SECTION I

GENERAL INFORMATION

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1 General Information

1-1 Utah Medicaid Provider Manual

The Utah Medicaid Program pays medical bills for people who have low incomes or cannot afford the cost of health care and who are found eligible for the program. The program is based on a medical need. The Utah Medicaid program is administered by the Utah Department of Health and Human Services, Division of Integrated Healthcare. The Utah Medicaid Provider Manual contains the coverage policy for the fee-for-service Medicaid Program. The manual consists of several distinct sections, attachments, and periodic published updates as described below.

- **Section 1** - General information applicable to all providers. It provides general information about the Utah Medicaid Program to assist enrolled providers with submitting claims for services rendered to Utah Medicaid members. Section 1 contains information common to all provider types, including eligibility, covered services, provider enrollment, and participation guidelines.
- **Section 2** - Consists of multiple sections (also called manuals) that address coverage specific to a provider or service type (e.g., dental services, home health services, physician services, hospital services, etc.).
- **Section 3, 4**, etc. - Some Section 2 manuals have subsections numbered 3, 4, etc. For example, Section 3, Anesthesia Services is a subsection of Section 2, Physician Services).
- **Attachments** - May contain information that is specific to the Section to which it is attached or an attachment is intended for general use and thus is found in General Attachments. Attachments often contain information that may change frequently. Forms are an additional type of attachment.
- **Medicaid Information Bulletin (MIB)** - The MIB is Utah Medicaid's official means for notifying providers of updates to manuals, policy changes, etc.

Note: An electronic version of the provider manual as well as other Medicaid information, is found on the Medicaid website https://medicaid.utah.gov.

Section 1 of the provider manual provides general information about the Utah Medicaid Program to assist enrolled providers with submitting claims for services rendered to Utah Medicaid members. Use Section 1 in conjunction with the other more specific provider manual sections, attachments and forms. Providers and their staff should familiarize themselves with these documents and refer to them to answer program and billing questions. This will reduce misunderstandings concerning the coverage of services, member eligibility, and proper billing procedures, which can result in payment delays, incorrect payments, or payment denials.

The information in the Utah Medicaid Provider Manual represents available services when medically necessary. Each Section outlines covered services as well as limitations. At times services may be more limited or may be expanded, using the utilization review process, if a proposed service is medically necessary and more cost effective than alternate services.

1-1.1 Manual Maintenance

Utah Medicaid makes every attempt to ensure that the information contained in each section of the manual is current and reliable. The contents of the Utah Medicaid Provider Manual are updated regularly. Sections with changes are published and a report of the changes is published in the Medicaid Information Bulletin (MIB) quarterly. The MIB is emailed to enrolled providers who subscribe to the Medicaid newsletter. To receive the newsletter, sign up on the "Utah Medicaid Official Publications" page at the Medicaid website. For additional information on obtaining updated information, refer to the Utah Medicaid website, https://medicaid.utah.gov, or contact medicaidops@utah.gov.

Payment for services is made in accordance with the policy and fee schedule in effect at the time services are rendered. The provider rendering services is responsible to be aware of and comply with the policies and procedures in the Utah Medicaid Provider Manual, the MIBs, the Coverage and Reimbursement Lookup Tool, and applicable policies and procedures of managed care plans.

Compliance with all applicable Utah state laws, regulations, and administrative guidelines is required of all providers. In particular, providers must adhere to the Utah Administrative Code R414-1, Utah Medicaid Program, which generally describes the Medicaid program. This rule incorporates by reference the Utah Medicaid Provider Manual. Therefore, you must consider the content of the provider manuals along with applicable federal and state laws and regulations. If you have questions or need further information, refer to the Medicaid website, or contact Medicaid (Refer to this *Chapter, Medicaid Contact Information*).

1-1.2 Statewide Provider Training

Annually a statewide provider training is offered. The training covers significant changes in Medicaid and other topics of concern to the provider as well as question and answer time. Refer to the Utah Medicaid website for dates https://medicaid.utah.gov.

1-2 Overview of the Medicaid Program

Utah Medicaid is a public assistance program providing medical services to individuals meeting certain income, resource, and eligibility criteria. Established by Title XIX of the Social Security Act, it is

administered by the State of Utah and financed jointly by state and federal funds. At the federal level, the program is administered by the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services, which provides funding to the states, establishes minimal program requirements, and provides regulatory oversight. Federal guidelines are designed to ensure the states administering Medicaid programs provide appropriate, medically necessary quality health care services for all members, while maintaining financial accountability. State funds are appropriated by the Utah Legislature. Utah's Medicaid program is administered by the Utah Department of Health and Human Services, Division of Integrated Healthcare, which is the single state agency responsible for administering the program.

Each state establishes and administers its own Medicaid program, and determines the type, amount, duration and scope of services covered within broad federal guidelines. States must cover certain mandatory benefits and may choose to provide other optional benefits. Federal law requires states to cover certain mandatory eligibility groups, including qualified parents, children and pregnant women with low income, as well as older adults and people with disabilities with low income.

Utah Medicaid establishes eligibility standards for Medicaid providers, determines benefits, sets payment rates, and reimburses providers. Medicaid maintains the State Plan and files amendments to the plan (state plan amendments, or SPA) with appropriate regulatory authorities.

On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan will end, and members formerly enrolled in the NTM plan will have the same benefits as the Traditional benefit plan starting on January 1, 2024. Information regarding NTM services will remain in the Utah Medicaid Provider Manuals until January 1, 2025, for reporting and eligibility purposes.

1-3 Application for Medicaid

Although this Section does not cover in detail, policies to determine if an individual is eligible for Medicaid, the following information provides a general summary of the member application process, a description of the member guide, and how to access to Medicaid constituent services which may be useful information for providers.

Individuals seeking assistance for payment for medical services may apply on-line at https://medicaid.utah.gov/apply-medicaid. Medicaid applications are available in English and Spanish. Application may also be made through the Department of Workforce Services (DWS) or outreach offices in most major hospitals and many area public health clinics. Call DWS Customer Relations at (801) 526-0950 or 1(866) 435-7414, or to find a local outreach office, go to http://jobs.utah.gov. The DWS offices also assist individuals who are seeking other types of assistance, including food stamps, financial assistance, and childcare assistance.

Individuals needing assistance with the application process may call the above DWS Customer Relations number. For additional information on applying for Medicaid, refer to the Medicaid website, https://medicaid.utah.gov.

1-4 Medicaid Contact Information

Internet

The Medicaid website address is https://medicaid.utah.gov.

Telephone - Medicaid Information:

Salt Lake City area.. (801) 538-6155

Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, and Nevada

(toll-free) ....1(800) 662-9651

From other states...1(801) 538-6155

Medicaid Information has a telephone menu to reduce waiting time and the number of transfers for Medicaid providers and members.

Customer service representatives are available:

Monday, Wednesday, Thursday, Friday..............................8:00 A.M. to 5:00 P.M.

Tuesday..11:00 A.M. to 5:00 P.M.
Closed on all state and federal holidays.

FAX Numbers

Each Medicaid team has its own FAX line in order to provide better customer service. These FAX numbers are found in the *General Attachments* section of the provider manuals.

Mailing Address

Office of Medicaid Operations
PO Box 143106
Salt Lake City, Utah 84114-3106

Street Address

Department of Health and Human Services
288 North 1460 West
Salt Lake City, Utah 84114

Note: The Department of Health and Human Services (the Martha Hughes Cannon Building) is a secure building. Public access is restricted to the lobby area, cafeteria, Vital Records, and a designated conference room, all located on the first floor. Access to other areas of the building requires an employee escort. State and Federal privacy laws do not permit staff at the Martha Hughes Cannon Building's information desk, or any other reception desk in the building, to handle Medicaid claims.

1-5 Medicaid Member Guide

The information booklet, "Medicaid Member Guide," is mailed to all new members. The guide explains the Medicaid program including rights and responsibilities, selection of a health care provider, and health care services covered by Medicaid. The Medicaid Member Guide may also be obtained by calling 1(866) 608-9422 or on the Medicaid website at http://health.utah.gov/umb/forms/pdf/Medicaid_Member_Guide.pdf. The guide can be read, printed, or saved from this screen.

1-6 Medicaid Member Card

The Division of Integrated Healthcare issues a wallet-sized plastic Medicaid Member Card to members eligible for Traditional Medicaid, Baby Your Baby, or Hospital Presumptive Eligibility. The card is the same for each program. Possession of the card does not guarantee a member's eligibility for any of these programs. It is the provider's responsibility to use the information on the card to verify program and eligibility information.

The Medicaid Member Card has the member's name, Medicaid ID number, and date of birth. The back of the card has contact information and websites useful to both providers and members. The member must present the card with a photo identification at each service.

To view a sample Medicaid Member Card, go to:
https://medicaid.utah.gov/Documents/pdfs/Medicaidcard_FINAL_sample%20(1).pdf

Medicaid members also receive a benefit letter in the mail. The letter has eligibility and plan information. When there are changes, Medicaid sends a new benefit letter.

A member's eligibility for Medicaid, Baby Your Baby, or Hospital Presumptive Eligibility may change from month to month. Additionally, most Medicaid members are enrolled in a managed care organization to receive their services. Before providing services to a Medicaid member, providers are responsible for determining a member's eligibility and whether the member is enrolled in an MCO. Eligibility and plan enrollment information for each member is available to providers from these sources: Eligibility Lookup Tool, or ANSI 270 or ANSI 271. Refer to *Chapter 6, Member Eligibility* for additional information and links.

1-7 Fee-for-Service and Managed Care

The Medicaid Provider Manual contains information regarding Medicaid policy and procedures for fee-for-service Medicaid members. Managed Care Organizations (MCO) must provide the services outlined in the applicable Sections as well as the applicable services described in the Utah Medicaid State Plan. However, MCOs may have different prior authorization requirements and post-payment review requirements. Providers who render services to members enrolled in MCOs should contact the MCO or refer to the MCO's manual for additional information. If a Medicaid member is enrolled in an MCO, they must receive services through that MCO.

At times there are exceptions to MCO coverage. Service exceptions are called "carve-out services," which may be billed directly to Medicaid on a fee-for-service basis. Medicaid will deny fee-for-service claims submitted directly to the DIH, unless payment for the service is not the responsibility of the MCO. In such cases the claim is considered for payment under the requirements found in this and other applicable Sections.

To determine if a member is enrolled in an MCO, or if services may be billed to DIH on a fee-for-service basis, providers must verify member eligibility using one of the following tools: Eligibility Lookup Tool, or ANSI 270 or ANSI 271, an online service, for providers enrolled in the Utah Health Information Network (UHIN). Refer to *Chapter 6, Member Eligibility* for links and more information or go to the Medicaid website, https://medicaid.utah.gov/.

Medicaid members not enrolled in an MCO and not enrolled in DIH's Restriction Program, may receive services from any qualified provider who accepts Medicaid.

1-8 Constituent Services

For general member concerns, contact the Utah Department of Health and Human Services, Division of Integrated Healthcare, Constituent Services representative at medicaidmemberfeedback@utah.gov or (801) 538-6417 or toll free at 1(877) 291-5583.

For concerns related to a managed care organization, contact the MCO first. If the concern is unresolved, contact a state DIH Health Program Representative at 1(866) 608-9422.

1-9 Definitions

Following is a list of definitions relevant to the administration, policies, and procedures of the Utah Medicaid Program:

Accountable Care Organization (ACO): A physical health plan that contracts with Utah Medicaid to provide services to Medicaid clients.

Assigned Claim: A claim for which the provider accepts the Medicare assignment of payment.

Assistant to Surgery: A physician or non-physician practitioner who actively assists the physician in charge of a case in performing a surgical procedure.

Accredited Standards Committee (ASC X12): An ANSI accredited standards organization responsible for the development and maintenance of electronic data interchange (EDI) standards for many industries. The "X12" or insurance section of ASC X12 handles the EDI for the health insurance industry's administrative transactions. Under HIPAA, X12 standards have been adopted for most of the transactions between health plans and providers.

Baby Your Baby (BYB): This program provides temporary Medicaid coverage for qualified low-income pregnant women prior to establishing eligibility for ongoing Medicaid. Members apply for the program through a qualified BYB provider and qualify based on preliminary information provided on the BYB application.

Carve-out Service: Services *not* included in the Medicaid contract with an MCO (ACO, PMHP or dental plan.)

Clinical Laboratory Improvement Amendments (CLIA): The federal Centers for Medicare & Medicaid Services (CMS) program which limits reimbursement for laboratory services based on the equipment and capability of the physician or laboratory to provide an appropriate, competent level of laboratory service.

Code of Federal Regulations (CFR): The publication by the Office of the Federal Register, specifically Title 42, used to govern the administration of the Medicaid program. Federal rules promulgated by the Centers for Medicare & Medicaid Services (CMS) place requirements upon the state Medicaid agency, Medicaid providers, and recipients.

Covered Medicaid Service: Service available to an eligible Medicaid member within the constraints of the Utah Medicaid Program and criteria for approval of service.

Current Procedural Terminology Manual (CPT)**:** The manual published by the American Medical Association that provides a systematic listing and coding of procedures and services performed by physicians and simplifies the reporting of services to third party payers.

Diagnosis Related Group (DRG): The system established to recognize and reimburse for the resources used to treat a client with a specific diagnosis or medical need. The Federal DRG relative weight, average length of stay (ALOS), and outlier threshold days are extracted from Utah Medicaid paid claims history files or from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS).

Division of Integrated Healthcare (DIH): The organizational division in the Utah Department of Health and Human Services which administers the Medicaid program in Utah.

Early Periodic Screening Diagnosis and Treatment (**EPSDT**)**:** The federal preventive health care services program for children, formally known as the Child Health Evaluation and Care (CHEC) Program. (For Medicaid members enrolled in Traditional Medicaid ages birth through twenty.)

Enrolled Provider: A licensed practitioner of the healing arts or an entity providing approved Medicaid services to patients under a provider agreement with the Department.

Explanation of Benefits (EOB): The form sent by a liable third party to a provider to explain whether a claim is paid and the amount paid or denied and the reason denied.

Explanation of Medicare Benefits (**EOMB**)**:** The form received by the provider from Medicare to explain whether a claim is paid, the amount paid, or denied and the reason denied.

Federal Financial Participation (FFP): The Medicaid program is funded jointly by the federal government and the state. FFP is the specified percentage the federal government pays the state for Medicaid program expenditure.

Federal Poverty Level (FPL): The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter, and other necessities. This level varies by household size. FPLs are used to determine financial eligibility for certain federal programs. The guidelines are issued each year in the Federal Register by the Department of Health and Human Services (HHS). The Federal Poverty Level is available on the Internet at http://aspe.hhs.gov/poverty/index.shtml.

Fee-for-Service: Medicaid covered services that are billed directly to and paid for directly by Medicaid based on an established fee schedule.

Fee-for-Service Medicaid Member: A member who is not enrolled in an MCO; or is enrolled in an MCO, but the service that is needed is a carve-out service covered directly by Medicaid.

Fraud: Refer to “Medicaid Fraud.”

Healthcare Common Procedure Coding System (HCPCS): The system mandated by the Centers for Medicare & Medicaid Services (CMS) to code procedures and services. This system incorporates the CPT Manual for physicians and individually developed service codes and definitions for non-physician providers.

Hospital Presumptive Eligibility (HPE): The program provides temporary Medicaid coverage for qualified low-income individuals prior to establishing eligibility for ongoing Medicaid. Members apply for this program through a qualified hospital provider and qualify based on preliminary information provided on the application.

Intermediary: An entity which contracts with Centers for Medicare & Medicaid Services (CMS) to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis and to perform other related functions.

International Classification of Diseases (ICD): The source for coding the diagnosis for which a patient is being treated.

Limited Enrollment Provider: Providers who wish only to order, refer, or prescribe and not provide any other services to Medicaid members. This type of enrollment does not allow Medicaid to reimburse the provider for services.

Managed Care Organization (MCO): For the purposes of this manual, means a health, behavioral health or dental plan that contracts with the Medicaid agency to provide services to Medicaid members and attempts to control the cost and quality of care by coordinating services. MCO is sometimes used as a generic term to mean an ACO, PMHP and/or dental plan.

Medicaid: The medical assistance program authorized under Title XIX of the Social Security Act.

Medicaid Agency: The Utah Department of Health and Human Services, Division of Integrated Healthcare.

Medicaid Audit: A civil or administrative process of reviewing Medicaid provider records to ensure accurate billing and payment for Medicaid claims.

Medicaid Fraud: Knowingly, recklessly, or intentionally presenting false information to the Medicaid agency with the intent to receive unauthorized Medicaid benefit for any person or entity. Refer to Utah Code Ann. §26-20-1, et seq. Some examples of fraud include: knowingly or intentionally billing Medicaid for services that were not provided, making a materially false statement in connection with any claim for payment to the Medicaid program, accepting kickbacks or bribes for referrals or services.

Medicaid Fraud Control Unit (MFCU): The official state Medicaid fraud control unit in the Utah Office of the Attorney General, certified by the federal government, to investigate and prosecute complaints of abuse and neglect of patients, and Medicaid fraud under state laws as required by 42 CFR 1007.7 through 1007.13. The MFCU has statewide prosecutorial authority.

Medicaid Information Bulletins (MIB): An official, periodic publication of the Division of Integrated Healthcare to update the Utah Medicaid Provider Manual or issue information to Medicaid providers.

Office of Inspector General: This office, like the MFCU mentioned above, also addresses issues related to fraud, utilization control, audits, and investigations, but is part of the Office of Inspector General.

Medicaid Provider Agreement: A signed contract between a provider and the Utah Medicaid program by which the provider agrees to abide by all state and federal law related to the Medicaid Program, including providing medical and billing records for the purposes of conducting Medicaid and MFCU audits to determine fraud or abuse of the Medicaid program. The provider also agrees to abide by any subsequent amendments to the Agreement published in the Medicaid Information Bulletin. This agreement, together with the recipient's Medicaid application, authorizes the release of Medicaid records for Medicaid and MFCU auditing purposes.

Medical Necessity: A service is "medically necessary" if it is (1) reasonably calculated to prevent, diagnose, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a disability; and (2) there is no other equally effective course of treatment available or suitable for the client requesting the service which is more conservative or substantially less costly. (R414-1-2 (18))

Medicare: The national health insurance program for aged and disabled persons under Title XVIII of the Social Security Act. Part A includes hospital and nursing home services. Part B pays professional fees, such as physicians, physical therapy, etc.

Member: The preferred term to refer to a person who is eligible for the Utah Medicaid Program. "Member" is often used interchangeably with "client," "recipient," "patient," or "enrollee" when the person is eligible for the Utah Medicaid Program.

Non-Physician Practitioner: A non-physician practitioner is a healthcare provider practicing either in collaboration with or under the supervision of a physician, including physician assistants and nurse practitioners.

Non-Traditional Medicaid (NTM): A medical plan based on the Traditional Medicaid Plan but additional limitations and/or restrictions are imposed, under a waiver of federal regulations, on benefits and services of Traditional Medicaid as covered by the Medicaid State Plan. Members eligible for NTM includes: adults on Family Medicaid programs (adults with dependent children) and adult caretaker relatives on Family Medicaid. Services are based on the program type a person is eligible to receive. For

services covered under NTM please refer to the Administrative Rule UT Admin Code R414-200. Non-Traditional Medicaid Health Plan Services and the Coverage and Reimbursement Code Lookup. (**Note**: On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan will end, and members formerly enrolled in the NTM plan will have the same benefits as the Traditional benefit plan starting on January 1, 2024. Information regarding NTM services will remain in the Utah Medicaid Provider Manuals until January 1, 2025, for reporting and eligibility purposes.)

Nurse Practitioner: A nurse practitioner (NP) is an individual who performs professional services within their scope of licensing, under Utah Code, Title 58: Occupations and Professions, Chapter 31b: Nurse Practice Act.

Overpayment: Refer to "Provider Overpayment."

Patient: An individual awaiting or receiving professional services directed by a licensed practitioner of the healing arts, also referred to as a Medicaid member or member.

Physician: A doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the state.

Physician Assistant: A physician assistant (PA) is an individual who performs professional services within their scope of licensing, under Utah Code, Title 58: Occupations and Professions, Chapter 70a: Utah Physician Assistant Act.

Prepaid Mental Health Plan (PMHP): The Medicaid mental and substance use disorder managed care plan operating under the authority of the Department's 1915(b) waiver.

Presumptive Eligibility: Provides temporary Medicaid coverage for qualified low-income individuals prior to establishing eligibility for ongoing Medicaid. Presumptive eligibility programs include the Baby Your Baby program and the Hospital Presumptive Eligibility program.

Prior Authorization (PA): Required approval obtained by a health care provider from Medicaid (the Division of Integrated Healthcare, Department of Health and Human Services) or from an MCO, if applicable before certain services are rendered.

Provider: An entity or licensed practitioner of the healing arts furnishing medical, mental health, dental or pharmacy services.

Provider Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices resulting in unnecessary Medicaid costs. Reimbursement for services that are not medically necessary, failure to meet professionally recognized standards of care, or any similar practice that results in increased costs to Medicaid are also considered abuse. Criminal intent need not be alleged nor proved to establish abuse.

Provider Agreement: Refer to “Medicaid Provider Agreement.”

Provider Overpayment: An overpayment occurs when a Medicaid provider receives more Medicaid reimbursement than the provider is entitled, regardless of which party is at fault.

Qualified Healthcare Professional (QHP): An individual who by way of education, training, and licensure performs a professional service within their scope of practice and independently reports that professional service.

Recipient: A person who is eligible for the Utah Medicaid Program and eligible to receive covered Medicaid services from an enrolled Medicaid provider also known as a member.

Reimbursement: An established amount of money paid to a provider in exchange for a specifically defined and coded service provided to a Medicaid client.

