative Code R414-23-4, the Department may automatically close a provider contract for any of the following reasons:

(1) Failure to revalidate within the required five-year cycle as directed by 42 CFR 424.515.

(2) Expiration of professional license, or expiration of any license associated with the program for clinical laboratory improvement amendments (CLIA).

Unless otherwise noted, all changes take effect on September 1, 2023

(3) Upon state or federal reporting of a deceased provider.

(4) Failure to bill Medicaid for one or more years without notification.

Providers who fail to complete their revalidation timely, will be closed at the end of their revalidation cycle. For questions or concerns, contact providerenroll@utah.gov.

23-61 Long Term Services and Supports (LTSS) Electronic Visit Verification (EVV)

EVV No Longer Required for T1001

Effective July 1, 2023, the State no longer requires EVV records to be submitted for the service code T1001 (Nursing assessment/evaluation).

New Technical Specifications for API and CSV File Submission

On October 5, 2023, Utah Medicaid will implement updates to the LTSS Electronic Visit Verification (EVV) File Technical Specifications (Version 1.7). Go to https://medicaid.utah.gov/evv/ to review and download the LTSS EVV File Technical Specifications v1.7. The current version (1.6) will be in effect until October 4, 2023. After implementation of the updates, the old version will no longer be functional.

EVV is Required for Home Health Services by January 1, 2024

As a reminder, CMS and the State require all Personal Care and Home Health Care providers to submit EVV records to accompany their claims. The State has included PCS and HHS services in audits related to EVV, but has not been assessing any penalties for missing EVV records for HHS services. Beginning January 2024, the State will begin assessing penalties for non-compliance to HHS and PCS EVV requirements.

Changes to Administrative Rule R414-522

The Administrative Rule that outlines the EVV requirements and audit practices has recently been updated. Updates include:

(1) Clarification to the penalties for noncompliance to EVV.

(2) Requirement for providers to submit EVV records within 3 months of submitting Medicaid claim.

23-62 Prior Authorization Updates

Updated Prior Authorization Submission Requirements

On all Fee-for Service prior authorizations there is a procedure line requiring a CPT, HCPCS, or DRG code. Providers are required to put in a Requested $ Amount upon submission. This amount must be $0.00 for claims to process correctly. This includes all manually priced items.

Modifications to any prior authorization request must be requested via a Modification Request Form. This form should be loaded directly to the active tracking number within PRISM. Do not create an additional request or entry into PRISM as this will further delay the review process.

Prior Authorization Status Updates

Updates have been made to the prior authorization phone tree. Please listen carefully before selecting a prompt. We will no longer be providing status requests over the phone. Status requests can be located through the PRISM portal. If you do not have access to view this status, please contact your domain administrator to obtain access.

23-63 Provider Billing Language Clarification

Chapter 3-1 of the Section I: General Information Provider Manual has been updated as follows:

3-1 Provider Agreement

A provider enrolls as a Medicaid Provider by completing the Medicaid Provider Application and signing the Provider Agreement. A provider must execute the Agreement before they are authorized to furnish Medicaid services. When the State accepts the provider's application and the agreement is signed, the State will notify the provider by approval letter with the effective date of enrollment. Providers submitting applications for Medicaid enrollment or re-credentialing of an existing enrollment, must send in a completed application packet with all required documentation and information. If the submission is incomplete or incorrect, the provider will be notified by letter that the application was not accepted due to missing and or incorrect documentation or information and the application will be discarded. Medicaid will consider a new application if the provider submits a completed application packet that includes all required documentation and information.

The following provisions are part of every Provider Agreement, whether included verbatim or specifically incorporated by reference:

- The provider agrees to comply with all laws, rules, and regulations governing the Medicaid Program.
- The provider agrees to follow, all guidelines and edits of the following agencies or organizations:
  - Medicaid Integrated Outpatient Code Editing obtained from CMS via secure Rissnet files.
  - American Medical Association Guidelines
  - National Correct Coding Initiative
  - National Uniform Billing Code
- The provider agrees that the submittal of any claim by or on behalf of the provider will constitute a certification (whether or not such certification is reproduced on the claim form) that:

- The medical services for which payment is claimed were furnished in accordance with the requirements of Medicaid;
- The medical services for which payment is claimed were actually furnished to the person identified as the patient at the time and in the manner stated;
- The payment claimed does not exceed the provider's usual and customary charges or the maximum amount negotiated under applicable regulations of the Division of Integrated Healthcare; and
- The information submitted in, with, or in support of the claim is true, accurate, and complete.

- Providers are prohibited from submitting inaccurate Medicaid claims.