Remittance Statement: The explanation from Medicaid as to claims which have been paid, denied or are in process.

Restricted Member: A Medicaid member who is enrolled in the Restriction Program due to unnecessary overutilization of their Medicaid Benefit. Restricted members are locked-in to one Primary Care Provider (PCP) who can authorize specialty providers as needed and are also locked-in to one pharmacy.

Restriction Program: Provides safeguards against inappropriate and excessive use of Medicaid services.

Services: The types of medical assistance specified in Sections 1905(a)(1) through (25) of the Social Security Act and interpreted in 42 CFR §440 [October 1, 1996, edition].

Single State Agency: The agency which administers the Medicaid program in the State of Utah is the Utah Department of Health and Human Services, Division of Integrated Healthcare.

Third Party Liability (TPL): The responsibility of an individual, entity, or program which is or may be liable to pay all or part of the medical cost of injury, disease, or disability of a patient.

Title XIX: The Medicaid Program authorized by the Federal Social Security Act.

Traditional Medicaid: A medical plan that will pay for many medical services for eligible individuals. Individuals eligible for Traditional Medicaid include: children; pregnant women; aged, blind or disabled adults; women eligible under the cancer program. Some services are available only to children and to pregnant women under Traditional Medicaid.

Utah Department of Health and Human Services: The single state agency designated to administer or supervise the administration of the Medicaid Program under Title XIX of the federal Social Security Act. All references to "the Medicaid agency" mean the Department of Health and Human Services. Reference: Utah Code Annotated §26-18-2.1 (1953, as amended) and Utah Administrative Code, Rule R414-1-2.

Utah Health Information Network (UHIN): (1) a coalition of insurers, providers, the Utah Medical Association, the Utah Hospital Association, and State Government which developed an electronic data exchange to centralize transactions for providers and payers, including Medicaid. (2) The electronic data exchange, also referred to as UHIN or the UHIN network.

Year: Any 12-month period of time unless specified as a calendar year.

2 Managed Care Entities

This section provides summary information about Utah Medicaid managed care; types of managed care entities (MCEs); member enrollment and disenrollment; services covered and not covered by MCEs; and grievances and appeals related to MCEs.

Managed care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid benefits through contract arrangements between the Division of Integrated Healthcare (DIH) and MCEs. DIH contracts with MCEs to provide physical health care, behavioral health care (mental health and substance use disorders), dental care, and pharmacy services for Medicaid members. DIH pays a monthly premium for each Medicaid member enrolled in the MCE. The MCEs are responsible for the services specified in their contracts with DIH.

The following types of MCEs provide services to Utah Medicaid managed care enrollees:

- Accountable Care Organizations (ACOs) that cover physical health care and some pharmaceutical services
- Prepaid Mental Health Plans (PMHPs) that cover behavioral health services
- Healthy Outcomes Medical Excellence (HOME) that covers both physical and behavioral health services
- Dental plans that cover dental services

Medicaid members enrolled in MCEs are entitled to the same Medicaid benefits as Fee-for-Service Members. However, MCEs may offer additional benefits and may have different prior authorization requirements than the Medicaid Fee-for-Service scope of benefits. A Medicaid member enrolled in an MCE must receive services through that MCE, with some exceptions called “carve-out services”. The MCE pays providers for services covered under the MCE’s contract. DIH pays providers for services that are carved out of MCE contracts.

2-1 Member Enrollment in MCEs

Specific Medicaid members are required to enroll in two of the types of MCEs (ACOs and dental plans). If the member lives in one of the counties in which enrollment is mandatory, the member must choose an ACO or dental plan, or both.

Enrollment in a PMHP is based on the county in which the member resides. Members do not choose a PMHP but are automatically enrolled with the PMHP(s) serving their county of residence. Members must receive behavioral services through their assigned PMHPs.

HOME is a voluntary program and therefore, members may choose to enroll in HOME if they meet certain criteria.

Health Program Representatives (HPRs) employed by DIH educate members on the Utah Medicaid Program, managed care, the ACO and dental MCE options, and the PMHP. In addition, the HPRs help members choose an ACO and dental plan. HPRs are resources for members and providers who may have issues related to MCEs.

2-2 Members Not Enrolled in MCEs

The following Medicaid members are not enrolled in MCEs:

- Members with presumptive eligibility
- Most Medicaid Expansion members
- Residents of the Utah State Developmental Center
- Residents of the Utah State Hospital
- Targeted Adult Medicaid (TAM) members

2-3 Member Eligibility Verification

Medicaid makes every effort to provide complete and accurate information regarding a member's enrollment in an MCE. However, it is the provider's responsibility to verify a member's eligibility and service delivery model (MCE or Fee-for-Service) before providing services. Eligibility for Medicaid and enrollment in an MCE may change from month to month.

To determine if a Medicaid member is enrolled in an MCE or is a Fee-for-Service member, providers may verify member eligibility using the provider Eligibility Lookup Tool, or ANSI 270/271.

- Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility

2-4 Authorization for MCE Services and Claims Filing

Each MCE is responsible to determine which services require prior authorization and the process providers must use to request authorization of services for Medicaid members enrolled in the MCE. DIH does not process prior authorization requests for services to be provided to a Medicaid member enrolled in an MCE when the services are the responsibility of the MCE. Providers requesting prior authorization from DIH for MCE-covered services for a member enrolled in an MCE will be referred to that MCE.

Each MCE has its own network of providers. Depending on the type of MCE and services that are covered, provider networks can include but are not limited to clinics, hospitals, physicians, dentists, and pharmacies. If a provider wishes to enroll with a specific MCE network, the provider must contact the MCE directly.

Claims for services covered by an MCE must be submitted to the MCE in which the member is enrolled using the methods established by the MCE.

2-5 Changing ACO or Dental MCEs

Once per year, between mid-May and mid-June, Medicaid has an open enrollment period during which Medicaid members can change to a different ACO or dental plan effective July 1st of the year. Medicaid members are also allowed to change their ACO or dental plan during the first 90 days after an MCE is chosen or has been assigned. Medicaid members who want to change their ACO or dental plan selection should contact an HPR toll-free at 1-866-608-9422.

Members enrolled in the Medicaid Restriction Program are not eligible to change to a different ACO, including within the ACO open enrollment period. For complete information on the Restriction Program, refer to Chapter 8-3 (Medicaid Restriction Program).

2-5.1 Transition of Care

If a member's enrollment is changed to a different MCEs or Fee-for-Service, approved prior authorizations for medical care from the previous MCE will be honored for the member until:

- A prior authorization (PA) has been evaluated for medical necessity of the service and the MCE has made a determination that the PA is no longer medically necessary; or
- The member is discharged from an inpatient hospital setting.

When a provider receives a PA, the provider must submit the associated claim for the authorized service to the entity that issued the PA (i.e., ACO, PMHP, HOME, dental plan, or DIH).

2-6 MCE Carve-Out Services

If a Medicaid member is enrolled in an MCE, DIH will not pay a claim unless it is for a carve-out service. A carve-out service is a service that is covered by Medicaid but not covered by an MCE. Services that are carved out from an MCE differ depending upon the type of MCE.

Listed below are carve-out services that are not covered by any of the MCEs. These services are paid by DIH:

- Apnea monitors
- Autism Spectrum Disorder services
- Chiropractic services
- Early Intervention Services
- Emergency and non-emergency transportation*
- Evaluations and psychological testing performed for physical health purposes, including prior to medical procedures, or for the purpose of diagnosing intellectual or developmental disabilities, or organic disorders
- Facility charges for dental services performed at a hospital or ambulatory surgical center
- Fertility preservation
- Genetic carrier screening
- Hemophilia disease management waiver services
- Home and Community-Based Waiver Services
- In vitro fertilization
- Methadone administration services
- Pharmaceutical drugs as follows:

  - Antianxiety
  - Anticonvulsant
  - Antidepressant
  - Antipsychotic
  - Attention deficit hyperactivity disorder stimulant
  - Hemophilia
  - Substance use disorder
  - Transplant immunosuppressive
- Services at the University of Utah School of Dentistry for adults who are eligible for Medicaid due to a disability or blindness
- Services performed at the Utah State Hospital or the Utah State Developmental Center
- Services performed by a provider or facility enrolled as Utah Provider Type 91 - Indian Health Services

*ACOs, PMHPs or HOME may be responsible for transportation in some situations. Contact the MCE to determine responsibility for coverage.

2-7 Accountable Care Organizations

DIH contracts with four ACOs: Health Choice Utah, Healthy U, Molina Healthcare, and SelectHealth Community Care. Not all ACOs are available in every county. There are from two to four ACOs available in each county.

Medicaid requires most Medicaid members living in the following counties to enroll with an ACO: Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber.

In addition to the Medicaid members listed in the *Members Not Enrolled in MCEs* section above, members who are admitted to a skilled nursing facility, intermediate care facility or a Long-Term Acute Care Hospital for a long term stay (i.e., a stay intended to last more than 30 days) will be disenrolled from the ACO. Disenrollment due to a long-term stay requires notification to DHMF. In addition, Medicaid members enrolled in Utah's Buyout Program do not have to enroll in an ACO.

Other than the excluded members above, when determined eligible for Medicaid, a member residing in one of the counties specified above must select an ACO.

ACOs cover most Medicaid-covered services with the exception of behavioral health and dental. In addition, the ACOs do not cover the carve-out services listed in the *MCE Carve-Out Services* section above.

Members enrolled in an ACO may need to be in the Restriction Program due to possible abuse or misuse of Medicaid services. A member enrolled in the Restriction Program must receive services provided by one PCP and one pharmacy, unless otherwise authorized by the PCP.

Referrals for possible enrollment in the Restriction Program may be submitted to medicaidrestriction@utah.gov or 801-538-9045 or to the ACO in which the member is enrolled. For complete information on the Restriction Program, refer to Chapter 8-3 (Medicaid Restriction Program).

2-8 Prepaid Mental Health Plans

DIH contracts with local county mental health and substance abuse authorities or their designated entities (as PMHPs) to provide inpatient hospital psychiatric services and outpatient mental health and outpatient substance use disorder services to Medicaid members.

The PMHPs cover most counties of the state. Medicaid members are automatically enrolled with the PMHP serving their county of residence. Members must receive inpatient and outpatient mental health services and outpatient substance use disorder services through their assigned PMHP.

In Box Elder, Cache and Rich counties, outpatient substance use disorder services are not covered under the PMHP. Medicaid members living in one of these counties may obtain outpatient substance use disorder services from any qualified Medicaid provider and providers may bill DIH. Medicaid members living in any of these counties are enrolled in the PMHP for mental health services, and must obtain their mental health services through the PMHP contractor serving these counties.

Wasatch County is not covered under the PMHP. Medicaid members living in Wasatch County may obtain mental health and substance use disorder services from any qualified Medicaid provider. Providers may bill DIH.

Exceptions to PMHP enrollment are:

- Medicaid members in state custody (foster care) are enrolled in the PMHP only for inpatient hospital psychiatric services. They are not enrolled in the PMHP for outpatient mental health and substance use disorder services. They may obtain these outpatient services from any qualified Medicaid provider. Providers may bill DIH.

- Medicaid members eligible for Medicaid under subsidized adoption may be disenrolled from the PMHP on a case-by-case basis for outpatient mental health and substance use disorder services. Once disenrolled, they remain enrolled in the PMHP only for inpatient hospital psychiatric services. They may obtain outpatient services from any qualified Medicaid provider. Providers may bill DIH.

- In some instances, individuals applying for Medicaid are given retroactive Medicaid eligibility. Although an individual's retroactive Medicaid eligibility may go back further than 12 months, PMHPs are financially responsible only for inpatient hospital psychiatric services, and outpatient mental health and substance use disorder services provided during the most recent 12 months of the individual's retroactive eligibility period. Providers must contact the PMHP contractor for payment of services provided during this 12-month time period.

PMHPs are responsible for inpatient hospital psychiatric services when they are performed on an inpatient basis under the direction of a physician for a psychiatric condition manifesting itself with a sudden onset. At the time of the inpatient admission, the psychiatric condition should be of such a nature as to pose a significant and immediate danger to self, others, or public safety, or which has resulted in marked psychosocial dysfunction or grave mental disability of the patient. PMHPs are also responsible for electroconvulsive therapy (ECT) and related charges.

PMHPs are not responsible for pharmacy services. In addition, the PMHPs do not cover the carve-out services listed in the *MCE Carve-Out Services* section above.

Medicaid members enrolled in the PMHP may get services directly from a federally qualified health center (FQHC). PMHP prior authorization is not required. FQHCs may bill DIH.

2-9 HOME

The Healthy Outcomes Medical Excellence program (HOME), operated by the University of Utah, is a voluntary MCE for Medicaid members who have a developmental disability and mental health or behavioral challenges.

HOME is a coordinated care program that provides services normally covered by the ACOs and the PMHPs. HOME is not responsible for pharmacy services. When Medicaid members enroll in HOME, they are disenrolled from their ACO and PMHP.

2-10 Dental Plans

Medicaid covers full dental services for the following Traditional Medicaid members who:

- Qualify for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT);
- Are pregnant;
- Qualify for Medicaid due to a disability or blindness.

DIH contracts with two dental plans, MCNA Dental and Premier Access, to deliver dental services.

Medicaid members who are eligible for full dental services are required to be enrolled in a dental plan except those eligible for the following Medicaid programs:

- Foster Care Medicaid
- Refugee Medicaid
- Nursing Home Medicaid

Dental plans cover most Medicaid dental services. General anesthesia performed at a hospital or ambulatory surgical center are carved out of the dental plans. Medical and surgical services of a dentist performed at a hospital or ambulatory surgical center are carved out of the dental plans. In addition, the dental plans do not cover the carve-out services listed in the *MCE Carve-Out Services* section above.

2-11 Emergency Services for Members in an MCE

All MCEs cover emergency services for members 24 hours a day, seven days a week whether or not the services are provided within the MCE's provider network.

2-12 Appeals Related to MCEs

When an MCE makes a decision that constitutes an adverse benefit determination, a member, provider, or an authorized representative, may request an appeal with the MCE. An appeal is a review by an MCE of an adverse benefit determination. Examples of MCE adverse benefit determinations are:

- The denial or limited authorization of a requested service

- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner

The timeline to request an appeal with the MCE is within 60 calendar days from the date on the notice of Adverse Benefit Determination. If the MCE's appeal resolution is not wholly in favor of the member, the member or provider may request a State fair hearing with DIH no later than 120 calendar days from the date of the MCE's notice of resolution. The hearing request form can be found at https://medicaid.utah.gov/utah-medicaid-forms.

Members, providers, or authorized representatives must exhaust the MCE's appeals process prior to requesting a State fair heating.

2-13 Grievances Related to MCEs

A grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Examples of grievance are:

- The quality of care or services provided by the MCE
- Aspects of interpersonal relationships such as rudeness of a provider or employee
- Failure to respect the member's rights regardless of whether remedial action is requested

Grievances may be filed with an MCE at any time by a member, provider, or authorized representative. A grievance should be submitted to the MCE. Aggrieved parties may also contact the DIH Constituent Services representative at medicaidmemberfeedback@utah.gov or 801-538-6417 or toll-free at 1-877-291-5583 to discuss the grievance.

3 Provider Participation and Requirements

This chapter covers topics such as provider agreement, co-payments, prohibition on billing clients, record keeping, provider sanctions, and audits.

There are general requirements which must be met for a provider to participate in the Medicaid Program. Any provider of health care services must be enrolled in the Utah Medicaid Program, will only render services within their scope of licensure, before Medicaid will cover any services provided by the provider to Medicaid members. Enrollment as a Medicaid provider is contingent upon the provider satisfying all rules and requirements for provider participation as specified in the applicable Section of this Provider Manual, and state and federal law. Section 2 of this manual, which comprises several individual manuals, contains additional requirements for each specific provider type. Medicaid can reimburse a provider who satisfies all credential requirements for each provider type, completes and signs the Utah Medicaid Provider agreement, and receives notice from the Utah Medicaid Program of acceptance.

Keep Medicaid informed of any address changes. Returned mail will result in your provider agreement being closed. Medicaid may close providers who have not billed Medicaid for one or more years without notification.

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.

3-2 Ineligibility of Provider

The Division of Integrated Healthcare may refuse to grant provider privileges to anyone who has been convicted of a criminal offense relating to that person's involvement in any program established under Titles XVIII, XIX, XXI or XX of the Social Security Act, or of a crime of such nature that, in the judgment of the Department, the participation of such provider would compromise the integrity of the Medicaid Program or put the clients at risk. The Division may terminate any provider from further participation in Medicaid if the provider fails to satisfy all applicable criteria for eligibility. Specific rules, including grounds for sanctions and termination, are found in Utah Administrative Code R414-22, and is discussed in *Chapter 5, Provider Sanctions*.

3-3 Civil Rights Compliance and Practice Capacity

When providing medical assistance under programs administered by the Utah Department of Health and Human Services, a provider must agree to provide services in accordance with Title VI of the Civil Rights Act as well as other federal provisions which prohibit discrimination based upon race, color, religion, national origin, disability, age, or gender.

A Utah Medicaid provider is under no obligation to accept all Medicaid members who seek care, and may limit the number of members accepted into the provider's practice. However, the limitation may not be based on prohibited discriminatory factors such as race, color, religion, national origin, disability, age, or sex. Restrictions to individual patient care, based upon the limits placed upon provider practice by specialty, and because of medically related determinations made within the scope of practice, are generally permissible. In addition, limitations are generally permissible if applicable to both Medicaid and non-Medicaid clients. Some grounds for denying or dismissing Medicaid clients include limiting the number or percentage of Medicaid clients, missed appointments, abusive behavior, and provider lack of training or experience. Providers may wish to consult their respective state licensing rules for definitions of standards of care for any additional limitations.

A provider should set up established business guidelines that delineate the limitations on accepting Medicaid members, and abide by those guidelines. Exceptions that would allow for accepting Medicaid clients outside the established guidelines would be acceptable as long as those exceptions did not violate the prohibited actions identified in this manual.

3-4 Medicaid as Payment in Full, Client Billing Prohibited

Medicaid and MCO

A provider who accepts a member as a Medicaid, Hospital Presumptive, or Baby Your Baby patient must accept the Medicaid or state payment as reimbursement in full. A provider who accepts a member enrolled by Medicaid in an MCO must accept the payment from the plan as reimbursement in full. If a member has both Medicaid and coverage with a responsible third party, do not collect a co-payment that is usually due at the time of service. The provider may not bill the member for services covered by Medicaid, Hospital Presumptive, or Baby Your Baby or by an MCO. The payment received from Medicaid or from an MCO is intended to include any deductible, co-insurance, or co-payment owed by the Medicaid member. In addition, the administrative cost of completing and submitting Medicaid claim forms are considered part of the services provided and cannot be charged to Medicaid members.

Qualified Medicare Beneficiary

Providers who serve Qualified Medicare Beneficiary (QMB) clients must accept the Medicare payment and the Medicaid payment, if any, for co-insurance and deductible as payment in full. Providers may not bill members eligible for the Qualified Medicare Beneficiary Program for any balance remaining after the Medicare payment and the QMB co-insurance and deductible payment from Medicaid. (42 CFR §447.15)

Providers must follow policies and procedures

Providers must follow policies and procedures concerning, but not limited to: medical services covered; medical service limitations; medical services not covered; obtaining prior authorization; claim

submission; reimbursement; and provider compliance, as set forth in all Sections of the Utah Medicaid Provider Manual, Medicaid Information Bulletins, and letters to providers. If a provider does not follow the policies and procedures, the provider may not seek payment from the member for services not reimbursed by Medicaid. This includes services that may have been covered if the provider had requested and obtained prior authorization.

3-5 Exceptions to Prohibition on Billing Members

There are certain circumstances in which a provider may bill a Medicaid member. They are: non-covered services, spenddown medical claims, Medicaid cost sharing (co-payments and co-insurance), and broken appointments. The specific policy for each item must be followed before the Medicaid member can be billed. Refer also to *Chapter 7, Member Responsibilities*.

Before collecting a co-payment, confirm the service requires a co-payment and that the member has a co-payment requirement. Give the member a receipt for the co-payment collected. The member is responsible to keep co-payment receipts in case of delayed billings by providers or discrepancies. If a co-payment is not collected at the time of service, the provider may bill the client for it.

3-5.1 Non-Covered Services

A non-covered service is a service not covered by a third party, including Medicaid. Since the service is not covered, a provider may bill a Medicaid member when the following conditions are met:

- The provider has an established policy for billing all members for services not covered by a third party. (The charge cannot be billed only to Medicaid members.)
- The member is advised prior to receiving a non-covered service that Medicaid will not pay for the service.
- The member agrees to be personally responsible for the payment.
- The agreement is made in writing between the provider and the member which details the service and the amount to be paid by the member.

Unless all conditions are met, the provider may not bill the member for the non-covered service. Further, the member's Medicaid Member Card may not be held by the provider as guarantee of payment by the member, nor may any other restrictions be placed upon the member.

3-5.2 Spenddown Payment

Some members are responsible for “spenddown” payments to qualify for medical services. The member may pay the spenddown amount to the DWS or may pay a medical bill and use this expense to offset their spenddown.

When rendering services to a member with a spenddown, the provider submits a claim to Medicaid for the full amount; do not submit a partial charge. If the member, as part of the spenddown, owes the full amount, the provider may choose not to bill Medicaid.

Medicaid bases reimbursement on the total claim, or on the standard reimbursement, whichever is less. Medicaid deducts the client’s obligation from the Medicaid reimbursement. The remainder is paid to the provider. Therefore, if the provider submits a partial charge (the total less the spenddown amount), the Medicaid reimbursement amount may be less than the actual amount owed to the provider. When the member’s obligation to pay is equal to or more than the Medicaid reimbursement amount, the Medicaid payment is zero.

Information concerning a member's spenddown requirement, if any, is available on the Eligibility Lookup Tool at https://medicaid.utah.gov/eligibility.

3-5.3 Broken Appointments

A broken appointment is not a service covered by Medicaid. Since the charge is not covered, a provider may bill a Medicaid member only when three conditions are met:

- The provider has an established policy for acceptable cancellations. For example, the member may cancel 24 hours before the appointment.
- The member has signed a statement agreeing to pay for broken appointments.
- The provider charges all members in the practice for broken appointments. The charge cannot be billed only to Medicaid members.

3-6 Referrals

The PCP, which includes physician, NPs, or PAs, may make any referral in writing or verbally. However, the member's medical record must indicate that a referral or consultation was requested.

The consulting physician is responsible for sending the PCP a letter describing the consult findings and a summary of the recommendations.

Providers who make referrals to another provider should consider that Medicaid limits medical transportation to the nearest provider or the nearest appropriate facility which can provide the needed services. Therefore, if the member must use medical transportation covered by Medicaid, the referral must be to the nearest provider or the nearest appropriate facility which can provide the needed services. This limitation includes all medical transportation, in both emergency and non-emergency situations.

3-6.1 Documenting the Referral/Consultation

Both the referring provider and the servicing/consulting physician are responsible for documenting the consultation or referral written or verbal request. When Medicaid conducts a post-payment review, all of the following information must be in the member's records to document the referral:

- The date the requesting provider contacted the servicing/consulting physician.
- Consultant physician's name and medical reason for the consultation/referral request.
- The consulting physician documents a summary of their evaluation, opinion, and recommendations in the patient's medical record. A separate written summary report is sent to the requesting physician and noted in the patient's medical record. If the consultant takes over as the servicing provider, the referring provider is notified.

3-6.2 Billing Claims Based on a Referral

Follow the CMS-1500 (08/05) instructions for entering the referring provider's number on the claim form. If it is an EPSDT Well Child follow-up referral, enter TS in the modifier field.

Follow the Implementation Guides for entering the referring provider's identifier/number on the electronic claim. If the visit is an EPSDT Well Child follow-up referral, enter TS in the modifier field.

3-6.3 Physician Ownership and Prohibition of Referrals

A physician or immediate family member of the physician who has a financial interest in a health service or item is prohibited from making referrals to those services when payment would be made as a

result. Services or items include physical therapy services, occupational therapy services, radiology, MRI and other advanced imaging services, durable medical equipment and supplies, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics, home health services, prescription drugs, inpatient and outpatient hospital services, and free-standing surgical centers, etc. The health service may not send a bill to an individual or file a claim with a third party for services provided as a result of such a referral.

A financial interest may be through ownership, or through a direct investment interest (such as holding equity or debt), or through another investment which has ownership or an investment interest in the health service. Penalties include denial of payment for the services provided, payment of civil penalties, and exclusion from participation in the Medicaid program.

3-7 Ensure Member Receives Medically Necessary Services

A Medicaid provider who accepts a Medicaid member for treatment accepts the responsibility to ensure the member receives all medically necessary services. A definition of medical necessity is provided in this manual in *Chapter 1, Definitions* and *Chapter 8, Programs and Coverage*. A provider's responsibilities include verifying program coverage; referring a member to other Medicaid providers; ensuring ancillary services are also delivered by a Medicaid provider; and ensuring the member receives all covered medically necessary services at no cost.

It is the responsibility of the provider to review Medicaid coverage policy for the procedure or service and request prior authorization (PA) or submit documentation for manual review as noted in the Coverage and Reimbursement Code Lookup tool. The ordering provider must provide the medical record documentation of medical necessity to ancillary providers such as the laboratory or radiology when requested so the ancillary provider may obtain the prior authorization or provide documentation to Medicaid for medical review of the service.

3-8 Medical Interpretive Services

Medicaid providers are required to provide foreign language interpreters for Medicaid members who have limited English proficiency. Members are entitled to an interpreter to assist in making appointments for qualified procedures and during visits. Providers must notify members that interpretive services are available at no cost. Medicaid suggests providers encourage members to use professional services rather than relying on a family member or friend, though the final choice is theirs. Using an interpretive service provider ensures confidentiality as well as the quality of language translation.

3-8.1 Member Enrolled in an MCO

If medical interpretative services are needed for a service covered by an MCO, the member is responsible for contacting the plan to obtain an interpreter. The MCO is required to provide interpretive services to the MCO's enrollees consistent with Medicaid policy.

3-8.2 Fee-for-Service Members

Medicaid will cover the cost of an interpreter when three conditions are met.

- Member is eligible for a federal or state medical assistance program. Programs include Medicaid, CHIP, and services authorized on a State Medical Services Reimbursement Agreement Form (MI-706).

- Member is fee-for-service, as defined in *Chapter 1, General Information, Definitions*.
- The health care service needed is covered by the medical program for which the member is eligible. Services covered by Medicaid are listed in Section 1 and the applicable other Sections of this Manual, under Covered Services.

If the three conditions of coverage are not met, the provider may be responsible for the cost of interpretive services. The provider may not bill the member for the service except under the conditions stated in *Chapter 3, Provider Participation and Requirements*.

3-8.3 How to Obtain an Interpreter

Medicaid offers a "Guide to Medical Interpretive Services." The guide lists member eligibility requirements, contractors, languages offered, and information required from the provider. The guide is available in General Attachments on the Medicaid website at https://medicaid.utah.gov.

4 Record Keeping

1

4-1 Government Records Access and Management Act (GRAMA)

The Utah Department of Health and Human Services, Division of Integrated Healthcare, follows the provisions of the Government Records Access and Management Act (GRAMA) in classifying records and releasing information.

4-2 Record Keeping and Disclosure

Medicaid providers must comply with all disclosure requirements in 42 CFR §455, Subpart B, such as those concerning practice ownership and control, business transactions, and persons convicted of fraud or other crimes. A provider must also disclose fully to Utah Medicaid information about the services furnished to Medicaid members, as circumstances may warrant.

Every provider must comply with the following rules regarding records:

- Maintain for a minimum of five years all records necessary to document and disclose fully the extent of all services provided to Medicaid members and billed, charged, or reported to the State under Utah's Medicaid Program;
- Promptly disclose or furnish all information regarding any payment claimed for providing Medicaid services upon request by the State and its designees, including the Office of Inspector General (OIG) and the Medicaid Fraud Control Unit, or the Secretary of the United States Department of Health and Human Services. This includes any information or records necessary to ascertain, disclose, or substantiate all actual income received or expenses incurred in providing services. In addition, all providers must comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B as applicable, except for individual practitioners or groups of practitioners. (A copy of these requirements will be furnished upon request);
- Allow for reasonable inspection and audit of financial or member records for non-Medicaid members to the extent necessary to verify usual and customary expenses and charges.

4-3 Confidentiality of Records

Providers must safeguard members' privacy and confidentiality, as required by all applicable state and federal laws. The use and disclosure of individually identifiable information or protected health information must be consistent with HIPAA. In accordance with HIPAA, HITECH, and the Government Records Access and Management Act (GRAMA), any information gained from member records is classified as *controlled* and must be protected pursuant to the guidelines established by law in order to protect the privacy rights of the members.

Any information received from providers is classified as *private* and will be protected pursuant to the guidelines established by law in order to protect the privacy rights of providers. Records and information acquired in the administration of any part of the Social Security Act are *confidential* and may be disclosed only under the conditions prescribed in rules and regulations of the Department of Health and Human Services, or on the express authorization of the Secretary of the Department of Health and Human Services.

A Medicaid provider may disclose records or information acquired under the Medicaid Program only under conditions prescribed in the rules and regulations of HIPAA, HITECH, and GRAMA.

4-4 Access to Records

The DIH may request records that support provider claims for payment under programs funded through the DIH. Responses to requests must be returned within 30 days of the date of the request and must include the complete record of all services for which reimbursement is claimed and all supporting services. If there is no response within the 30-day period, or a provider cannot provide adequate records for reimbursed services, the services will be deemed undocumented. The Department will recover all payments for undocumented services.

A provider who receives a request from Medicaid for access to or inspection of documents and records must comply with free access to the records and facility. A provider may not obstruct any audit or investigation, including the relevant questioning of employees of the provider.

Repeated refusal to provide or grant access to the records as described above will result in the termination of the Medicaid provider agreement.

4-5 Documentation Requirements

To support its mission to provide access to quality, cost-effective health care for eligible Utahans, the Division of Integrated Healthcare requires providers to meet the *Evaluation and Management Documentation Guidelines* developed jointly by the American Medical Association and the Centers for Medicare and Medicaid Services. Documentation requirements are as follows:

General Principles of Medical Record Documentation in the *Evaluation and Management Documentation Guidelines*:

- The medical record should be complete and legible.
- There is no specific format required for documenting the components of an E/M service. However, the provider must determine whether they are using 1995 or 1997 CMS evaluation and management

guidelines in their practice. When auditing, the OIG will request this information. The documentation of each member encounter should include:

- The chief complaint and/or reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
- Assessment, clinical impression, or diagnosis;
- Plan for care; and
- Date and a verifiable, legible identity of the healthcare professional that provided the service.

- If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be able to be easily inferred.
- To the greatest extent possible, past and present diagnoses and conditions, including those in the prenatal and intrapartum period that affect the newborn, should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The member's progress, response to and changes in treatment, planned follow-up care and instructions, and diagnosis should be documented.
- The CPT and international classification of diseases codes (ICD) reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
- An addendum to a medical record should be dated the day the information is added to the medical record, not the day the service was provided.
- Timeliness: A service should be documented during, or as soon as practicable after it is provided, in order to maintain an accurate medical record.
- The confidentiality of the medical record should be fully maintained consistent with the requirements of medical ethics and of law.

4-6 Signature Requirements

In keeping with the objectives of 42 CFR §456 Subpart B (to review and evaluate utilization, service, exceptions, quality of care, and to promote accuracy and accountability), providers and the service they provide must be clearly recognized by name and specialty. Any professional providing service and entering documentation in the member record must include a verifiable, legible signature and professional specialty designation following all entries.
 The physician's signature must accompany every documented member encounter if the service is being billed with the physician provider number.
 Other professionals working in group practices, clinics or hospitals such as nurses, physical therapists, occupational therapists, dietitians, or social workers, etc., providing service under a plan of care or following orders of a physician, must provide appropriate documentation, signature and professional designation following entries in the member's medical record.

In order for a signature to be valid, the following criteria are used:

- Services that are provided/ordered must be authenticated by the author
- Signatures will be handwritten or an electronic signature.
- Signatures are legible
- Rubber Stamps for signatures are allowed in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to Medicaid, if requested, their

inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that he/she has reviewed the document.

- Medical record entries completed by a scribe must be authenticated by the treating physician's/non-physician's (NPP's) signature and date.

4-6.1 Dated Signature

All signatures need to be dated; however, when requested Medicaid must be able to determine on which date the service was performed or ordered. If the entry immediately above or below the entry is dated, Medicaid may reasonably assume the date of the entry in question.

4-6.2 Missing Signature

Providers should not add late signatures to the medical record, other than those that result from the short delay that occurs during the transcription process. Providers should use the signature attestation process. Medicaid does not accept retrospective orders.

If a clinical diagnostic test order does not require a signature, regulations state there must be medical documentation by the treating physician (e.g., a progress note) that he/she intended the clinical diagnostic test be performed. This must also be authenticated by the author via a handwritten or electronic signature.

4-6.3 Illegible Signature

Illegible signatures should be accompanied by a typed/printed name on the documentation. If requested by Medicaid, providers may submit a signature log or attestation to support the identity of the signer. However, Medicaid will look for some indication in other documentation to support the identity of the signer.

4-6.4 Signature Log

A signature log is a typed listing of provider names followed by a handwritten signature. A signature log may be used to establish signature legibility as needed throughout the medical record documentation. Providers should include their professional credentials/titles on the signature log, illegible signatures will be processed more quickly than those that do not have a signature log provided.

4-6.5 Electronic Signatures

Providers must have a system and software products that maintain an auditable signature record, protect against modification, and have administrative procedures that correspond to recognized standards and laws.

The individual whose name is on the electronic signature and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided.

4-6.5.1 Acceptable Electronic Signatures (Examples; Not Limited To)

- Chart 'Accepted By' with provider's name
- 'Electronically signed by' with provider's name
- 'Verified by' with provider's name
- 'Reviewed by' with provider's name
- 'Released by' with provider's name
- 'Signed by' with provider's name
- 'Signed before import by' with provider's name
- 'Signed: John Smith, M.D.' with provider's name
- Digitalized signature: Handwritten and scanned into the computer
- 'This is an electronically verified report by John Smith, M.D.'
- 'Authenticated by John Smith, M.D.'

  Note: 'Signed but not read' is not acceptable

4-7 Physician Responsibilities

- The physician has the major responsibility for the member's medical record and services provided. A recognizable signature, customary to the way in which the physician identifies himself or herself, should be found throughout the record on all direct service entries, consultations or reports.
- When service to the member is provided "incident to" or "under the supervision" of the physician and documented by non-physician personnel, the medical record entry must have sufficient documentation to show active participation of the physician in planning, supervising or reviewing the service.

4-8 Determining Compliance with Standards

A provider's failure to comply with medical standards, federal audit, quality assurance review, or prior authorization requirements may be determined in the course of manual claim review. Coding errors are often discussed with billers either in the course of manual review or through the pre-hearing process.

Either the Division of Integrated Healthcare or the provider may request a pre-hearing or peer review of the reimbursement determination. A written request by either the Division or the provider for a pre-hearing review must be made within 30 days following the date of the original notice to the provider of the determination of noncompliance. The written request from the provider must be submitted to:

Office of Administrative Hearings
Division of Integrated Healthcare
PO Box 143105
Salt Lake City, UT 84114-3105

Or via UPS or FedEx
Office of Administrative Hearings Division of Integrated Healthcare
288 North 1460 West
Salt Lake City, UT 84116-3231

In situations of violations of compliance of professionally recognized medical standards, as identified by peer review, the Division of Integrated Healthcare may pursue any legal sanction for recovery of overpayments.

If the provider is found at fault, and Federal Financial Participation is disallowed on reimbursements made to the provider, the provider must reimburse to the State the total amount the State paid for the services disallowed. When manual review documentation suggests attempts to circumvent prior authorization or coverage policy, a case may be referred to the OIG for review. (Refer to *Chapter 5, Provider Sanctions.*)

5 PROVIDER SANCTIONS

Sanctions, which include termination or suspension from participation in the Medicaid program, may be imposed against a provider for conduct such as fraudulent billing practices, failure to keep records to substantiate services to members, failure to repay unauthorized funds, and conviction of certain criminal offenses. Prospective providers may also be excluded from the Medicaid program on certain grounds, such as fraud or current license limitation imposed by the Division of Professional and Occupational Licensing (DOPL) or another state's licensing board. Before a sanction may be imposed, a provider must be notified of the pending sanction and of his hearing rights. Utah Administrative Code R414-22, Administrative Sanction Procedures and Regulations, provides a more complete description of grounds for sanctions, and administrative sanctions that may be taken against providers.

5-1 Suspension or Termination from Medicaid

The Department may suspend or terminate from Medicaid participation any medical practitioner or other health care professional licensed under state law who is convicted of Medicaid or Medicare related crime(s) in either a federal or state court.

When a practitioner or other health care professional is convicted and sentenced in a state court of Medicaid-related crime(s), the Department notifies the Office of Inspector General. (Refer to *Chapter 5, Provider Sanctions.)*

The Department may request a waiver of suspension or termination if the sanction is expected to have a substantial negative impact on the availability of medical care in the community or area. The waiver request should contain a brief statement outlining the problem, and be submitted to the Centers for Medicare and Medicaid Services (CMS). CMS will notify the Department if and when it waives the sanction. Waivers should only occur if:

- The Secretary of the Department of Health and Human Services has designated a health manpower shortage area; and
- An insufficient number of National Health Services Corps personnel has been assigned to the needs of that area.

5-2 Employment of Sanctioned Individuals

Federal Fraud and Abuse regulations adopted by Health and Human Services, Office of Inspector General, provide for significant civil and criminal actions that may be taken against Medicaid providers who employ federally sanctioned individuals. This is true even if the sanctioned individual does not work directly in providing services to individuals under the Medicaid program.

Providers need to be aware that it is their responsibility to verify that the individual is not on a federal sanctions list. Thus, it is essential that providers regularly check (i.e., monthly) the federal sanctions list, which is at https://exclusions.oig.hhs.gov/. If a provider employs an individual who is on the

federal sanctions list, and that person provides services which are directly or indirectly reimbursed by a federally funded program, the employer may be subject to legal action which could include civil penalties, criminal prosecution and exclusion from program participation.

It is essential that providers regularly check the federal sanctions list which can be found at the website listed above. It would be advisable for all providers to check current and potential employees against the list on the federal database to ensure that no sanctioned individuals are working for their organization.

5-3 Medicaid Audits and Investigations

Federal regulations require the implementation of a statewide surveillance and utilization control program that safeguards against excessive Medicaid payments, and unnecessary or inappropriate utilization of care and services.

The Utah Office of Inspector General (UOIG) for Medicaid Services, and the Medicaid Fraud Control Unit, Office of Attorney General, address issues related to fraud, utilization control, audits, and investigations. These programs work to ensure Utah's Medicaid program are in compliance with applicable state and federal law. These offices may receive complaints and referrals from Medicaid recipients, the public, providers, or federal and state agencies. Medicaid fraud is a crime which may result in criminal charges and possibly conviction, incarceration, fines, penalties and also exclusion from the Medicaid and Medicare programs. What constitutes fraud is defined by statute under the False Claims Act found at Utah Code Ann. 26-20-1, et. seq. (Refer to, http://le.utah.gov/xcode/Title26/Chapter20/26-20.html). Some examples of fraud include, but are not limited to, the knowing or intentional act of billing Medicaid for services that were not rendered, including billing for items or materials that were not delivered. Fraud also includes the making of a materially false statement or representation in connection with any claim for payment to the Medicaid program. Providers are also prohibited from accepting illegal kickbacks or bribes for referrals or services, and are also prohibited from billing for services that are medically unnecessary or charging for those services at a rate higher than those charged by the provider to the general public. It is important that you familiarize yourself with the False Claims Act, or contact the Utah Office of Inspector General for Medicaid Services or the Utah Medicaid Fraud Control Unit if you have questions or concerns.

Contact Information for Complaints and Reporting Fraud, Waste and Abuse

Director, Medicaid Fraud Control Unit
Office of the Attorney General
Medicaid Fraud Control Unit
5272 South College Drive, Suite 300
Murray, Utah 84123
(801) 281-1259

Utah Office of Inspector General for Medicaid Services
288 North 1460 West
PO Box 143103
Salt Lake City, Utah 84114

(801) 538-6087, 1(855) 403-7283
https://oig.utah.gov/

5-4 Hearings and Administrative Review

A provider or member may request an administrative hearing to dispute an action taken by the Division of Integrated Healthcare (DIH) or an MCO. Actions taken that may be appealed include, but are not limited to:

- Denial of a prior authorization request.
- Denial of a claim, as indicated by an explanation of benefits or other remittance document issued by Medicaid.
- Denial by manual review.

With respect to denials issued by an MCO, providers or members must complete the MCO's appeal process prior to requesting a hearing with DIH.

To request a hearing, send a completed hearing request form to the Office of Administrative Hearings. The form must be faxed or postmarked within 30 calendar days from the date DIH or the MCO sends written notice of its denial or intended action, unless a different time period is indicated on the denial document. Failure to submit a timely request for a hearing constitutes a waiver of the due process right to a hearing. The agency is not required to grant a hearing if the sole issue is a federal or state law requiring an automatic change. Utah Administrative Code R410-14 et seq. sets forth the administrative hearing procedures for Medicaid hearings.

A *Request for Hearing/Agency Action* form (Hearing Request) is available on the Utah Medicaid website at: https://medicaid.utah.gov/utah-medicaid-forms, Hearing Request, or a copy may be requested from the Office of Administrative Hearings by calling (801) 538-6576.

Submit the form by mail or fax.

Mail:
Division of Integrated Healthcare
Office of Administrative Hearings
Box 143105
Salt Lake City, UT 84114-3105

FAX: (801) 536-0143

6 Member Eligibility

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6-1 Verifying Medicaid Eligibility

A Medicaid member is required to present the Medicaid Member Card before each service, and every provider must verify each member's eligibility each time before rendering services. Presentation of the Medicaid Member Card does not guarantee a member continues eligible for Medicaid. Verify the member's eligibility, and determine whether the member is enrolled in an MCO, Emergency Only Program, or the Restriction Program; assigned to a PCP; covered by a third party; or responsible for a

co-payment or co-insurance. Eligibility and health plan enrollment may change from month to month. Retain documentation of the verified eligibility for billing purposes.

Verify member eligibility using the Eligibility Lookup Tool, and ANSI 270 and ANSI 271. Brief descriptions of each are below; for detailed information, call Medicaid Information, or go to the Medicaid website at https://medicaid.utah.gov/medicaid-online.

Note: Medicaid staff makes every effort to provide complete and accurate information on all inquiries. However, federal regulations do not allow a claim payment even if the information given to a provider by Medicaid staff was incorrect.

6-1.1 Tools to Verify Medicaid Eligibility

These tools may be used to verify member eligibility:

Eligibility Lookup Tool

The eligibility lookup tool allows providers to electronically view a member's Medicaid eligibility and plan enrollment information. To use this tool a provider must register with the State of Utah Master Directory (UMD), available at https://medicaid.utah.gov/eligibility.

ANSI 270 and ANSI 271

These two HIPAA compliant transactions offer member eligibility and claim status for providers who are members of the Utah health Information Network (UHIN).