23-64 P&T Committee Updates

The Pharmacy and Therapeutics (P&T) Committee will review insulin pumps in September.

P&T Committee meeting minutes are posted on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/pt-committee.

23-65 DUR Board Updates

In July 2023, the Drug Utilization Review (DUR) Board met to review newer disease-targeted agents for sick cell disease. In August 2023, the DUR Board met to review Hemgenix (etranacogene dezaparvovec).

DUR Board meeting minutes are posted on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board/. DUR Board meeting recordings can be found on the YouTube Channel @dmhf_webdohdhhs2.

23-66 Pharmacy Prior Authorization Processing

Pharmacy prior authorization requests received for pharmacy services, including pharmacy related HCPCS codes, must be complete upon submission. An incomplete submission means required information is missing, which may result in the prior authorization being denied. The Utah Medicaid pharmacy team attempts to contact providers to obtain additional information for the prior authorization request at least two times. Providers and their staff are encouraged to complete the prior authorization request to include the exact medication name the member will be using, or indicate if a substitution is not permissible.

Medication Name/ Strength:	Dose:
❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

If a provider's intent is for a member to use a brand product, they will check "Do Not Substitute". In the example below, the request would be reviewed for the non-preferred name brand Percocet 5/325mg.

Medication Name/ Strength: *Percocet 5/325mg*	Dose:
☒ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

If a provider submits a prior authorization request without indicating "Do Not Substitute", the request will be processed for the preferred Generic/Brand equivalent. In the example below, the request would be reviewed for the preferred generic equivalent, Oxycodone/APAP 5/325mg.

Medication Name/ Strength: *Percocet 5/325mg*	Dose:
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

In all cases, providers should submit prior authorization requests using the most current form available on the Utah Medicaid Pharmacy Website, complete all fields legibly, and include all supporting documentation required for the pharmacy service requested.

23-67 Pharmacy Policy, Coverage, Prior Authorization and HCPCS Codes

The Utah Medicaid Preferred Drug List is updated monthly and is the most up-to-date source of information pertaining to drug specific pharmacy coverage, limitations, and policies, in addition to the Utah Medicaid State Plan, Utah Administrative Rule, Utah Medicaid Provider Manuals and Medicaid Information Bulletins, and Pharmacy prior authorization forms.

Pharmacy prior authorization forms and pharmacy related HCPCS codes are reviewed and updated at a minimum annually, but may be updated more frequently as drug labels are expanded.

Per the Utah Medicaid Provider Manual Section I: General Information, 2-3 Member Eligibility Verification, Providers who administer and bill Utah Medicaid for pharmacy related HCPCS codes shall verify member eligibility. Pharmacy related HCPCS code coverage and the HCPCS NDC Crosswalk shall be used together to verify coverage, reimbursement, and covered NDC's for pharmacy related HCPCS.

To access the most recent pharmacy resources, go to https://medicaid.utah.gov/, click on Healthcare Providers, Medicaid Pharmacy Program.

23-68 Definitive Drug Testing Update

The Centers for Medicare and Medicaid Services (CMS) will implement a new replacement file that will go into effect on October 1, 2023. The replacement file will be effective for July 1, 2023. The National Correct Coding Initiative (NCCI) issued the following statement in regards to that update:

> Effective July 1, 2023, CMS implemented NCCI PTP edits between Column One codes 80305, 80306, and 80307 for presumptive test(s), and Column Two codes G0480 – G0483, and G0659 for definitive test(s). Currently, these edits cannot be bypassed using an NCCI modifier; however, CMS will change these edits to a CCMI of 1, which will allow for the use of a modifier to bypass the edits in those circumstances when billing these codes together is allowable. This change to allow the use of a modifier will be retroactive to July 1, 2023, and will be implemented in the next quarterly update effective on October 1, 2023.

In accordance with the changes made to the NCCI tables, providers are required to report the allowable modifier to definitive urine drug test CPT codes when reporting a presumptive urine drug test CPT code on the same date of service. The modifiers that have been approved are:

- 59 - Distinct Procedural Service
- XE - Separate Encounter, a service that is distinct because it occurred during a separate encounter
- XP - Separate Structure, a service that is distinct because it was performed on a separate organ/structure
- XS - Separate Practitioner, a service that is distinct because it was performed by a different practitioner

- XU - Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service

MLN 1783722 was issued in March of 2023 as an educational tool by CMS for guidance on how these modifiers should be used.

23-69 Laboratory Services – Urine Drug Testing (UDT)

Providers may submit claims for urine drug testing (UDT) using a singular NPI. Each facility location performing and reporting laboratory services requires its own Clinical Laboratory Improvement Amendments (CLIA) certification number. UDT performed by the same organization at one location cannot be reported using another location's CLIA certification number.