6-1.2 Documentation of Medicaid Coverage for Medicaid Members

Medicaid members who need confirmation of coverage may call Medicaid Information (Refer to *Chapter 1, General information*) or access the member Benefit Lookup Tool at https://medicaid.utah.gov.

6-2 Temporary Proof of Eligibility

The Interim Verification of Eligibility (Form 695) is a temporary proof of eligibility. Form 695 is issued when a member needs proof of eligibility and does not yet have a Medicaid Member Card. When a temporary proof of eligibility expires, Medicaid will no longer pay claims, unless the member has since been issued a ten-digit Medicaid identification number.

6-3 Third Party Liability

Information on third party coverage should be verified. Note that some members of a family may have third party coverage, while others may have no coverage or different coverage.

If third party liability (TPL) information is incorrect, advise the member to call the TPL unit in the Office of Recovery Services at the Department of Human Services at (801) 536-8798. Providers may also call the TPL unit about incorrect information. TPL information is corrected by the Office of Recovery Services:

In the Salt Lake area, call..(801) 741-7437

Medicaid policy states the provider must pursue payment from all other liable parties such as insurance coverage. Refer to *Chapter 11, Billing Medicaid*, for information on billing the TPL.

6-4 Ancillary Providers

Providers who accept a member covered by Medicaid are asked to ensure that any ancillary services provided to the member are delivered by a participating Medicaid provider. This includes lab, x-ray, and anesthesiology services. Give all ancillary providers a copy of the member's Medicaid Member Card or, at minimum, the Medicaid identification number. In addition, when the service requires prior authorization (PA) and a PA number is obtained from Medicaid; give the PA number to any other provider rendering service to the member. This will assist other providers who may be required to submit the prior authorization number when billing Medicaid.

6-5 Medicaid Member Identity Protection

A provider should ask for the member's Medicaid Member Card and a picture ID prior to each service to assure the individual presenting the card is the same person on the Medicaid Member Card. Medicaid is a benefit only to eligible persons. Possession of a Medicaid Member Card does not ensure the person presenting the card is eligible for Medicaid.

7 Member Responsibilities

Members are responsible for providing complete and accurate information to establish eligibility, providing information about all other health insurance, paying co-payment amounts at the time of service, and cooperating with the PCP to receive medical services.

7-1 Charges that are the Responsibility of the Member

A Medicaid member is responsible for certain charges, including:

- Charges incurred during a time of ineligibility
- Charges for non-covered services, including services received in excess of Medicaid benefit limitations, if the member has chosen to receive and agreed to pay for those non-covered services.
- Charges for services which the member has chosen to receive and agreed in writing to pay as a private pay member.
- Spend down liability.
- Cost sharing amounts such as premiums, deductibles, co-insurance, or co-payments imposed by the Medicaid program.

7-1.1 Cost Sharing

The Medicaid program may require certain members to pay for services or benefits, referred to as cost sharing. Cost sharing amounts may include such items as premiums, deductibles, co-insurance, or co-payments.

Refer to Utah State Plan Attachments 4.18-A through H, for additional cost sharing information.

7-2 Charges Not the Responsibility of the Member

Except for the cost sharing responsibilities discussed above, members are not responsible for the following charges:

- A claim or portion of a claim that is denied for lack of medical necessity. (For exceptions refer to *Chapter 3, Provider Participation and Requirements, Exceptions to Prohibition on Billing Members*.)

- Charges in excess of Medicaid maximum allowable rate.
- A claim or portion of a claim denied due to provider error.
- A service for which the provider did not seek prior authorization or did not follow up on a request for additional documentation.
- A claim or portion of a claim denied due to changes made in state or federal mandates after services were performed.
- The difference between the Medicaid cost sharing responsibility, if any, and the Medicare or Medicare Advantage co-payments.
- Medicaid pays the difference, if any, between the Medicaid maximum allowable fee and the total of all payments previously received by the provider for the same service by a responsible third party. Members are not responsible for deductibles, co-payments, or co-insurance amounts if such payments, when added to the amounts paid by third parties, equal or exceed the Medicaid maximum for that service, even if the Medicaid amount is zero.
- The member is not responsible for private insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the member as a Medicaid member. Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third-party insurance is equal to or greater than the Medicaid allowable rate.
- Laboratory, radiology, outpatient mental health, and substance use disorder (SUD) services.

8 Programs and Coverage

This chapter covers services available under the Utah State Medicaid Plan. Services are reimbursed either directly by Medicaid or by a Managed Care Organization (MCO) with which Medicaid contracts to provide the covered services. When the Medicaid member has a PCP, this provider must provide an appropriate referral for medical services received from any other provider (Refer to *Chapter 3, Provider Participation and Requirements.*)

Covered services are limited by federal guidelines as set forth under Title XIX of the federal Social Security Act, Title 42 of the Code of Federal Regulations (CFR), and the Utah Administrative Code, Rule R414-1-5, Services Available.

Utah Medicaid pays for medically necessary, covered health services, as well as certain services, available by special waiver, provided to eligible members by Medicaid providers. The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Certain services are covered only for specific categories of eligible members. All covered services, both traditional and special services, must be medically necessary, may be limited in scope (i.e., specific number of units of services), and may be subject to prior authorization. Refer to the applicable Section 2 provider manual for specific provider policy and billing instructions and to the *Coverage and Reimbursement Code Lookup Tool* for covered services [http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php].

Medicaid may exceed the limitations on covered services under certain circumstances. Some services may be provided if Medicaid staff determine, through the utilization review process, the proposed services are medically appropriate and more cost effective than alternative services.

8-1 Medical Necessity

A provider must only furnish or prescribe medical services to the member that are medically necessary. A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a disability, and there is no other equally effective course of treatment available or suitable for the member requesting the service which is more conservative or substantially less costly. Medical services will be of a quality that meets professionally recognized standards of health care, and will be substantiated by records including evidence of such medical necessity and quality. Those records will be made available to the Medicaid upon request. Medicaid reserves the right to make the final determination of medical necessity.

Services or procedures considered experimental or investigational are not considered medically necessary and thus are not covered by Medicaid. (Refer to *Chapter 9, Non-Covered Services and Limitations, Experimental, Investigational, or Unproven Medical Practices*). This policy does not apply to members participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the "Consolidated Appropriations Act, 2021."

8-2 Medicaid Programs

To qualify for a Medicaid program, an individual must fit into a specific category and within that category, meet certain citizenship and income criteria (some programs also have a resource or asset test). Some categories and programs provide a full range of medical benefits, while others may offer limited benefits or may require cost sharing by a member. If an individual has income over the limit ("excess income"), he may be asked to spend the excess on medical care or "spenddown" to the Medicaid income level to qualify for the Medicaid Medically Needy Program. Refer to the Medicaid website https://medicaid.utah.gov/ for program details.

The categories of Medicaid:

- Age 65 or older
- Legally disabled or blind (for example, an SSI recipient)
- Pregnant
- Children from birth through 20 years
- Parent or caretaker relative of a child under age 19
- Woman with breast cancer or cervical cancer

8-2.1 Medically Needy Program and Spenddown Program

An individual who is below the asset limit and has monthly income which exceeds the monthly income standard, but less than the amount needed to pay his or her medical bills, may be considered for the Medicaid Medically Needy Program. The program, also known as the "spend down" program, requires the individual to "spend down" his income to the Medicaid income level. The individual may choose to either pay the "excess" monthly income to the state (by sending a payment to DWS), or to pay a portion of his monthly medical bills directly to the medical provider. Pursuant to federal law, Medicaid cannot

accept spenddown payments when the source is from a Medicaid provider's own funds, or if a Medicaid provider has loaned the money to the individual.

8-2.2 Medicare Cost-Sharing Programs

There are three Medicare cost-sharing programs for people with Part A Medicare: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary program (SLMB), and Qualified Individual program (QI). While these are not Medicaid programs, they help cover some of the member's costs for Medicare services. For further information refer to https://medicaid.utah.gov/, Medicare Cost-Sharing Programs.

8-2.3 Retroactive Eligibility

The eligibility worker may approve Medicaid coverage for a beneficiary for the three months prior to application date. This is called the retroactive period. Coverage can begin as early as the first day of the third prior month. For example: The application date is April 15, this coverage may begin January 1.

8-2.4 Breast and Cervical Cancer Program (BCCP)

The Breast and Cervical Cancer Prevention and Treatment Act allows states to provide full Medicaid benefits to qualified individuals in need of treatment for breast and cervical cancers, including precancerous conditions and early stage cancer. The Utah Cancer Control Program (UCCP) refers the individuals for Medicaid coverage.

To qualify the individual must meet all of the following requirements:

- Diagnosis after April 1, 2001, by a Utah health care provider, of breast or cervical cancer which requires treatment, including precancerous conditions.
- Under the age of 65.
- Does not have insurance to cover the needed treatment.
- U.S. citizen or qualified non-citizen.
- Income at or below 250% of the Federal Poverty Level (The FPL is available on the Internet at http://aspe.hhs.gov/poverty/index.shtml.) Note: There is no asset test to qualify.

For more information, call the Utah Department of Health and Human Services, Utah Cancer Control Program: (801) 538- 6157 or 1(800) 717-1811. Please have the member's complete name and telephone number(s).

8-2.5 Baby Your Baby (BYB)

The Baby Your Baby presumptive eligibility program covers outpatient, pregnancy-related, Medicaid covered services for eligible pregnant women prior to establishing eligibility for ongoing Medicaid. Pregnant women apply for this program through a qualified health provider, usually a community health center or public health department. Inpatient hospital services, and labor and delivery are not covered benefits during the Baby Your Baby presumptive eligibility period.

Members eligible for the Baby Your Baby program are given a 'Presumptive Eligibility Receipt' to show they are approved for coverage. A Medicaid Member Card is mailed to the member within a few days of eligibility determination. The member card is used to verify the member's eligibility. Do not collect a co-payment from a member eligible for the Baby Your Baby Program; a co-payment is not

assessed by Medicaid. For more information about application, eligibility, and covered or non-covered services under this program, call the Baby Your Baby Hotline, 1(800) 826-9662.

Note: A newborn infant is not covered when the mother is eligible only for the Baby Your Baby Program. A Medicaid application must be submitted on behalf of the child if assistance is needed in paying the child's medical bills.

8-2.6 Hospital Presumptive Eligibility Program (HPE)

The Hospital Presumptive Eligibility Program (HPE) provides temporary fee-for-service Medicaid coverage for qualified low-income individuals prior to establishing eligibility for ongoing Medicaid. Members apply for this program through a qualified hospital provider.

There are different subprograms under HPE: Child Medicaid 0-5 or Child Medicaid 6-18, Parent/Caretaker Relative, Pregnant Woman, and Former Foster Care Individuals. HPE has the same coverage benefits as Medicaid, and the same prior authorization requirements apply, when provided by any Utah Medicaid provider, with one exception. The Pregnant Woman subprogram under HPE covers only outpatient, pregnancy-related, Medicaid covered services like BYB. Under the Pregnant Woman subprogram, inpatient hospital services, and labor and delivery are not covered benefits during the presumptive eligibility period. In addition, the Pregnant Woman subprogram does not cover charges for services for a newborn infant. (Refer to "Baby Your Baby")

Similar to BYB presumptive eligibility program, members eligible for the Hospital Presumptive Eligibility Program are given a 'Presumptive Eligibility Receipt' to show they are approved for coverage. A Medicaid Member Card is mailed to the member within a few days of eligibility determination.

8-2.7 Non-Traditional Medicaid Plan

On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan will end, and members formerly enrolled in the NTM plan will have the same benefits as the Traditional benefit plan starting on January 1, 2024. Information regarding NTM services will remain in the Utah Medicaid Provider Manuals until January 1, 2025, for reporting and eligibility purposes.

Non-Traditional Medicaid (NTM) provides a scope of service similar to that currently covered by the Utah Medicaid State Plan (i.e., Traditional Medicaid) but with some additional limitations or reduced benefits. Authorization of Non-Traditional Medicaid is by way of waiver approval through the Centers for Medicare and Medicaid Services (CMS) and Section 1115(a) of the Social Security Act.

Providers of NTM services are responsible for complying with all applicable federal and state laws and regulations and Medicaid policy and requirements outlined in the 1115 Waiver, Utah Administrative Code R414-200. Non-Traditional Medicaid Health Plan Services, the Medicaid Provider Agreement, the Medicaid provider manuals, attachments specific to the provider manuals, and the Medicaid Information Bulletins.

Refer to *Chapter 6, Member Eligibility*, for information about verifying member eligibility, third party liability, ancillary providers, and member identity protection requirements.

The scope of service under NTM is similar to Traditional Medicaid but with some limitations, reduced benefits, and non-covered services.

For specific code coverage and reimbursement information see the Coverage and Reimbursement

Code Lookup.

8-2.7.1 Limitations

Audiology- Hearing evaluations or assessments for hearing aids are covered. Hearing aids are covered only if hearing loss is congenital.

Emergency Transportation Services- Coverage of ambulance (ground and air) for medical emergencies only. Non-emergency transportation (including bus passes) is not covered.

Medical Supplies and Equipment- Coverage outlined in the Coverage and Reimbursement Code Lookup.

Organ Transplants- The organ transplants covered under NTM include bone marrow, cornea, heart, kidney, liver, lung, and stem cell.

Physical Therapy (PT) and Occupational (OT) Therapy Services- PT and OT are limited to 16 aggregate visits (in any combination) per calendar year.

Vision services- NTM covered services are the same as those for non-pregnant adults. One eye examination is covered every 12-months.

8-2.7.2 Non-Covered Services

Non-covered services are the same for Traditional Medicaid and NTM members.

The following services are also non-covered for NTM members:

- Chiropractic services
- Long-term care services
- Private duty nursing
- Speech-language pathology services

8-2.8 EPSDT Medical Services for Individuals Ages Birth through 20

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program is federally mandated for enrolled Medicaid Members and is an integral part of the Medicaid program. EPSDT services are available to all members enrolled in Traditional Medicaid ages birth through twenty. (Individuals aged 19 through 20 enrolled in Non-Traditional Medicaid do not qualify for EPSDT services.)

Note: On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan will end, and members formerly enrolled in the NTM plan will have the same benefits as the Traditional benefit plan starting on January 1, 2024. Information regarding NTM services will remain in the Utah Medicaid Provider Manuals until January 1, 2025, for reporting and eligibility purposes.

This program provides comprehensive and preventive health care services and ensures that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. Screening services to detect physical and mental conditions are covered at established intervals, including a physical exam, appropriate immunizations, laboratory tests, and health education. In addition, dental, vision and hearing services are available. All medically necessary diagnostic and

treatment services within the federal definition of Medicaid is covered, regardless of whether or not such services are otherwise covered for individuals over age 20.

In certain cases, if Medicaid staff determine that the proposed services are both medically necessary and more cost effective than alternative services, then the agency may exceed established limitations on coverage.

There are three major components to EPSDT: Preventive Health Care, Outreach and Education, and Expanded Services. Refer to Section 2, EPSDT Services Provider Manual for details at https://medicaid.utah.gov/utah-medicaid-official-publications.

8-2.9 Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) is not a Medicaid program but it is a state health insurance plan for children who do not have other insurance. It provides well-child exams, immunizations, doctor visits, hospital, emergency care, prescriptions, hearing and eye exams, mental health services and dental care. Preventative services (well-child visits, immunizations, and dental cleanings) do not require a co-pay. For more information, call 1(877) 543-7669 or visit the CHIP website.

8-2.10 Custody Medical Care Program (Children in Foster Care)

The Custody Medical Care Program pays medical bills for a child placed in the custody of the State and has not yet been determined eligible for Medicaid or is not eligible for Medicaid. The program may pay for services not covered by Medicaid and for services from a provider who may not be a current Medicaid provider.

Medical services are authorized on State Medical Services Reimbursement Agreement Form (MI-706), by the assigned case manager in the Division of Child and Family Services. The case manager gives the foster parent this form, and it must be presented at the time of the medical visit.

Only services identified on the MI-706 form are payable. Every service must be individually authorized before payment is made. Services provided without authorization will not be paid by the Division of Child and Family Services nor by Medicaid. Emergency services may be authorized after the fact, if the service is within the scope of service of the program, and Form MI-706 is obtained before billing. Services must be billed within 365 days of the date of service or six months of the date Form MI-706 was issued, whichever is later. To bill claims, follow the same instructions as for billing Medicaid claims with one exception: every claim requires a prior approval number. (The prior approval number is the MI-706 number.) Medicaid processes the claim, and the payment method and amount is the same as that for the Medicaid Program, even though the child is not eligible for Medicaid.

8-2.10.1 Children in State Custody (Foster Care)

Medical services for most children placed in state custody are covered by either Medicaid or the Custody Medical Care Program. The State pays medical bills only when the child is eligible for either of these programs. The State does not automatically pay medical bills for children in foster care. Before providing services, determine the child's health care coverage. Using the available tools found in *Chapter 6, Member Eligibility*, determine if the child is eligible for Medicaid and assigned to a PCP or ACO.

This information is intended to assist providers in determining and providing health coverage for a child in state custody. Provide services to these children within the time frames outlined in Time Frame for Services below. The Division of Child and Family Services contracts with the Department of Health and Human Services to provide health care case management for children in foster care. Contact the Fostering Healthy Children Program with questions about serving children in state custody.

Children in Foster Care Eligible for Medicaid

Before providing services to children in foster care, check for Medicaid eligibility. Services will not be reimbursed when the child is not eligible for Medicaid, nor when the child is covered by a health plan or Prepaid Mental Health Plan and the provider is not affiliated with the plan. To check eligibility and provider assignment, use the Eligibility Lookup Tool online at https://medicaid.utah.gov/eligibility-lookup-tool or call (801) 538-6155 or 1(800) 662-9651.

Many of the children placed in state custody are already eligible for Medicaid and enrolled in an MCO. As with any other enrollee, these children are covered only for services received from providers affiliated with the MCO(s) identified. The provider receives payment from the child's MCO. If a child is taken to a provider who is not affiliated with the child's plan, referred to as "out of plan," services may not be reimbursed by the plan or by Medicaid.

The child may be enrolled in a Prepaid Mental Health Plan (PMHP) for inpatient psychiatric services only. (Foster care children may obtain outpatient mental health services from any participating Medicaid provider.) The caseworkers in the Division of Child and Family Services are responsible for coordinating any needed outpatient or inpatient mental health services.

For new enrollees, the Division of Child and Family Services (DCFS) chooses an ACO which contracts with the provider(s) the child has seen in the past. Foster parents are trained to use providers affiliated with the health plan and PMHP plans in which the child is enrolled.

When the child is eligible on the date of service and not assigned to a health plan or a PMHP, services may be billed directly to Medicaid as fee-for-service. Some children in state custody come from outside the Wasatch Front (Weber, Davis, Salt Lake, and Utah counties) for medical treatment and are thus not enrolled in a health plan.

Children in Foster Care Not Eligible for Medicaid

When a foster child is not eligible or not yet eligible for Medicaid, the child may qualify for the Custody Medical Care Program (see above Children in Foster Care Eligible for Medicaid). A nurse from the Fostering Healthy Children Program (FHC) may authorize medical services on State Medical Services Reimbursement Agreement Form (MI-706), and give it to the foster parent. (FHC is a program within the Department of Health and Human Services which contracts with the Division of Community and Family Health Services, to provide nurse case manager services). This form must be presented at the time of the visit. Services provided without this authorization will not be paid by DCFS or Medicaid.

Time Frame for Services (Foster Care)

Children removed from their homes must receive certain services within the specific time frames listed below. Providers are encouraged to do everything possible to provide service to the child placed in state custody within the following time frames.

Children must receive

- An initial physical exam within five days of removal.
- A complete EPSDT exam within 30 days of removal.
- A mental health assessment within 30 days of removal.
- A dental exam within 60 days of removal.

8-2.11 Emergency Services Program for Non-Citizens

Emergency services for non-citizens are designed to cover a limited scope of services as outlined in 42 CFR 440.255(c). Individuals meeting all Medicaid eligibility requirements except citizenship may receive coverage for a qualifying emergency service as defined in Utah Administrative Code R414-1-2(11) and meeting service coverage criteria outlined in Utah Administrative Code R414-518.

When determining eligibility and coverage related to outpatient hemodialysis, see the "Provider Instructions for EOP Dialysis Coverage."

8-2.11.1 Medicaid Member Card and Documentation

Individuals who qualify for these services are issued a Medicaid Member Card. Services require documentation and review before payment to determine the services meet the definition and limitations stated above.

8-2.11.2 Billing for Emergency Services Provided to a Non-citizen

Any payment made by the Medicaid Agency for a service is considered payment in full. Once the payment is made to the provider for covered services, no additional reimbursement can be requested from the member. Because the emergency services program for non-citizens has a very restricted scope of services, it does not have some of the same restrictions on billing the member as is the case in other Medicaid covered services. If a provider does not receive payment from Medicaid because the provider failed to follow procedure to get a service covered, the provider is prohibited from pursuing payment from the member. However, if payment is not made because the service was not an emergency, or the service is not covered under the program, then the member can be billed for those services.
If a service is a covered service and meets the Medicaid definition of "emergency," Medicaid will pay for the service (subject to correct coding). However, if a non-citizen eligible for emergency services only presents at the ER with symptoms that do not appear to be emergent in nature, the provider would be prudent to inform the member, prior to the service, that the service might not be covered by Medicaid, and in that case the member will be financially responsible for paying the bill.
Billing for services provided to an emergency services only program member:

- Submit a claim to Medicaid
- If payment denial is received - ***Do not rebill the claim***.
- Follow these instructions, rather than rebilling the claim.
  - Fax or mail -
  - A *Document Submission Form* (from website) with all required fields completed.
    - Include the transaction control number for accurate claim matching.
  - Medical records specific to the case, these may include:
    - Reports and consultations (e.g. admissions history and physical, physician notes, operative report, progress notes, and/or discharge summary)
    - Other documentation in support of the services as a medical emergency
    - Retroactive prior authorizations

- Any required consent forms

FAX to:
Emergency Services Program for Non-Citizens
(801) 536-0475
(This number is also on the *Documentation Submission Form*)
The Medicaid billing address is in *Chapter 1, General Information*.
All information to be considered for review MUST be included in the initial submission. A second submission will not be considered for payment, unless additional records are requested.

8-2.11.3 Review Process

All claims are held in queue for 60 days from the date of service prior to undergoing manual review, this allows for receipt of all related documentation and to help assure representation of the full episode of care.

- Medicaid staff review submitted documentation. See Utah Administrative Code R414-1-14.
- Notification of denial.
  - If criteria are not met, a letter of denial is sent from the Office of Medicaid Operations outlining the reasons. Administrative Review and Fair Hearing rights are explained in the denial letter.
  - A provider who does not agree with Medicaid's decision should refer to *Chapter 5, Hearings/Administrative Review*.

8-2.12 Refugee Medicaid

Refugees entering the United States are eligible to apply for Medicaid for a period of up to eight months starting on the date they enter into the country. If an individual is a refugee and does not qualify for Medicaid, they may apply for enrollment in the Emergency Medicaid Program, which covers services for medical emergencies.

In accordance with 45 CFR 400.105, refugees that qualify for Medicaid enrollment are able to receive coverage for services as outlined in the State Plan, Section 3.1(a)(6)(ii). Furthermore, refugee children may receive additional preventative services upon their enrollment into the Medicaid program. To verify specific services, please use the coverage criteria established in the Coverage and Reimbursement Code Lookup.

Medicaid offers interpretative services for those who do not speak or read English.

8-3 Medicaid Restriction Program

The Medicaid Restriction Program safeguards against inappropriate and excessive use of Medicaid services. If a Medicaid member utilizes pharmacy services, emergency department or provider services at a frequency or amount that is not medically necessary, that individual may be referred to and enrolled in the Restriction Program. Members enrolled in the Restriction Program are assigned to one PCP to oversee the member's healthcare and one Primary Pharmacy.

Members are identified for the Restriction Program through on-going surveillance of member profiles to detect excessive use of services and by referral from providers, pharmacies, law enforcement, citizens etc. Medicaid members enrolled in an ACO and Fee-for-Service members can be enrolled in the

Restriction Program. Restricted ACO members are managed by the ACO's Restriction Program, while restricted Fee-for-Service members are managed by the Department of Health and Human Services (DHHS) Medicaid Restriction Program.

If it is suspected that a Medicaid member is over-utilizing, abusing or fraudulently using Medicaid services, referrals for possible enrollment in the Restriction Program may be submitted to medicaidrestriction@utah.gov or 801-538-9045 or to the specific ACO Restriction Program in which the member is enrolled, as applicable.

Medicaid members, referred to a Restriction Program or identified by Medicaid surveillance, will be subject to a utilization review for meeting or exceeding the following Restriction criteria during their most recent 12 months of Medicaid eligibility:

- Accessing ≥ 4 non-affiliated providers
- Accessing ≥ 4 pharmacies for abuse potential prescriptions
- Having ≥ 6 prescriptions for abuse potential medications in a two-month period
- Having ≥3 providers prescribing abuse potential medications in a two-month period
- Having ≥ 5 non-emergent ED visits
- Concurrent prescriptions for scheduled medications from different prescribers
- Cash payments for Medicaid covered services

Member's diagnoses, extenuating circumstance and limited access to care (as sometimes seen in rural geographic locations or homelessness) will be taken into consideration during each utilization review. Subsequent to such considerations, members who meet or exceed Restriction Program criteria will be enrolled in the Restriction Program for a minimum of 12 months of Medicaid eligibility.

Restricted members are encouraged to use Urgent Care services when their assigned PCP is not available for immediate medical needs and the need is not emergent. In order for prescriptions written by Urgent Care Providers to be paid, the Urgent Care prescriber's name and NPI must be added to the member's case by contacting the ACO or DHHS Medicaid Restriction Program, as applicable. As per federally mandated "*Emergency Medical Treatment and Labor Act* (EMTALA)", access to emergent medical services are available to restricted members

Members selected for enrollment in the Restriction Program are notified of the reasons for the enrollment, counseled in the appropriate use of health care services, and offered assistance in selecting a single PCP and a single pharmacy. Prior to assigning a PCP to a restricted member's case, the PCP must approve of the assignment and agree to manage the restricted member's healthcare needs.

Assigned PCPs must provide referrals for restricted members in need of specialty or secondary healthcare services. In addition, PCPs must notify the ACO or DHHS Medicaid Restriction Program of the addition of the approved specialty or secondary providers to the member's restriction case. To submit approval for the additional providers/prescribers to a restricted member's case, the PCP or PCP's designee must contact the DHHS Medicaid Restriction Program at 801-538-9045 or medicaidrestriction@utah.gov for FFS members or by contacting the specific ACO Restriction Program in which the member is enrolled, as applicable.

In making provider and pharmacy assignments, DHHS and the ACOs ensure that the member has reasonable access to healthcare, taking into account geographic location, reasonable travel time to pharmacy services, and adequate quality of necessary healthcare.

Temporary pharmacies may be approved for use by restricted members for good cause such as filling prescriptions for compounded medications; the primary pharmacy is temporarily out of a prescribed medication, hospital discharge medications filled by a hospital pharmacy etc. To request approval for additional temporary pharmacies to be added to the restricted member's case, members, pharmacies and providers may contact the DHHS Restriction Program at 801-538-9045 or the specific ACO Restriction Program in which the member is enrolled, as applicable.

8-3.1 Payment on Claims for Restricted Members:

Claims will not be paid unless services rendered to restricted members are submitted by the assigned PCP or submitted by other specialty or secondary providers to whom the PCP has provided a referral. Claims submitted for services rendered by specialty or secondary providers to restricted members must note the name and NPI of the referring PCP on the submitted claim in order to be eligible for payment. Claims submitted for specialty services for restricted members with modifiers 23, 25, 30, 47, 55, 56, 62, 75, 66 and 80 are only eligible for payment with a referral from the assigned PCP. Hospital in-patient claims are not subject to the Restriction Program.

Prior to providing services to Medicaid members, all providers are strongly advised to use the available resource of the online Eligibility Lookup Tool in order to identify member's enrollment in the Restriction Program. These tools will list any approved providers and pharmacies on the restricted member's case. Providers and pharmacies not listed on a restricted member's case are not approved for payment by the ACO or DHHS Medicaid Restriction Program.

8-3.2 Inmates of Public Institutions

Medicaid members who are inmates of a public institution (including jail) are not entitled to ongoing Medicaid services. The facility is responsible for all medical expenses incurred during the member's stay, unless the member becomes an inpatient in a hospital. An inmate may qualify for Medicaid for the inpatient stay days. An inmate must meet eligibility criteria for a Medicaid program.

8-4 Covered Services

8-4.1 Pharmacy Services

For information related to the coverage and payment of outpatient drugs, including medications obtained through the 340B program, which are dispensed or administered to Medicaid recipients, refer to the Utah Medicaid Provider Manual for Pharmacy Services at: https://medicaid.utah.gov.

8-4.2 Telehealth

Definitions

Telehealth - is the use of electronic information and telecommunications technologies that support distant healthcare to provide ease of access to health assessments, diagnostics, intervention, consultations, supervision, and education.

Telemedicine – see Telehealth.

Teledentistry is the use of information technology and telecommunications for dental care, consultation, and education.

Telepsychiatric Consultation is a consultation between a physician and a board-certified psychiatrist that utilizes:

- the health records of the patient, provided from the patient or the referring physician
- a written, evidence-based patient questionnaire

Authorized Provider means a provider in compliance with requirements as specified in this manual, refer to Chapter 3, *Provider Participation and Requirements*.

Distant site (hub site) – is where the provider delivering the service is located at the time the service is provided via telecommunications system.

Originating site (spoke site) – is the location of the Medicaid member at the time the service is being furnished via telecommunications.

Synchronous care is a live two-way interaction via telecommunication technology between a member at an originating site and a provider at a distant site that includes audio-visual (videoconference) or audio-only (telephone) communication.

Remote Patient Monitoring (RPM) is the deployment and use of technology to capture biometric information that is automatically shared with a remote provider. The transmission of patient data and clinical information to the provider may occur either through in-home devices or information entered and transmitted electronically by the patient.

8-4.2.1 Services

Telehealth services seek to improve an individual's health by permitting two-way communication between members and their providers and may be performed for a variety of medically necessary services. This communication often requires the use of interactive telecommunications equipment that can include both audio and video components but may also be conducted via audio-only. Audio-only telehealth is not allowed if it is solely for the sake of provider convenience. The utilization of telehealth services is dependent upon the member and their situation. As such, providers must determine the clinical appropriateness and medical necessity of the services being delivered through clinical-based decision making. Some examples of when telehealth may be appropriate are:

- Diagnostic review and discussion of results
- Evaluation and management services
- Management of chronic conditions
- Medication management
- Mental health, behavioral health, and substance use disorder services
- Telepsychiatric consultation
- Teledentistry
- Treatment counselling
- Wellness checks

There are no geographic restrictions surrounding the use of telehealth services. Medicaid covers telehealth services when performed via synchronous care. Telecommunication technologies that support synchronous care include:

- Live video two-way, face-to-face interaction between the member and the provider using audio-visual communication, including E-visits through an online patient portal.

- Audio only visits by means of telephone or other forms of communication without video.

As outlined by the Centers for Medicare and Medicaid Services (CMS), audio-only synchronous care or care that does not clinically require visual inspection, is covered for a limited number of services. Medicaid limits these services to:

- Behavioral health, including substance use disorders (SUD)
- Diabetes self-management
- Speech and hearing
- Nutritional counselling
- Tobacco cessation
- Education for chronic kidney disease
- Advanced care planning
- Medication therapy management

Providers are responsible for determining the applicable CPT and HCPCS codes associated with each of the above-listed services and ensure the codes are covered. Reporting requirements for services provided via telehealth are the same as those provided for services performed in-person.

Medicaid does not cover telehealth services when performed by means of asynchronous communication. Examples of asynchronous communication include:

- Email communication
- Text messaging
- Other forms of messaging with follow-up instructions or confirmations
- Mobile Health (mHealth)
    - Fitness tracker
    - Phone applications that record a patient's exercise
    - Automatic reminders such as when to take medicine.
    - Storing information or educational materials such as discharge instructions
- Remote patient monitoring (RPM)
    - Blood pressure monitors
    - Pacemakers
    - Glucose meters
    - Oximeters
    - Wireless scales
    - Heart rate monitors
- Store-and-forward imaging
- Transmission of lab or other diagnostic/screening results

Telepsychiatry

When psychiatrists consult with a physician regarding a member's possible need for telepsychiatry, they must report the following CPT codes to receive payment for services:

- 99446 Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting

physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
- 99447 11-20 minutes of medical consultative discussion and review
- 99448 21-30 minutes of medical consultative discussion and review
- 99449 31 minutes or more of medical consultative discussion and review

The treating physician, consulting with the psychiatrist, reports CPT code 99358 - *Prolonged evaluation and management service before and/or after direct patient care*

Teledentistry

Teledentistry services are covered for eligible members statewide.

Providers must report one of the following CPT codes to receive reimbursement for services:
- **D0140** –*Limited oral evaluation - problem focused; An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.*
- **D0170** - *Re-evaluation - limited, problem focused (established patient; not post-operative visit); Assessing the status of a previously existing condition. For example: - a traumatic injury where no treatment was rendered but patient needs follow-up monitoring; - evaluation for undiagnosed continuing pain; - soft tissue lesion requiring follow-up evaluation.*
- **D0171** – *Re-evaluation - post-operative office visit.*

The dentist, to receive reimbursement, must reports CPT code D9995- teledentistry - synchronous; real-time encounter; Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service to denote that services were rendered via teledentistry. Rates for approved teledentistry are the same as rates for in-person dental services.

8-4.2.2 Billing

Refer to the following when billing for services provided through telehealth:

Distant providers:
- CMS 1500 Professional Claims- Provider must indicate that the service(s) was provided via telehealth by indicating Place of Service (POS) 02 – Telehealth Provided Other than in Patient's Home, or POS 10 – Telehealth Provided in Patient's Home on the CMS 1500 claim form with the service's usual billing codes.
- UB-04 Institutional Claims- Providers must indicate that the service(s) was provided via telehealth by appending the GT modifier to the UB-04 institutional claim form with the service's usual billing codes.
    - GT - Via interactive audio and video telecommunication systems
- Services provided via telehealth have the same service thresholds, authorization requirements, and reimbursement rates as services delivered face-to-face.

8-4.2.3 Limitations

Telehealth encounters must comply with HIPAA privacy and security measures and the Health Information Technology for Economic and Clinical Health Act, Pub. L. No.111-5, 123 Stat. 226, 467, as amended to ensure that all member communications and records, including recordings of telehealth encounters, are secure and remain confidential. The provider is responsible for ensuring the encounter is HIPAA compliant. Security measures for transmission may include password protection, encryption, and other reliable authentication techniques. Compliance with the Utah Health Information Network (UHIN) Standards for Telehealth must be maintained. These standards provide a uniform standard of billing for claims and encounters delivered via telehealth.

Services not otherwise covered by Utah Medicaid are not covered when delivered via telehealth.

The provider, if the member is in a facility i.e. the originating site, receives no additional reimbursement for the use of telehealth services.

8-4.3 Other Covered Services

The following is a high-level list of covered services. More detailed information is described in State Plan Attachments 3.1-A and B and corresponding sections of this manual

1. Hospital Services:
   - Inpatient hospital services with the exception of those services provided in an institution for mental disease.
   - Outpatient hospital services
   - Outpatient surgical centers
   - Free-standing birth centers
2. Services for members age 65 or older in institutions for mental diseases:
   - Inpatient hospital services
   - Skilled nursing services
   - Intermediate care facility services
   - Intermediate care facility services, other than such services in an institution for mental diseases, for persons determined, in accordance with Section 1902(a)(31)(A) of the Social Security Act, to be in need of such care, including those furnished in a public institution or a distinct part thereof for the intellectually disabled or persons with related conditions.
3. Rural health clinic and federally qualified health clinic services.
4. Laboratory and x-ray services.
5. Family planning services and supplies.

   Family planning services and supplies are covered by Medicaid on a fee-for-service basis for an ACO plan member only if that member receives services from a Medicaid provider outside of her plan.
6. Physician’s services whether furnished in the office, the member's home, a hospital, a skilled nursing facility or elsewhere.
7. Autism Spectrum Disorder Related Services for EPSDT Eligible Individuals.
8. Podiatry services.
9. Optometry services.
10. Psychology services.
11. Chiropractic services

12. Home health services including intermittent or part-time nursing services provided by a home health agency, home health aide services, and medical supplies, equipment, and appliances.
13. Private duty nursing services.
14. Clinic services.
15. Dental services.
16. Physical therapy, occupational therapy, and related services.
17. Services for individuals with speech, hearing, and language disorders furnished by or under the supervision of a speech pathologist or audiologist.
18. Drugs, dentures, prosthetic devices, and eyeglasses prescribed by a qualified practitioner.
19. Medical supplies and durable medical equipment.
20. Other diagnostic, screening, preventive, substance abuse, and rehabilitative services, such as other than those provided elsewhere in the State Plan.
21. Nurse-midwife services and free-standing birth centers.
22. Hospice care in accordance with Section 1905(o) of the Social Security Act.
23. Case management services in accordance with Section 1905(a)(19) or Section 1915(g) of the Social Security Act, as to the group or groups.
24. Enhanced services for pregnant women in addition to services for uncomplicated maternity cases and Certified Nurse Midwife services. Enhanced services may include:
    - Medical or remedial care or services provided by licensed practitioners, other than physician's services, within the scope of practice as defined by state law
    - Medical transportation
    - Skilled nursing facility services for members through age 20
    - Emergency hospital services
    - Personal care services in the member's home, prescribed in accordance with a plan of treatment and provided by a qualified person under the supervision of a registered nurse
25. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider in accordance with Section 1920 of the Social Security Act.
26. Extended services to pregnant women including pregnancy-related and postpartum services to the end of the 12th month after the pregnancy ends, including additional services for any other medical conditions that may complicate pregnancy with increases of service.
27. Skilled nursing facility services, other than services in an institution for mental diseases, for members over 20 years of age.
28. Child Health Program - Medical Services for Medicaid members enrolled in Traditional Medicaid ages birth through twenty. (Refer to *Chapter 8, Programs and Coverage*).
29. Other medical care and other types of remedial care recognized under State law, specified by the Secretary of the United States Department of Health and Human Services, pursuant to 42 CFR §440.60 and 170, including:
    - Medical or remedial care or services, provided by licensed practitioners, other than physician's services, within the scope of practice as defined by state law
    - Medical transportation
    - Skilled nursing facility services for members through age 20
    - Emergency hospital services
    - Personal care services in the member's home, prescribed in accordance with a plan of treatment and provided by a qualified person under the supervision of a registered nurse
30. Medical interpretive services for members with limited English proficiency or disabilities.

31. Third party insurance premiums, including the Medicare Part A and/or Part B payments. Payments for Medicare members are covered under the Buy-in Program. Other third-party health care premium(s) may be covered under the Buy-Out Program if continued third party coverage for the eligible recipient is determined to be cost-effective.

9 Non-Covered Services and Limitations

9-1 Limited Abortion Services

Medicaid reimbursement for abortion services is limited to procedures consistent with the Hyde Amendment restrictions. The Hyde Amendment allows for the use of federal funds for abortion procedures to terminate a pregnancy under two conditions:

- In the professional judgment of the physician overseeing the pregnant woman's care, abortion is necessary because the life of the mother would be endangered if the fetus were carried to term; and all requirements of 42 CFR 441 Subpart E have been satisfied; or
- The pregnancy is the result of rape or incest reported to law enforcement agencies, unless the woman was unable to report the crime for physical reasons or fear of retaliation.

In addition to the above conditions, Medicaid reimbursement for abortion services is allowed only when:

- Prior authorization is obtained,
- A properly executed and completed Utah Medicaid Abortion Acknowledgement and Certification Form is submitted, and
- A properly executed and completed Utah Medicaid Prohibition of Payment for Certain Abortion Services Provider Certification form is on file with the Office of Medicaid Operations.

When circumstances occur that lead to a natural pregnancy loss or inevitable abortion, Medicaid will not reimburse any procedures or misoprostol when fetal heart tones are present. Ultrasound must confirm no fetal heart activity before procedures or misoprostol are initiated or administered.

9-2 Services Not Covered Regardless of Medical Necessity

The following services are not covered by Medicaid regardless of medical necessity. The list is not all-inclusive. Additional non-covered services are described in the Physician Services Section of this manual and other corresponding sections.

Examples:

- Complementary Alternative Medicine (CAM) (e.g., Acupuncture, biofeedback)
- Cosmetic surgery
- Medications for weight loss or those considered experimental, investigational, or unproven (See Note below)
- Experimental or investigational, or unproven procedures or services (See Note below)
- Laser eye surgery used to correct refractive errors
- Fees for missed appointments

Note: Experimental, investigational, or unproven services do not include qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the “Consolidated Appropriations Act, 2021

9-3 General Non-Covered Services

9-3.1 Limiting Amount, Duration, or Scope of Services

The Division of Integrated Healthcare has the authority to limit the amount, duration, or scope of services or to exclude a service or procedure from coverage by Medicaid. Policy recommendations are based on medical necessity, appropriateness, and utilization control concerns [42 CFR §440.230]. Recommendations consider the following:

- Existing policy for non-covered cosmetic, experimental, or unproven medical practices (excluding members who are participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the "Consolidated Appropriations Act, 2021")
- Information available from the Centers for Medicare and Medicaid Services, Department of Health and Human Services. Information and recommendations from physician consultants employed by the Utah Department of Health and Human Services, Division of Integrated Healthcare. Consultation with appropriate groups or individuals from various professional organizations
- Legal counsel
- Consultation with policy staff of the local Medicare carrier
- Consultation with policy staff of Medicaid programs in other states (selected)

9-3.2 Out-of-State Services

Medically necessary, scheduled, medical services are furnished out-of-state to Utah Medicaid members in accordance with 42 CFR §431.52. Medical necessity is indicated when the same services or the closest Medicaid providers are not available within the state, or a higher level of expertise is available in another state, or there is no other equally effective course of treatment available or suitable for the patient requesting the service, that is more conservative or substantially less costly. The out-of-state provider must be enrolled or will be enrolled with Utah's Medicaid program on or before the date of service.

Emergency medical services are reimbursed if the services are a covered Utah Medicaid benefit and if the provider becomes a Utah Medicaid provider.

9-3.2.1 Non-Resident Provider Telehealth Reporting for In-State Members

A non-resident provider may report telehealth services given to an in-state Medicaid member when the following conditions are met:

- The provider meets the licensing requirements of the Department of Professional Licensing (DOPL) as outlined in Utah Annotated Code 58-1-302.1
- The provider is enrolled as a Utah Medicaid provider as explained in Chapter 3 *Provider Participation and Requirements*
- Follow the policies outlined in Chapter 8-4.2 *Telehealth*.