Effective July 1, 2023, providers must append one of the appropriate modifiers to the definitive UDT when a presumptive UDT is performed on the same date of service. These modifiers include 59, XE, XP, XS, and XU. The Centers for Medicare and Medicaid Services (CMS) has published guidance regarding the Proper Use of Modifiers 59, XE, XP, XS, and XU.

Claims submitted without the appropriate modifier will be denied in accordance with NCCI PTP editing.

For additional information related to Utah Medicaid laboratory policies, providers may reference Chapter 8-12 Laboratory Services, of the Physician Services Provider Manual.

23-70 Medicaid Ordering, Referring, and Prescribing Update

Under the 21st Century Cures Act, state Medicaid agencies must require all ordering, referring, and prescribing (ORP) providers to enroll with the state Medicaid agency as a Medicaid provider.

In addition, certain Medicaid providers, such as home health, DME, and others, are required to include an ordering/referring provider NPI on their claim to Medicaid. If the ORP NPI is not included and/or is not enrolled with Medicaid, states are required to deny the billing provider's claim.

On April 14, 2023, Utah Medicaid worked with our federal partners to use temporary authority granted to the State of Utah under the public health emergency to waive this requirement until September 1, 2023. The PRISM system disabled the ORP edits, which allowed ORP providers additional time to submit their enrollment before the editing was enabled.

The temporary extension did not exempt providers from federal compliance.

Beginning September 1, 2023, all ORP editing will be enabled to enforce the federal requirement. Claims with dates of service between April 3, 2023 - August 31, 2023 will be reprocessed and ORP claim editing will apply. Please note this may result in the recoupment of overpayments to those providers who are not in compliance. Utah Accountable Care Organizations (ACO's) are also required to comply with these federal regulations.

Utah Medicaid published the following documents in an effort to notify providers and ACO's of the federal requirement and the temporary waiver:
MIB Article
ORP Notice

Additionally, Utah Medicaid granted an interim extension between April 3, 2023 - October 5, 2023 for providers requesting retro-enrollment. Beginning October 6, 2023, Utah Medicaid will go back to the previous retro-enrollment process of up to 120 days. Publication and guidance on the retro-enrollment extension can be found here: Retro Enrollment.

We encourage everyone to share this information to avoid any disruption in services to members or payment to providers when the waiver of this requirement is lifted on September 1, 2023.

23-71 FQHC Preventative Dental Services

Beginning April 1, 2023, preventative dental services will be a covered benefit for Federally Qualified Health Centers (FQHC). The Rural Health Centers and Federally Qualified Health Centers Services Provider Manual, Chapter 9-1 Non-Covered Services, will be modified to remove preventative dental services from the list of non-covered services for FQHCs.

In addition, the following preventative dental service CDT codes will be open for coverage for Provider Allowable Code (PAC) 066 – Federally Qualified Health Center (FQHC) in PRISM:

D1110 Prophylaxis – adult
D1120 Prophylaxis – child
D1206 Topical fluoride varnish
D1351 Sealant - per tooth
D1354 SDF treatment
D1510 Space maintainer - fixed, unilateral - per quadrant
D1516 Space maintainer - fixed - bilateral, maxillary
D1517 Space maintainer - fixed - bilateral, mandibular
D1520 Space maintainer – removable, unilateral – per quadrant
D1526 Space maintainer – removable, bilateral – maxillary
D1527 Space maintainer – removable, bilateral – mandibular
D1551 Re-cement or re-bond bilateral space maintainer – maxillary
D1552 Re-cement or re-bond bilateral space maintainer – mandibular
D1553 Re-cement or re-bond bilateral space maintainer – per quadrant
D1575 Distal shoe space maintainer - fixed, unilateral - per quadrant

FQHC providers that have denied claims for preventative dental services since PRISM go-live may resubmit these claims for reprocessing. For additional policy information for preventative dental services, reference the Coverage and Reimbursement Code Lookup Tool.

23-72 Well Child Visit Tracking Card

The Accountable Care Organization (ACO) health plans in collaboration with DHHS have created a well child visit tracking card. Health plans will begin distributing these cards to Medicaid members later this year. A printable copy of the card is located on the DHHS Website. Providers can download this card for in-office use.

The American Academy of Pediatrics (AAP) recommends children receive eleven (11) well child check-ups by the time they reach 3 years old. Following the recommended schedule of visits helps keep children's immunizations up to date, makes sure important milestones are met, and ensures that developmental screenings are completed.