9-3.3 Experimental, Investigational, or Unproven Medical Practices

Medicaid does not reimburse providers for medical, surgical, other health care procedures or treatments, including the use of drugs, biological products, other products, or devices that are considered experimental, investigational, or unproven. (See Note below)

- **Experimental, investigational, or unproven medical practice**: Any procedure, medication product, or service that is not proven to be medically efficacious for a given procedure; or

performed for or in support of purposes of research, experimentation, or testing of new processes or products; or both. (See Note below)

- **Medically efficacious:** A medical practice that has been proven to be as effective or superior to conventional therapies, and is widely utilized as a standard medical practice for specific conditions; and has been approved as a covered Medicaid service by division staff and physician consultants on the basis of medical necessity.
  Some procedures may have research supporting efficacy, but do not yet have a HCPCS code available for billing. Coverage determination recommendation is made through Utilization Review or EPSDT committees on a case by case basis when there is evidence-based efficacy research and documentation of member medical necessity. If coverage is recommended, the case then goes through the administrative approval process before the provider is notified of the final decision.

Note: Experimental, investigational, or unproven services do not include qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the "Consolidated Appropriations Act, 2021.")

9-3.3.1 Qualifying Clinical Trials

A "Qualifying Clinical Trial" is a clinical trial (in any clinical phase of development) that is conducted in relation to the prevention, detection, or treatment of any serious life-threatening disease or condition and is described in any of the following as defined in the Consolidated Appropriations Act, 2021 as follows:

1. The study or investigation approved, conducted, or supported (which may include funding through in-kind contributions) by one or more of the following:
   - The National Institutes of Health
   - The Centers for Disease Control and Prevention
   - The Agency for Healthcare Research and Quality
   - The Centers for Medicare and Medicaid Services
   - A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veterans Affairs
   - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
   - Any of the following if the conditions described below are met:
     - The Department of Veterans Affairs
     - The Department of Defense
     - The Department of Energy
       - Conditions, with respect to a clinical trial approved or funded by an entity described above, are that the clinical trial has been reviewed and approved through a system of peer review that are:
         - Comparable to the system of peer review of studies and investigation used by the National Institutes of Health; and
         - Assured unbiased reviews of the highest scientific standards by qualified individuals with no interest in the outcome of the reviews

2. The clinical trial is conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act.
3. The clinical trial is a drug trial that is exempt from being required to have an exemption described in 2.
4. Providers and the principal investigator (entity conducting the qualifying clinical trial) must validate the appropriateness of the trial by using the National Clinical Trial Number found at https://clinicaltrials.gov/. The National Clinical Trial Number must be placed on the Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial Form.
5. This form is found on the Medicaid.gov website page Medicaid SPA Processing Tools for States under the "Benefits and Coverage SPA Tools" section. Coverage determinations are not restricted to the location of the trial. Not all services that are a part of the clinical trial may require prior authorization. However, when they do, providers must include the completed Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial Form along with the completed Prior Authorization Request Form. Fax both forms to 801-536-0162 or email both completed forms to fax_allotherauth_prior@utah.gov.
6. Please review the Qualifying Clinical Trials and Medicaid FAQ for more information regarding qualifying clinical trials.

9-3.4 Exceptions when Medicaid will pay for Non-Covered Procedures

Generally, Medicaid does not reimburse non-covered procedures. However, exceptions are considered through the utilization review process in the circumstances listed below:

- The member is eligible for services under the ESDT program. EPSDT may pay for services which are medically necessary but not typically covered by Medicaid.
- Reconstructive procedures following disfigurement caused by trauma or medically necessary surgery.
- Reconstructive procedures to correct serious functional impairments (for example, inability to swallow).
- When performing the procedure is more cost effective for the Medicaid Program than other alternatives, unless otherwise prohibited by the Utah Medicaid State Plan.

9-3.5 Quantity Limits

Some services, medical supplies, and durable medical equipment have established quantity limits. Specific quantity limits are indicated on the Coverage and Reimbursement Code Lookup tool. A prior authorization request must be submitted when requesting more than the allowed amount.

The prior authorization request must include proper documentation of medical necessity, specifically why the quantity limit needs to be exceeded, how much is being requested, and over what period of time.

10 Prior Authorization

The information in this chapter pertains to prior authorization (PA) requests for Utah Medicaid fee-for-service authorizations only. If the prior authorization request is for a member covered under a Managed Care Organization (MCO), and the service being requested is not a carve-out service, contact the MCO for instructions on requesting prior authorization. Contact information for Managed Care Organizations

is found on the Utah Medicaid website at https://medicaid.utah.gov/prior-authorization, *Contact Us*; scroll to the applicable MCO.

When prior authorization is required for a health care service, the provider must obtain approval from Medicaid before service is rendered to unless the program specific Section of the provider manual states that there are exceptions to obtaining authorization prior to service delivery. Medicaid can pay for services only if all conditions of coverage have been met, including but not limited to, the requirement for prior authorization. Failure to obtain prior authorization may result in a denial of payment. Providers are responsible for determining whether prior authorization is required.

There are exceptions to the requirement for written prior authorization for specific provider types and services; these are noted in the related sections of this manual.

Code specific criteria and instructions are in the Coverage and Reimbursement Lookup Tool at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

10-1 Request Prior Authorization

To obtain prior authorization, the provider must complete a current copy of the appropriate prior authorization request form and submit it, with all required documentation, to the Prior Authorization Unit at the Division of Integrated Healthcare. The appropriate forms are found at https://medicaid.utah.gov/prior-authorization, *General PA Forms or Pharmacy Criteria Forms.*

When a prior authorization request is submitted without complete documentation, the request is returned without processing. Medicaid returns the request and indicates what additional documentation is required before the request can be reviewed to determine medical necessity. A returned request is not a denial and has not accrued hearing rights. When a prior authorization request is returned for lack of documentation, the provider is required to resubmit the entire request including the additional documentation. Upon receipt of the resubmitted request, Medicaid staff reviews the PA request to determine if the service is covered by Medicaid and if the service is medically necessary. The date in which a complete request, with all necessary supporting documentation, is received will be the date posted for the PA request.

When a prior authorization request is denied, Medicaid sends a written notice of decision to the member, and a copy to the provider. Either or both may appeal the denial.

10-1.1 Denial Letter

If Medicaid denies authorization, the letter of denial is sent and includes this information:

- The action Medicaid intends to take
- The reasons for the action
- Statement of the laws and criteria supporting the action
- The right to a hearing
- The process to request a hearing
- The right to be represented by an attorney or other person
- The circumstances, if any, under which the service is continued pending the outcome of the hearing

Copies of applicable policies, laws, and criteria supporting the decision are included with the letter. A *Hearing Request Form* with instructions for requesting a hearing is also attached. The denial letter does not include a request for new or additional information.

When a request for a hearing is submitted, Medicaid follows the policy and procedure under Utah Administrative Code, Section R410-14.

10-1.2 Prior Authorization Submission Methods

FAX Requests:

FAX the PA request to the appropriate number listed on the applicable prior authorization request form. The prior authorization request forms are found at https://medicaid.utah.gov/prior-authorization, General PA Forms or Pharmacy Criteria Forms.

Mail PA requests to:
Medicaid Prior Authorization Unit
P. O. Box 143111
Salt Lake City, UT 84114-3111

Telephone Submission:
When policy permits, submit a request by calling (801) 538-6155 or 1(800) 662-9651; Select option 3, option 3 and then select the appropriate program.

Medicaid PA unit hours are M, W, Th, F, 8:00 a.m. to 5:00 p.m. and Tuesday 11:00 a.m. to 5:00 p.m.

10-2 Prior Authorization for EPSDT Eligible Members

Coverage may be available for EPSDT eligible members when a service is not covered by Medicaid for an adult. For complete information concerning prior authorization for EPSDT eligible members, refer to the applicable Section 2 of *the Utah Medicaid Provider Manual*: *EPSDT Services* and *Autism Spectrum Disorder Related Services for EPSDT Eligible Individuals*.

Prior authorization requests for EPSDT services must be in writing and include all applicable information listed below:

- Estimated cost for the service or item.
- Photocopy of any durable medical equipment item(s) requested.
- Current comprehensive evaluation of the child's condition, completed by the appropriate therapist, that includes the diagnosis, general medical history, therapy treatment history, age, height, weight, capabilities, prognosis, specific limitations, and the purpose for any durable medical equipment that is requested.
- Letter from the physician describing medical necessity and including the diagnosis, the medical reason for the request, the medical condition that justifies the request, and the portion of the medical history that applies to the specific request. The letter must be patient specific, indicate the reasons the physician is recommending the service or equipment, and whether the service or equipment would contribute to preventing a future medical condition or hospitalization.

All providers involved in the diagnosis, evaluation or treatment of the patient, should communicate directly and work together as a team to evaluate the most appropriate services for the child.

10-3 Retroactive Authorization

When providers have delivered a service requiring prior authorization without having obtained prior authorization, Medicaid allows requests for retroactive approval under limited circumstances outlined in this chapter. If the criteria are not met, Medicaid will not consider retroactive authorization and the claim will be denied.

In addition to the criteria outlined throughout Chapter 10-3.1 *Retroactive Medicaid Member Eligibility*, services provided must meet all Medicaid criteria for coverage and providers must:

- Complete the appropriate prior authorization request form,
- Provide documentation supporting the medical necessity of the services; and
- Include documentation describing why the provider delivered the service(s) without authorization

A provider must request retroactive authorization within 180 days following delivery of services or Medicaid will deny coverage of the services.

Providers should request authorization, whenever possible, prior to the service being rendered.

Refer to the program-specific Utah Medicaid provider manuals for documentation and criteria requirements of the requested service.

10-3.1 Inaccurate Information

If a provider demonstrates that a Medicaid representative or Medicaid's website gave inaccurate information about the need for prior authorization, a retroactive authorization may be requested.

Providers must submit supporting documentation of inaccurate information in writing via email, fax, or letter. The documentation must include corroborating information such as the customer service representative's name with the date and time of the phone call or screenshots from the website with a timestamp, etc.

10-3.2 Medicaid Member Eligibility

There are circumstances in which an individual's eligibility and enrollment with Medicaid have yet to be determined. Upon verification of Medicaid eligibility, a provider may request retroactive approval of services that require prior authorization. Refer to Chapter *8-2.3 Retroactive Eligibility* of this manual for additional information. Medicaid eligibility verification, including retroactive eligibility, is the provider's responsibility.

Once member eligibility has been determined, a provider may submit a retroactive authorization request for services rendered during the retroactive period.

10-3.3 Medical Emergency

Services performed during a medical emergency, that require prior authorization, are eligible for retroactive authorization including medical supplies and durable medical equipment.

Documentation must support emergent and medical necessity criteria as well as any other Medicaid coverage criteria.

10-3.4 Medical Supplies Provided in a Medical Emergency

Certain medical supplies and equipment that require prior authorization may be provided in a medical emergency before authorization is obtained from Medicaid. When a medical emergency occurs, Medicaid may consider the request for retroactive authorization and payment.

It is the responsibility of the medical supplier to substantiate the emergency and provide the necessary documentation to support a prepayment review.

Providers must obtain prior authorization for all other services, supplies, and equipment, even if the member's circumstances appear to qualify as an emergency.

Examples of medical supplies that may meet this condition: hospital bed, oxygen and related equipment. Refer to *Medical Supplies Provider Manual, Section 2,* for details.

10-3.5 Surgical Procedures

If, during a surgical procedure, a physician determines that an additional or different procedure is medically necessary, and if the service meets all Medicaid criteria for coverage but requires prior authorization, the service is eligible for retroactive authorization. The provider must provide documentation supporting the change in the planned procedure.

10-3.6 Anesthesia Providers

When a surgical procedure requires prior authorization, the associated anesthesia codes are typically prior authorized as a component of the procedure.

When a surgical procedure does not require prior authorization, but the associated anesthesia code does, the anesthesia code, in this instance, does not require prior authorization.

When a surgical procedure requires prior authorization and the surgeon fails to obtain prior authorization, retroactive authorization may be approved when all required documentation is submitted and upon confirmation that the surgery was not:

- Previously denied by Medicaid
- Cosmetic, investigational, or experimental (excluding members participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the "Consolidated Appropriations Act, 2021")
- A non-covered service (for more information see General Information: Section I, Chapter 12-7.5 *Appealing Denial*)
- A service prohibited without state or federally required consent forms.

10-3.7 Inmates of Public Institutions

Inmates are not eligible for Medicaid while incarcerated. However, the Eligibility Lookup Tool will indicate that the individual is eligible for Medicaid if they were eligible before incarceration. The prior authorization (PA) reviewer will verify admission to an inpatient hospital setting and that they are an inmate before issuing a PA.

Before rendering services that require a PA, acquisition of a PA is not necessary for inmates. Medicaid authorizes requests retroactively when services are deemed medically necessary and documentation meets Medicaid policy requirements.

Providers must include the following as part of their retroactive prior authorization request:

- Complete the appropriate PA request Form(s) and provide documentation that justifies the requested retroactive authorization
- Include inmate status on the PA request
- Include medical documentation that establishes the medical necessity of the requested services

10-3.8 Members with Medicaid and Medicare (Dual Eligibility)

Due to considerable variances in Medicare and Medicaid coverage policies, retroactive authorization for durable medical equipment, medical supplies, prosthetics, or orthotics may qualify for retroactive authorization of services.

Medicaid does not make exceptions for retroactive authorization for Medicare Supplement Plans. For additional information regarding dual eligibility, refer to *Chapter 11-5.1 Medicare Crossover Claims* of this manual.

Note: Medicare Crossover claims only apply to Medicare Part A and Part B. No exceptions will be made for Medicare Supplement Plan Coverage.

10-3.9 Exceeding Quantity Limits

Providers may request retroactive authorization when quantity limits are inadvertently exceeded. For example, a provider unknowingly exceeds quantity limits for a previously performed service by a different provider. The new provider should make every reasonable effort, such as contacting customer service, to determine if quantity limits have been met.

Each provider is responsible for checking quantity limits and requesting prior authorization once quantity limits are met. Quantity limits are counted toward the member and are not unique to the provider. Additionally, if more than one request is received for the same item or service, authorization for the first complete request will be the one approved.

This exception does not apply to pharmacy claims. For more information, refer to the Pharmacy Services provider manual.

10-4 Exceptions to Prior Authorization Requirements and Non-Covered Services

Medicaid delay in prior authorization

When a delay in prior authorization rests with Medicaid, the date of the complete submission for prior authorization is considered. However, the submitted documentation must meet the criteria for approval.

Non-covered services

Generally, Medicaid does not provide reimbursement for non-covered services. However, exceptions may be considered through the prior authorization/utilization review process in the circumstances listed below and when there is no code that is a covered Medicaid benefit that accurately describes the service to be provided:

- The member is EPSDT eligible. The EPSDT program may pay for services which are medically necessary but not typically covered by Medicaid.
- Reconstructive procedures following disfigurement caused by trauma or medically necessary surgery.
- Reconstructive procedures to correct serious functional impairments (for example, inability to swallow).
- When providing a service which is more cost effective for the Medicaid program than other alternatives.

11 Billing Medicaid

This chapter covers topics such as billing procedures, third party claims, coding, and manual review.

The provider may bill Medicaid only for services which were medically indicated and necessary for the member and either personally rendered or rendered incident to his professional service by an employee under immediate personal supervision, except as otherwise expressly permitted by Medicaid regulations. The billed charge may not exceed the usual and customary rate billed to the general public, such as individual member accounts or third-party payer accounts.

11-1 Medicaid is the Payer of Last Resort

As required by law, Medicaid is the payer of last resort, meaning that other third parties must be billed before Medicaid can be billed for the service. Medicaid members may have third party coverage of health expenses, such as Medicare, employment-related insurance, private health insurance, long-term care insurance, court judgments, automobile insurance, and so forth. Again, all other resources must be exhausted before Medicaid can consider payment.

11-2 Unacceptable Billing Practices

The use of any device or strategy that may have the effect of increasing the total amount claimed or paid for any service beyond the maximum allowable amount payable for such service is not allowed. Following are examples of unacceptable billing practices.

- Duplicate billing or billing for services not provided.
- Submitting claims for services or procedures that are components of a global procedure.
- Submitting claims under an individual practitioner’s provider number for services performed by the practitioner as an employee of or on behalf of a group practice or clinic when the service has been billed under the group or clinic number.
- Use of more intensive procedure code than the medical record indicates or supports.
- Separate charges for freight, postage, delivery, installation, or facility visits. These services are considered part of the providers’ or facilities' rates unless otherwise specified in policy.

11-3 Business Agents

A billing or business agent is a person or an entity that submits a claim for a provider and receives Medicaid payments on behalf of a provider. Payments may be made to a business agent, such as a billing service or an accounting firm that furnishes statements and receives payments in the name of a provider, if the agent's compensation for this service meets three conditions: (1) is related to the cost of processing the claim; (2) is not related on a percentage or other basis to the amount that is billed or collected; and (3) is not dependent upon the collection of payment.

11-3.1 Attending Provider

When reporting for facility services, the attending provider is a physician or other qualified healthcare professional who has the overall responsibility for the member’s medical care.

11-4 Factoring Prohibited

As a reminder to all providers, federal regulations prohibit the use of a factor to obtain payment from Medicaid for any service furnished to a Medicaid member. The regulations define a factor as an individual or an organization, such as a collection agency or service bureau, which advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. A factor does not include a business representative. Payment for any service furnished to a Medicaid member by a

provider may not be made to or through a factor, either directly or by power of attorney. (Services provided under Emergency Only programs are exceptions to this factoring prohibition.)

11-5 Third Party Coverage

11-5.1 Medicare Crossover Claims

Medicaid Members who have Medicare: Accepting Members with Dual Coverage

When a Medicaid member also has Medicare, a provider may either accept the member as having dual coverage *or* not accept either type of coverage. Federal Medicaid regulations do not permit a provider to reject Medicaid and accept only Medicare. For example, when a member has Medicare, a provider cannot bill the member for services that would have been provided under Medicaid, and accept only Medicare payment. A provider can only refuse Medicaid and insist the member must be "private pay" *if* there is no Medicare coverage. Of course, the Medicaid agency urges that providers accept the patient as a Medicaid member, then follow the procedures outlined in the applicable Sections of the *Utah Medicaid Provider Manual* for billing TPL.

Medicare/Medicaid Crossover Claims

To ensure prompt processing, the Medicaid provider’s NPI must be on the claim. The deadline for filing a Crossover claim is 365 days from date of service or six months after Medicare disposition. Medicaid may then consider payment of a Medicare deductible and co-insurance, even if the Medicare intermediary or carrier crosses the claim to Medicaid after more than a year has passed since the date of service. Medicaid may also consider such a claim for payment if Medicare notifies only the provider and does not electronically forward the claim to Medicaid.

If the provider accepts assignment for Medicare Part A or Part B, the Crossover claim is sent to Medicaid Crossovers automatically from the intermediary. If the provider does not accept assignment, a claim is not sent automatically, and the provider must submit the claim directly to Medicaid Crossovers.

Payment is reported on the Crossover section of the Medicaid Remittance Statement. The Medicare and Medicaid payment are considered payment in full.

Submit claims directly to Medicaid Crossovers. Instructions are online at https://medicaid.utah.gov/ under Coordination of Benefits.

Non-Covered Medicare Services

Bill claims for non-covered Medicare services, such as non-durable medical supplies, drugs, and Intermediate Care Facility (ICF) nursing home care provided to Medicare/Medicaid eligible members directly to Medicaid.

Submission of Crossover Claims

Electronic Claims Only

It is necessary to submit an Explanation of Medicare Benefits (EOMB) for $0 payment or denials. Complete the other payer payment information, including payer paid amount, member liability, and reason codes.

Submit to:
Utah Medicaid Crossovers HT000004-005
Fee-for-Service HT000004-001
Atypical HT000004-801

11-5.2 Correcting Third Party Liability Information

If third party liability (TPL) information appears to be incorrect (for example, the TPL denies a claim as "patient not eligible"), the provider should advise the member to call the TPL unit in the Office of Recovery Services (ORS) at the Department of Human Services. Providers may also call ORS to advise them of correct third-party liability information.

11-5.3 Billing Third Parties

If a member has both Medicaid and coverage with a responsible third party, do not collect a co-payment that is usually due at the time of service. The provider should include the primary insurance co-payment as part of the submitted charges to Medicaid. A provider must seek and secure payment from all other liable third parties such as insurance coverage, a health plan and Medicare Part A and B. The Medicaid payment is made after all other liable third parties have made payment or sent a denial.

Bill the responsible third party, then Medicaid, as follows:

1. Submit the claim to the third party or parties.
2. If the third party pays the claim, submit a claim to Medicaid and show the TPL payment according to instructions. Medicaid bases any subsequent reimbursement on the Medicaid fee schedule.
3. Medicaid will make an additional payment to a provider for services rendered if the payment received from the insurance company is less than the Medicaid reimbursement amount or

   Medicaid will not make an additional payment if the amount received from the insurance company is equal to or greater than the Medicaid reimbursement amount. In this case, the TPL payment is considered payment in full. A provider will not bill the member for any difference between the amount charged and the TPL payment received.

If a provider receives a third-party payment and does not bill Medicaid for the balance because he or she anticipates the Medicaid payment to be zero, the TPL payment is considered payment in full, and the provider may not bill the member.

An exception is inpatient hospital claims with third party insurance. Refer to*, Hospital Services of Provider Manual, Section 2*.

If the third party denies the claim for any reason (non-covered benefit, patient not eligible, etc.) submit a claim to Medicaid. The claim may be filed electronically, include written documentation on the TPL response. Documentation sent separately goes to ORS. If the third party pays less than

reported on the Medicaid claim, submit a replacement claim showing the correct amount received from the TPL.

When a Medicaid claim is suspended for third party liability information, you can expedite the processing of the claim by faxing the complete Explanation of Benefits (EOB) directly to the Health Claims team at ORS. Include the second page which usually has the definitions of coded reasons for not paying the claim.

For claims other than Medicare or TPL use FAX number (801) 536-8513.

For additional guidance on TPL and/or Coordination of Benefits, please visit the following website resource pages: https://medicaid.utah.gov/utah-medicaid-official-publications/ and https://medicaid.utah.gov/hipaa/providers/#companion-guides.

11-5.4 Billing Services for Newborns

Bill all services for newborns with the baby's own (unique) Medicaid member number. You may obtain the baby's Medicaid number by calling Medicaid Information. Refer to Chapter 1, Member Information.

If the baby does not have a unique Medicaid member number, the mother must notify her eligibility worker immediately. The worker determines the child's eligibility, and a unique Medicaid member number is assigned to the child.

Note: A newborn infant is not covered when his or her mother is eligible only for the Baby Your Baby Program. In this case, the mother must apply for Medicaid on behalf of the child if she needs assistance in paying the child's medical bills.

11-6 Submitting Claims

11-6.1 Electronic Claims

Utah Medicaid promotes the use of electronic transactions. Electronic Data Interchange (EDI) is the exchange of health-related information, including claims, electronically. The Medicaid EDI team is available to provide direction, answer questions, and assist providers or billing agents with the submission of electronic transactions. In order to submit claims electronically, providers must complete an EDI application form, which can be found on the Medicaid website at https://medicaid.utah.gov/.

Medicaid utilizes the Utah Health Information Network (UHIN), an internet-based system that can be used to interface between a medical billing system and UHINet (UHIN's internal portal). It can also be used to directly type in claims, eligibility inquiries, exchange administrative messages (claims, remits, claim attachments). UHIN is the receiving point for Medicaid health care transactions, and transactions sent to Medicaid via UHIN are immediately placed in the MMIS for processing during the next claim cycle. For more information, visit the UHIN website at https://UHIN.org or contact UHIN at (801) 466-7705.

If providers use software other than UHIN, it must be compatible with UHIN and conform to ANSI standards. Your software vendor can advise you as to the systems which use the ANSI standards in compliance with HIPAA and UHIN requirements.

11-6.2 Paper Claims (Discontinued)

For questions about Utah Medicaid's former paper claims process, please contact Customer Service at 1(800) 662-9651 or (801) 538-6155.

11-6.3 NCPDP Pharmacy Point of Sale (POS) System

The Point of Sale (POS) system accepts standardized claims for pharmacy services to be submitted through an electronic data exchange. For information about acceptable software for submitting inquiries, transmitting claims, and electronic procedures and messages, refer to Pharmacy Services Provider Manual, *Chapter 6 Billing*. As electronic data interchange features become available, Medicaid will notify providers in the Medicaid Information Bulletin.

11-6.4 Electronic Data Interchange (EDI) Resources

Utah Medicaid follows the HIPAA mandated TCS standards as set forth by DHHS and CMS. Electronic Data Interchange (EDI) is the most efficient method of submitting and receiving large amounts of information within the Utah Medicaid Management Information System (MMIS). Accredited Standards Committee (ASC X12) Implementation Guides are available from the Washington Publishing Company.

Utah Medicaid-specific Companion Guides to the X12 Implementation Guides and National Council of Prescription Drug Programs (NCPDP) payer sheets are available on the Medicaid website at https://medicaid.utah.gov.

Utah Medicaid EDI Help Desk

Telephone 1(800) 662-9651 or (801) 538-6155, option 3, option 5
Mail written correspondence to:
Office of Medicaid Operations
PO Box 143106
Salt Lake City, UT 84114-3106

11-6.5 Time Limit to Submit Medicaid Claims

Federal regulations require that a claim must be submitted to Medicaid within 365 days from the date of service. The date of service, or "from" date on the claim, begins the count for the 365 days to determine timely filing. For institutional claims that include a span of service dates (i.e., a "from" and "end" date on the claim), the "end" date begins the count for the 365 days to determine timely filing. Any adjustments or corrections must also be received within the 365-day time period.

Requesting Review of Claim That Exceeds Billing Deadline

It is to the provider's advantage to submit claims and follow-up on unpaid balances within the billing deadline. Claims received by Medicaid after the billing deadline will be denied. Providers may request

to correct a claim outside of the timely filing deadline; however, no additional funds will be reimbursed. Any exception to the 365-day limit is stated below.

Untimely Claims - When Payment Can Be Made

If Medicaid denied a claim for exceeding the billing deadline, the provider may request a review for payment. The situations listed below may be considered for review, provided specific, appropriate documentation is submitted.

- Provider is under investigation for fraud or abuse.
- Court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.
- Situations involving a provider who conforms with Medicaid requirements by billing a third-party payer first, resulting in non-payment after the 365-day billing deadline, have been allowed as an exception to the filing deadline in hearing decision numbers 13-078-02 and 13-239-03. In accordance with 42 CFR §447.45(d)(4)(iv) and the above paragraph, if a provider files a claim beyond the 365-day limit in such a situation, it is a "same situation" as to prior agency hearing decisions and may be processed.
- Situations involving agency error in processing a timely clean claim resulting in the provider having to again file the claims beyond the one-year deadline have been allowed as an exception to the filing deadline in hearing decision numbers 13-212-08 and 13-212-22. In accordance with 42 CFR §447.45(d)(4)(iv) and paragraph 2 above, if a provider files a claim in such a situation, it is a "same situation" as to prior agency hearing decisions and may be processed.

Requesting Review for Payment

If the provider has documentation to demonstrate one of the above situations, send the documentation with a copy of the Medicaid remittance and a Document Submission Form, to:

Office of Medicaid Operations
Attn: Timely Filing Review
PO Box 143106
Salt Lake City, Utah 84114-3106

When the documentation is received, the request is reviewed. If Medicaid finds that criterion for one of the timely filing exceptions is met, Medicaid will waive the time limit and initiate processing of the claim.

11-6.6 Clean Claims and New Claims

The definitions of the terms "clean claim" and "new claim" affect which claims and adjustments Medicaid may consider for payment when more than 365 days have passed since the date of service.

Clean claim - Federal regulations define a clean claim as a claim that Medicaid can process without obtaining additional information from the provider of the service or from a third party, including a claim with errors originating in a State's claim system. A claim that denies for omitted or incorrect date or for

missing attachment is not a clean claim. A claim filed more than 365 days after the date of service is not a clean claim.

New claim - A new claim is a claim that is unique, differing from all other claims in at least one material fact. It is important to note that identical claims received by Medicaid on different days differ in the material fact of their receipt date and are both new claims unless defined otherwise.

11-6.7 Resubmit Claims with Corrected Information

If a claim is denied for incorrect information, correct the claim and resubmit it, rather than calling Medicaid Information. Until the claim is billed correctly, it cannot be processed.

Claim Corrections through Re-Submission

Occasionally a claim is paid incorrectly (e.g., a line denied), if this occurs a replacement claim must be filed. Refer to the EOB for denial or payment information. The following data elements are required to identify the claim as a replacement or void of an original claim:

Claim Frequency Code

Acceptable values:	6 or 7 for replacement, 8 for void
Electronic:	X12 element 2300 CLM05-3
Paper:	UB-04 - Form Locator 4, position 3
	CMS 1500 (08/05) - Box 22 (Code)

Dental - Process not available on paper.

Original Reference Number

Transaction Control Number (TCN) of original claim to be replaced or voided

Electronic:	X12 element 2300 REF02
Paper:	UB-04 - Form Locator 37 A-C (same line as Medicaid in 50A-C)
	CMS 1500 (08/05) - Box 22 (Original Ref. No.)

Dental - Process not available on paper.

Replacement claims void the original claim and process the replacement claim. Consult with your programmer to verify the required data elements are available in your software. Claims submitted without a valid original reference number (TCN) will be rejected.

The NPI must be the same on both the replacement/void and the original claim. If providers are different, send a void for the original claim and resubmit an original claim for the correct provider.

11-7 Payment Denial for Members Not Eligible for Medicaid or Enrolled in an MCO

Medicaid is a benefit only to eligible persons. Medicaid will not pay for services rendered to an individual who is not eligible for Medicaid benefits on the date the service is rendered. Medicaid will not make fee-for-service payments when a member is enrolled in an MCO unless the service is carved out. It is the provider's responsibility to verify the individual's eligibility for Medicaid for the date the service is rendered. It is also the provider's responsibility to verify if the individual is enrolled in an

MCO. Claims for ineligible individuals or claims that are the responsibility of an MCO will not be paid even when information was given in error by Medicaid staff. Staff make every effort to provide complete and accurate information on all inquiries.

11-8 HIPAA Transaction and Code Set Requirements

With established national standard for electronic claims and other transactions, healthcare providers are able to use consistent procedures and codes when submitting transactions to a health plan anywhere in the United States[1].

Standards for nine electronic transactions and code sets are used in claims transactions. These include:

- Claims or Encounter Information
- Eligibility Inquiry and Response
- Payment and Remittance Advice
- Referral Certification and Authorization (Prior Authorization)
- Claim Status Inquiry and Response
- Enrollment/Dis-enrollment in Plan
- Premium Payments

- Professional Claims (837 Professional)
  837 Professional Transaction
  The ASC X12N 837 Professional transaction is the electronic equivalent for the CMS-1500 (08/05) paper claim form.

- Institutional Claims (837 Institutional)
  837 Institutional Transaction
  The ASC X12N 837 Institutional transaction is the electronic equivalent of the UB-04 paper claim form.

- Dental Claims (837 Dental)
  837 Dental Transaction
  The ASC X12 837 Dental transaction is the electronic equivalent of the ADA 2006 paper claim form.

- Eligibility Inquiry/Response (270/271 Transactions)
  270 Eligibility Inquiry Transaction (Batch)
  ASC X12N 270 Eligibility Inquiry Transaction set is used to transmit health care eligibility benefit inquiries from health care providers, clearinghouses and other health care adjudication processors.

- 271 Eligibility Inquiry Transaction
  The ASC X12N 271 Eligibility Response Transaction set is used to respond to health care eligibility benefit inquiries as the appropriate mechanism.

- Claim Inquiry/Response (276/277 Transactions)
  276 Claim Inquiry Transaction (Batch)

[1] Accredited Standards Committee (ASC X12) – An ANSI accredited standards organization responsible for the development and maintenance of electronic data interchange (EDI) standards for many industries. The "X12" or insurance section of ASC X12 handles the EDI for the health insurance industry's administrative transactions. Under HIPAA, X12 standards have been adopted for most of the transactions between health plans and providers.

The 276 Transaction Set is used to transmit health care claim status request/response inquiries from health care providers, clearinghouses and other health care claims adjudication processors. The 276 Transaction Set can be used to make an inquiry about a claim or claims for specific Medicaid members.

- 277 Claim Inquiry Response Transaction (Batch)

  The 277 Transaction Set is used to transmit health care claim status inquiry responses to any health care provider, clearinghouse or other health care claims adjudication processors that has submitted a 276 to the Utah MMIS.

- Enrollment (834 Transactions)
  834 Enrollment Transaction

  The 834 Transaction Set is used to transmit health care enrollment into an Accountable Care Organization (ACO). Medicaid uses this transaction to notify the ACOs that a Medicaid recipient has been enrolled in the ACO. The transaction provides the plan with the recipient's demographics and some health data.

- Remittance Advice (RA) (835 Transactions)
  835 Remittance Advice

  The 835 Transaction Set will only be used to send an Explanation of Benefits (EOB) RA. For Utah Medicaid, payment is separate from the EOB RA and will therefore not be affected by changes to how the provider receives payment. The 835 transaction will be available to the providers and contracted clearinghouses requesting electronic remittance advice (ERA). Providers may choose to receive ERA or paper RA, or both.

- Premium Payment (820 Transactions)
  820 Premium Payment Transaction

  The 820 Transaction Set is used to transmit premium payment data to the ACO.

- Prior Authorization (278 Transactions)
  278 Referral Certification and Authorization. Health Care Service Review Transaction

  The 278 Transaction Set is used to transmit requests for prior authorization of services.

11-8.1 Electronic Claim/Prior Authorization with Attachment(s)

Medicaid allows claims or prior authorization request submitters to continue billing their claims or PA requests electronically even if a paper attachment needs to be sent with the claim or PA request. If documentation is required to support the claim, the claim may deny; however, once documentation is received the claim will be reprocessed.

To ensure proper handling of attachments, ensure the attachment contains the following information:

- *Document Submission Form*
- A provider assigned attachment control number (ACN) unique to this attachment. Each attachment associated with the claim must display a unique number.
- The attachment control number (ACN) (This can be the transaction control number (TCN) of the accepted claim as reported in the 277FE when sending to Medicaid) in the PWK segment in the electronic claim must be identical to the ACN or TCN on paper. Write number reported in

2300 PWK06 (Identification Code) or TCN of accepted claim as reported in the 277FE on documentation before sending to Medicaid.

- All ACNs must be unique.
- The provider and recipient numbers on the claim must match the provider and recipient numbers on the attachment.
- The ACN/TCN number on attachment must be clear and legible.

11-8.2 Pharmacy Claims NCPDP Version D.0

All interactive electronic pharmacy claims should be submitted using the NCPDP version D.0 standard. All pharmacy claims submitted electronically in batch must be in NCPDP version 1.1 standard.

11-9 Electronic Visit Verification Requirements for Home Health and Personal Care Services

In accordance with Utah Administrative Code R414-522 and section 12006 of the 21st Century CURES Act, providers of Home Health and Personal Care Services (including similar services offered through the Home and Community-Based Waiver programs) must comply with Electronic Visit Verification (EVV) requirements.

Home Health and Personal Care Services providers may select the system of their choosing, provided it captures the following data elements and is compliant with the standards set in the Health Insurance Portability Accountability Act. EVV systems must the collect the minimum information:

1) type of service performed;
2) individual receiving the service;
3) date of the service;
4) location of service delivery;
5) individual providing the service;
6) time the service begins and ends; and
7) the date of creation of the electronic record.

Additional information, including technical specifications for file creation/submission can be found at https://medicaid.utah.gov/evv.

11-10 Reporting and Billing Covered and Non-Covered Services for Acute Inpatient Hospital Claims

Correct coding guidelines encourage the reporting of all delivered services. Therefore, providers should report covered and non-covered services when billing acute inpatient hospital claims. However, there are instances where the Medicaid claims processing system will deny an entire claim for a single denied line. Generally, this occurs for services that require prior authorization, but the hospital did not obtain one.

When an entire claim denies for a non-covered line item(s), Medicaid requires that acute inpatient hospitals report covered services and omit non-covered services that would otherwise deny the claim. Additionally, providers must omit the reporting of any other ICD-10-PCS, CPT, HCPCS, or revenue codes related to the non-covered services.

For example, a member is admitted for labor and delivery and elects to have a sterilization procedure performed but does not have prior authorization for the sterilization. In this instance, the sterilization,

and the associated services, are non-covered. The facility must omit the non-covered services from the claim.

Furthermore, if admission to an acute inpatient hospital is primarily for services not otherwise covered by Medicaid, all services performed for that episode of care are non-covered and will not be reimbursed. This policy stands regardless of whether or not Medicaid would have covered some of the services performed.

12 Coding

All Utah Medicaid claims require diagnosis codes and procedure codes. The appropriate diagnosis code must be entered on all claims. Procedure codes are dependent on the type of service and claim type. Medicaid recognizes guidelines in current editions of established coding manuals or other standard literature. However, those guidelines are adopted only as far as they are consistent with application to Utah Medicaid policy. The established coding guidance materials consist of the following:

1. Healthcare Common Procedure Coding System (HCPCS)
    a. Physicians' Current Procedural Terminology (CPT) Manual
    b. Healthcare Common Procedure Coding System, HCPCS Level II
    c. Healthcare Common Procedure Coding System, HCPCS Level III
2. International Classification of Diseases (ICD), Clinical Modification (CM), and Procedural Coding System (PCS)
3. Revenue Codes (Uniform Billing Codes-UB-04)

1. Healthcare Common Procedure Coding System (HCPCS)

a. The HCPCS System incorporates the American Medical Association, Current Procedural Terminology (CPT) Manual as Level I of the system. CPT represents the major portion of the HCPCS system. CPT uses 5-digit numeric codes and a uniform language to accurately classify medical, surgical, and diagnostic services for effective communication among health care providers, health care facilities, and third-party payers. Although the CPT Manual is primarily for physician use, other providers may be authorized by Medicaid policy to use the codes and descriptors if other HCPCS codes are not available or appropriate.
b. HCPCS Level II codes are alphanumeric codes which are uniform in description throughout the United States. The codes begin with a letter followed by four numbers. The descriptions cover equipment, supplies, materials, injections and other items used in health care services. Although the codes and descriptors are uniform, processing and reimbursement of HCPCS Level II codes is not necessarily uniform throughout all states.
c. HCPCS Level III codes and descriptors are developed for Medicare carriers for use at the local (carrier) level. These are 5-position alpha-numeric codes in the W, X, Y or Z series represented in the Level I or II codes. Level III codes and their descriptions are available from the local part B carrier.

2. International Classification of Diseases (ICD)

The International Classification of Diseases (ICD): Clinical Modification is a statistical classification system that arranges diseases and injuries into groups according to established criteria.

3. **Revenue Codes (Uniform Billing Codes UB-04)**

Uniform billing guidelines are a standard data set and format used by the health care community to transmit charge and claim information on hospital services to third party payers. The guidelines are developed on a national basis by the National Uniform Billing Committee. The Billing Manual is maintained and updates provided locally by the Utah Hospital and Health Systems Association. The approved codes in the Medicaid section of the UB-04 Manual are established consistent with Medicaid policy, reviewed and maintained by Medicaid staff periodically.

12-1 Coding Maintenance

Industry updates to CPT, HCPCS, and ICD-10-CM codes are published toward the end of each year. Medicaid staff review each new edition of the coding manuals. The purpose of the review is to identify new services, eliminated services or procedures, and altered descriptions of service. Where additions, deletions, and/or changes have occurred, research is initiated with subsequent development of appropriate policy recommendations and rulemaking to establish service coverage and/or limitations consistent with Medicaid policy. Notice of any change is given in the Medicaid Information Bulletin (MIB). All codes will be discontinued or added based on the date of implementation set by the standard setting organization.

Note: Coding information, clarification or review is not available through the Medicaid Information Hotline. In other words, Medicaid staff may not advise providers which codes to use.

12-2 Classifying Patients as New or Established

Providers must observe CPT and Medicaid guidelines on classifying a patient either as *new* or as *established*. Under CPT guidelines, a new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

- In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.
- No distinction is made between new and established patients in the emergency department. E&M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department. Medicaid considers the term "emergency department" only to be a designated emergency unit of a licensed hospital.

When a physician is on call for or covering for another physician, classify the patient's encounter as it would have been by the physician who is not available. Medicaid considers any physician in the same clinic, group practice or other facility to be "of the same specialty" unless the member has specifically been referred to another physician of a different specialty for issues related to that specialty.

12-3 Diagnosis Must Agree with Procedure Code; Use of 'Z' Codes

When an ICD-10-CM 'Z' code is used, an additional diagnosis code must also be added to the claim form. As always, the diagnosis and procedure codes must agree.

Examples:

- Personal history of malignant breast neoplasm, Z875.3, should be accompanied by other ICD-10-CM code(s) indicating the differential diagnoses that led to a decision for CT scans of the brain and spine. The ICD-10 codes should reflect symptoms and/or the differential diagnosis that led to the decision for extensive imaging, laboratory tests, and/or a procedure.
- When using 'Z' codes in the range of Z40-Z53 (follow-up examination after surgery) include the diagnosis code related to the original surgery, injury, or fracture.

Supplying the correct diagnosis and procedure codes for payment is the responsibility of the provider. The differential diagnosis must support the medical necessity of the procedure for reimbursement. Often, more than one diagnosis is required to explain and support a service. When the diagnosis does not support the procedure, a diagnosis to procedure discrepancy will be reported on the remittance advice. Providers should then resubmit a claim with additional or other appropriate diagnoses.

12-4 Procedures for Children

When the majority of procedures are related to a routine health visit and/or childhood immunizations, Z codes related to routine child health examinations, such as Z00.121, Z00.129, Z76.1, Z76.2, will be accepted alone for payment. However, when the child also has a medical condition that requires additional procedures (such as x-rays, laboratory examinations, etc.), include on the claim the ICD-10-CM code which describes the differential diagnoses for the medical condition. The ICD-10-CM codes assist in explaining the diagnostic test.

12-5 Diagnosis and Procedure Incomplete or Not in Agreement

Claims submitted with a diagnosis which does not agree with the completed procedure will be denied. For example: A claim for CT of the abdomen which is submitted with diagnoses of headache and myalgia will not be paid. Also, with the exception of child health, maternal health, or refugee exams, claims submitted with only a Z code will not be paid; all claims require a code which describes the diagnoses for the medical condition.

Medicaid must have an accurate record of the diagnosis and procedures on submitted claims to evaluate programs and payment trends. Claim payment to providers is delayed when inaccurate diagnoses are submitted. Direct questions to Medicaid Operations (Refer to *Chapter 1, General Information*).

12-6 Procedures with Time Definitions

Many procedure codes contain time frames built into the definition. For billing services that fall between the time frames, Medicaid's policy is to round to the nearest full unit or appropriate procedure code. No partial units may be reported.

12-7 Manual Review

The manual review of claims is reserved for specific types of claims. A provider may not request a manual review of a claim unless the denial meets the criteria found in this chapter. Upon receipt of a properly submitted request, medical staff trained in reviewing these claims manages each case.

12-7.1 Manual review criteria

- Remittance advice statement exception code contains an error message stating documentation required
- All unlisted procedure codes. These typically end with "99"
- Denial for "No Prior Authorization" may actually require manual review (e.g., Diagnosis code) (These codes can only be flagged in the system by indicating prior authorization is required.)
- Radiology planning requires manual review of documentation when more than 4 units are requested. IMRT planning requires manual review of documentation to ensure the treatment site is a covered service and the documented purpose is to protect a critical structure. Refer to the Coverage and Reimbursement Lookup Tool for additional codes requiring manual review. [http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php]
- Certain modifier use. Refer to this *Chapter, Modifier used in a Claim*.

12-7.2 Request a Manual Review

To request manual review of a claim, complete the following steps.

1. Review the claim to determine it meets criteria for manual review. If any one of the following is true go to step 2.
   - Remittance advice states the claim is missing documentation, lacks information required for adjudication or information received does not meet the procedure(s) or date of service for the claim under review.
   - The code is listed in the reference file as "2" (requires manual review) or the Coverage and Reimbursement Code Lookup special note indicates documentation is required.
   - The code has a modifier which requires review (Refer to this *Chapter, Modifier used in a Claim*)

2. Submit the following documentation to the applicable FAX number on the *Documentation Submission Form*:
   - *Documentation Submission Form*
   - Supporting documentation, consisting of medical records giving evidence and support the claim/code under review. Documentation may need to include similar procedures completed on the same date of service (e.g., multiple chest films)

   Note: Documentation that is illegible, not applicable, or sent to an incorrect FAX number will not be returned or verified and the case will not be reviewed.

When the request is complete, the claim is reviewed and the provider is notified of the results.

12-7.3 Modifiers

All Modifiers are subject to manual review. For information on the manual review process see chapter 12-7 *Manual Review*.

Modifier 22: (Unusual procedural services) Modifier 22 is suspended for manual review. If approved, it will be paid at an additional 10% of the established fee schedule. Exception: multiple gestation births.

Modifier 24: Claims submitted with modifier 24 require the submission of documentation substantiating correct reporting of an *Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period* and qualifies for manual review. The provider may need to indicate that an E/M service was furnished during the postoperative period of an unrelated procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

Additionally, modifier 24 is appropriately applied when it is used for anesthesia pain management service reporting. Documentation must include when the epidural or block injection is given relative to the general anesthesia.

Modifier 25 - Claims submitted with modifier 25 require the submission of documentation substantiating correct reporting of a *Significant, Separately Identifiable Evaluation and Management (E/M) Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service* and qualifies for manual review. Medicaid considers an E/M as a significantly separately identifiable service when the provider may need to indicate that on the day of service, the member's condition required an E/M above and beyond the other services provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the service was provided and therefore does not require a different diagnosis when reporting.

Coverage of diagnostic or therapeutic procedures includes taking vital signs, asking the member how they feel, and obtaining written consent. Therefore, it is not appropriate to report a different E/M code for these services per the National Correct Coding Initiative (NCCI) unless the criteria mentioned above are met. When these criteria are met, a provider may report the E/M by adding modifier 25 to the appropriate level of E/M service.

Modifiers 26 and **TC:** Certain diagnostic and procedural services are comprised of two components: a professional component (PC); and a technical component (TC). The PC and TC may be furnished independently or by different providers, or they may be furnished together as a global service. When services have separately billable PC and TC components, the payment for the global service equals the sum of the payment for the TC and PC.

- **Professional (Modifier 26) -** Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.
- **Technical (Modifier TC) -** Under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable x-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.

If the same provider is performing both the technical and professional component of a service, the global service (i.e. the procedure code without the TC or 26 Modifier) should be reported.

Modifier 27: (Multiple Outpatient Hospital Evaluation and Management Encounters on the Same Day) Medicaid will not recognize Modifier 27. Modifier 27 is only appended to facility-based services

performed in the hospital outpatient setting. Medicaid does not reimburse for services attached to Modifier 27.

Modifier 50: (Bilateral Procedures) Medicaid will not recognize modifier 50.

Modifier 51: (Multiple Procedures) When more than one procedure is performed during an operative session the surgeries are subject to the multiple surgery rules and are ranked in descending order by the Medicaid fee schedule allowed amount.

Modifier 52: (Reduced Service) Modifier 52 is paid at 50% of the established fee schedule.

Modifier 53: (Discontinued Procedure) Modifier 53 is paid at 50% of the established fee schedule.

Modifier 54: (Surgical Care Only) Modifier 54 is paid at 70% of the established fee schedule.

Modifier 55: (Post-Operative Management Only) Modifier 55 is paid at 20% of the established fee schedule.

Modifier 56: (Pre-Operative Management Only) Modifier 56 is paid at 10% of the established fee schedule.

Modifier 57: (Decision for surgery) Medicaid will ***not*** recognize modifier 57. Decision for surgery performed for the purposes of hospital accreditation requirements that indicate every patient must have an initial hospital history and physical, is not a covered service and is integral to the surgical global fee.

Modifier 59* and subsets: Are reviewed when the CPT code posts an incidental or mutually exclusive edit to the primary procedure. Submit documentation showing that the procedure is not a component of another procedure, but is a distinct, independent procedure. Mutually exclusive edits occur when two or more procedures that are usually not performed during the same member encounter on the same date of service. The less clinically intense procedure(s) is denied. Incidental edits occur when relatively minor procedures are performed at the same time as complex primary procedures, and are considered clinically integral to the performance of the primary procedure.

Modifier 59 and the subset modifiers are the modifiers of last resort and should not be used when a more descriptive modifier is available. The subset modifiers are more selective versions of the 59 modifiers so it would be incorrect to include both modifiers on the same line.

- XE Separate encounter: A service that is distinct because it occurred during a separate encounter
- XP Separate practitioner: A service that is distinct because it was performed by a different practitioner
- XS Separate structure: A service that is distinct because it was performed on a separate organ/structure
- XU Unusual non-overlapping service: The use of a service that is distinct because it does not overlap usual components of the main service.

The provider may submit medical records supporting the distinct or independent identifiable nature of the service. Modifier 59 or a subset modifier, are considered for manual review only after editing program denial.

Modifier 62: (Two surgeons of a different specialty are required to perform a specific procedure) Modifier 62 is suspended for manual review and requires each co-surgeon to submit a separate operative report clearly describing the separate portions of the procedure that each surgeon completed. Modifier 62 is paid at 62.5% of the established fee schedule.

Modifier 66: (Surgical Team) Modifier 66 is suspended for manual review and is priced by Medicaid physician consultants.

Modifier 73: (Discontinued outpatient hospital/ambulatory surgical center (ASC) procedure prior to the administration of anesthesia) Modifier 73 is to be utilized by facilities when an outpatient service is only partially completed or discontinued by the physician prior to completion of the service. This modifier may not be submitted by the operating surgeon. Only ASCs should submit this modifier. This modifier is to be paid at 50% of established fee schedule.

Modifier 74: (Discontinued outpatient hospital/ambulatory surgical center (ASC) procedure after the administration of anesthesia) Modifier 74 is to be utilized by facilities when an outpatient service is only partially completed or discontinued by the physician prior to completion of the service. This modifier may not be submitted by the operating surgeon. Only ASCs should submit this modifier. This modifier is to be paid at 50% of established fee schedule.

Modifier 76 or 77: When an edit posts that the claim is an exact duplicate of a paid claim, the claim is only manually reviewed when submitted with a 77 or 76 on the denied line. Submit documentation supporting the rationale for a repeated procedure or service by the same or another provider.

Modifier 80: (Assistant at Surgery) Modifier 80 for assistant surgeon is limited to 20% of the established fee schedule.

Modifier AS: (PA or NP assistant at surgery) Modifier AS for PA or NP assistants to surgery is limited to 20% of the established fee schedule.

Modifier 81: (Minimal assistant at surgery) Medicaid does not reimburse for services reported with Modifier 81.

Modifier 82: (Minimal surgical assistance is needed, but the qualified resident was not available) Medicaid does not reimburse for services reported with Modifier 82.

Modifier 91: Submit documentation supporting the claim that separate services were provided for a distinct medical purpose.

12-7.4 Multiple Procedure Payment Reduction

Each CPT, HCPCS, and PCS code has a designated rate and are weighted based on Relative Value Units (RVUs). These values are established based on the concept that the services reported are standalone procedures. In some instances, providers will perform multi-staged procedures that are separate but related to one another. In these instances, the expense of performing the associated procedures is reduced as they do not require a different surgical session, incisions, anesthesia, etc. This is known as Multiple Procedure Payment Reduction (MPPR). Multiple procedures performed during the same service session by the same provider are reported using modifier 51. Even if a modifier is not used, MPPR can be applied for services performed on the same date.

The MPPR applies to procedures when:

- Two or more procedure codes are subject to reductions (i.e., two or more codes on the Multiple Procedure Reduction Codes list)
    - If two codes are reported, but only one is subject to reduction, no reduction will be taken on either procedure
- A single code subject to the MPPR is submitted with multiple units

  - *For example, CPT code 11300 (Shaving of epidermal or dermal lesion, single lesion, trunk, arms, or legs; lesion diameter 0.5 cm or less) is submitted with three units, then MPPR would apply to the second and third units*

The MPPR will be applied using the pricing method outlined below:

- **100**% of the allowable amount for the primary/major procedure
- **50%** of the allowable amount for the secondary procedure
- **25%** of the allowable amount for all subsequent procedures

Multiple Procedure Payment Reduction (MPPR) for Assistant Surgeon Services

Multiple procedures performed by an assistant surgeon or a nurse practitioner/physician assistant are subject to the MPPR concept defined above when performed by the same provider on the same service date. There are instances when a surgical procedure requires and allows for reporting an assistant surgeon. In these circumstances, the assistant surgeon reimbursement will be 20% of the allowable amount for each procedure.

Refer to chapter 12-7.3 *Modifier used in a Claim* of Section I: General Information provider manual for additional details related to reporting assistants to surgery.

Multiple Procedure Payment Reduction (MPPR) for Co-Surgeon/Team Surgeon Services

Multiple procedures performed by a co-surgeon are subject to the MPPR when performed by the same physician or other qualified health care professional on the same date of service. Co-surgeon and team surgeon services are considered separately and independently of any other co-surgeon or team surgeon services.

12-7.5 Appealing Denial

In cases where the service has been denied after manual review, the remittance advice indicates manually reviewed and denied. At this point the provider may consider submitting a request for a hearing. All hearing requests require a *Request for Hearing/Agency Action* form and supporting documentation in addition to that sent for the manual review.

A hearing request to appeal the denial of an unlisted CPT code also requires the following.

- Documentation supporting the use of an unlisted code
- A letter citing methodologies employed
- Suggested CPT code(s) that is/are most similar in work and malpractice value (for pricing)
- Clinical publications supporting the methodology under review for safety, outcomes, and cost containment
- Document a strong case for why this method is the best strategy for the member (medical records, operative report, patient history, physical examination report, pathology report, discharge summary)

13 References

Current Procedural Terminology, American Medical Association, current edition

Health Care Procedure Coding System, HCPCS

Hearing decision numbers 13-078-02 and 13-239-03

State Plan Amendment

Attachment 3.1-A, Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy

Attachment 3.1-B, Amount, Duration, and Scope of Services Provided Medically Needy Group(s)

Social Security Act Titles XVIII, XIX, XXI, or XX

Social Security Act Sections 1902(a)(31)(A), 1903(v)(1), 1905(a)(19), 1905(o), 1915(g)

Title VI of the Civil Rights Act

Utah Administrative Code

R410-14

R414-1-2, 5, 14

R414-22

R590-164

Utah Code Annotated

§26-20-1, et seq, Utah False Claims Act

§26-18-2.1 (1953, as amended) Medical Assistance Act, Medical Assistance Programs, Division-Creation

§26-23-2-(1) UCA, (1953)

§63G-2

42 CFR

§431.52

§440 [October 1, 1996, edition]

§440.60, 170, 230, 255(c)

§455

§447.15, 45(d)(4)(iv)

§§1007.7 through 1007.13, State Medicaid Fraud Control Units

14 Acronyms

Following is a list of acronyms commonly used in the administration, policies, or procedures of Utah's Medicaid Program.

ACO	Accountable Care Organization
ALOS	Average length of stay
ANSI	American National Standards Institute
ASC X12	Accredited Standards Committee (see definitions)
CDEN	Child Health Insurance Program Dental Claims
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology

DCFS	Division of Child and Family Services
DIH	Division of Integrated Healthcare
DHS	Department of Human Services
DHHS	Department of Health and Human Services
DRA	Deficit Reduction Act
DRG	Diagnosis Related Group
DUR	Drug Utilization Review
DWS	Department of Workforce Services
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early Periodic Screening Diagnosis and Treatment
EREP	Electronic Resource and Eligibility Product
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee for Service
FPL	Federal Poverty Level
FR	Federal Register
GRAMA	Government Records Access and Management Act
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHS	Department of Health and Human Services (Federal)
HIPAA	Health Insurance Portability and Accountability Act
HPR	Health Program Representative
ICD-9	International Classification of Diseases, Ninth Revision
ICD-10	International Classification of Diseases, Tenth Revision
ICF	Intermediate Care Facility
IPA	Independent Practice Association
LTAC	Long Term Acute Care Hospital
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MFU	Medicaid Fraud Unit, now the MFCU
MMCS	Medicaid Managed Care System
MMIS	Medicaid Management Information System
NCPDP	National Council of Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
OBRM	Omnibus Budget Reconciliation Act
ORS	Office of Recovery Services
ORSIS	Office of Recovery Services Information System
PA	Prior Authorization

PERM	Payment Error Rate Measurement
PMHP	Prepaid Mental Health Plan
POS	Point of Sale
PPO	Preferred Provider Organization
PRO	Peer Review Organization
QMB	Qualified Medicare Beneficiary
RBRVS	Resource-Based Relative Value Scale
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
TPL	Third Party Liability
UHA	Utah Hospital Association
UHCA	Utah Health Care Association
UHIN	Utah Health Information Network
UMA	Utah Medical Association
UPP	Utah's Premium Partnership
WIC	Special Supplemental Food Program for Women, Infants, and Children

Utah Medicaid Provider Manual

Autism Spectrum Disorder Services

Division of Integrated Healthcare

Updated July 2023

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1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, note the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to the Utah Medicaid Provider Manual Section I: General Information, Chapter 1, General information.

1-1 Autism Spectrum Disorder related services

Autism Spectrum Disorder (ASD) services are covered as medically necessary services based upon the recommendation and referral of a qualified health care professional (QHP) for members with a diagnosis of ASD. ASD-related services may include the following:

1. Diagnostic assessments and evaluations
2. Therapies such as physical, occupational, or speech therapy
3. Applied Behavior Analysis (ABA) therapy

2 Health plans

For more information about Managed Care Entities (MCE), refer to Section I: General Information, Chapter 2-7, Accountable Care Organizations.

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information, Chapter 2-8, Prepaid Mental Health Plans, and the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual. A list of MCEs and PMHPs that Medicaid has a contract to provide health care services is found on the Medicaid website.

For members enrolled in an MCE, requests for ASD-related medical services, including but not limited to physical, occupational, and speech therapies, must be submitted to the MCE.

For members enrolled in a Prepaid Mental Health Plan (PMHP), requests for services related to co-occurring mental health conditions will be referred to the PMHP.

3 Provider participation and requirements

Refer to Section I: General Information, Chapter 3, Provider participation and requirements.

3-1 Provider credentials

Medicaid enrolled providers delivering and reporting ASD services must adhere to the requirements outlined in their provider enrollment agreement. Additionally, providers are expected to deliver services acting within their scope of license and training, which included adhering to Utah Code Title 58, Chapter 61 – Psychologist Licensing Act, Administrative Rule 156-61, Psychologist Licensing Act Rule, and R156-61a, Behavior Analyst Licensing Act Rule as applicable.

Behavior analysts in training

Claims submitted to Medicaid, for services provided by a behavior analyst in training, are covered when the services are provided under the supervision of a psychologist or behavior analyst and delivered in accordance with Utah Code 58-61-707(10-12), Psychologist Licensing Act, Exceptions from licensure.

4 Record keeping

Refer to Section I: General Information, Chapter 4, Record keeping.

5 Provider sanctions

Refer to Section I: General Information, Chapter 5, Provider sanctions.

6 Member eligibility

It is the responsibility of the provider to verify the member’s eligibility prior to every service. For additional information regarding member eligibility refer to Section I: General Information, Chapter 6, Member eligibility.

7 Member responsibilities

For information on member responsibilities including establishing eligibility and co-payment requirements refer to Section I: General Information, Chapter 7, Member responsibilities.

8 Programs and coverage

ASD service coverage requires that the member receiving services have a valid ASD diagnosis. Clinicians authorized under the scope of their licensure and trained in the use and interpretation of the selected assessment tool may render the ASD diagnosis. The diagnostic evaluation process includes:

1. Health, developmental, socioemotional, and behavioral histories
2. Developmental, adaptive, and/or cognitive evaluation to determine the member's overall level of functioning, and
3. Determination of the presence of the DSM-5 criteria for ASD, using evidence-based standardized measures to operationalize the DSM-5 criteria.

A copy of the medical records that includes the ASD diagnosis and the screening or evaluation instruments used must be submitted with the initial prior authorization request.

8-1 Definitions

Applied Behavioral Analysis (ABA): Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorder (ASD): a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave.

Behavior analyst in training: an individual who is enrolled in a behavior analysis course sequence approved by the Behavior Analyst Certification Board at an

accredited institution of higher education and whose activities are part of a defined program of study or professional training as defined by Utah Code 58-61-707(10-12).

Behavior technician: is a paraprofessional certified in behavior analysis that assists in delivering behavior analysis services and practices under the direct supervision of a QHP, who is responsible for all work performed.

Board Certified Assistant Behavior Analyst (BCaBA): is an individual who holds an undergraduate-level certification in behavior analysis and is licensed to engage in the practice of behavior analysis under the supervision of a qualified supervisor, as defined by Utah Code 58-61.

Board Certified Behavior Analyst (BCBA): is a graduate-level independent practitioner in behavior analysis who provides behavior-analytic services and may supervise the work of BCaBAs, Behavior Technicians, and other professionals who implement behavior-analytic services and is licensed in the State of Utah per Utah Code 58-61.

Board Certified Behavior Analyst-Doctorate (BCBA-D): is a doctoral prepared independent practitioner in behavior analysis who provides behavior-analytic services and may supervise the work of BCaBAs, Behavior Technicians, and other professionals who implement behavior-analytic services and is licensed in the State of Utah per Utah Code 58-61.

Functional analysis: an assessment for evaluating the separate effects of each of several environmental events on a target behavior by systematically presenting and withdrawing each event to a patient multiple times and observing and measuring occurrences of the behavior in response to those events.

Functional behavior assessment: comprises descriptive assessment procedures designed to identify environmental events that occur just before and just after occurrences of potential target behaviors and that may influence those behaviors. The information may be gathered by interviewing the patient's caregivers having care givers complete checklists, rating scales, or questionnaires and/or observing and recording occurrences of target behaviors and environmental events in everyday situations.

Non standardized instruments and procedures: includes, but not limited to, curriculum-referenced assessments, stimulus preference assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual patient and behaviors.

Onsite: means that the clinician is to be immediately available and able to be interrupted as needed to assist and provide direction throughout the entire procedure. However, the clinician is not required to be physically present in the room for the procedure.

Psychologist: a licensed or registered psychologist certified by the American Board of Professional Psychology in Behavioral and Cognitive Psychology who was tested in applied behavior analysis and is licensed in Utah as per Utah Code 58-61.

Qualified Healthcare Professional (QHP): an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within their scope of practice and independently reports that professional service. Examples of QHPs include licensed behavior analyst, board certified behavior analyst doctoral, board certified behavior analyst, psychologist or other credentialed professional as defined by Utah Code 58-61.

Standardized instruments and procedures: includes, but not limited to, behavior checklists, rating scales, and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all patients.

8-2 General ASD diagnostic services

Mental health evaluations and psychological testing performed for the purpose of diagnosing developmental disorders are covered by Medicaid when coverage criteria are met. Coverage of ABA services require a behavior identification assessment and the development treatment plan. Guidance related to the coding and billing of these services may be found in Chapters 11 Billing and 12 Coding of this manual.

ABA therapy requires prior authorization for coverage of services. This does not apply to initial or ongoing behavior identification assessments.

8-2.1 Adaptive behavior services

Adaptive behavior services address deficient adaptive behaviors, maladaptive behaviors, or other impaired functioning secondary to deficient adaptive or maladaptive behaviors.

Adaptive behavior describes age-appropriate behaviors that people need to live and function independently, socially, and successfully in their day-to-day lives. Most often adaptive behavior services are provided to those who have a learning disability, social impairment, or behavior that may put themselves or others at risk for physical harm.

The majority of these services are provided, created, and overseen by a behavior analyst or a psychologist specializing in behavior analysis and delivered by an assistant behavior analyst and/or technician(s).

8-2.2 Adaptive behavior analysis assessments

ABA assessment must be conducted by a QHP. Assessments are generally performed on the initiation of services and every six months thereafter. On occasion, a member may need a revision to their treatment plan or require a change in provider. In such cases, the reporting of an additional assessment is appropriate. As with all Medicaid services, these services are subject to post-payment review.

Behavior identification assessment is conducted by the QHP and may include:

1. Analysis of pertinent past data (including medical diagnosis)
2. A detailed behavioral history
3. Patient observation
4. Administration of standardized and/or non-standardized instruments and procedures
5. Functional behavior assessment
6. Functional analysis, and/or guardian/caregiver interview to identify and describe deficient adaptive behaviors
7. Maladaptive behaviors

8. Other impaired functioning is secondary to deficient adaptive or maladaptive behaviors
9. Any impaired social skills
10. Communication deficits
11. Destructive behaviors, and
12. Any additional functional limitations resulting from noted maladaptive behaviors.

This service includes the QHP:

1. Obtaining a detailed history relative to the patient's behavior,
2. Observation of behaviors,
3. Administration of standardized and non-standardized testing,
4. Focused interviews with the primary guardian or caregiver,
5. Non-face-to-face time reviewing and analyzing the information,
6. Scoring/interpreting test results,
7. Discussion of findings and recommendations with the primary guardian(s)/caregiver(s),
8. Preparation of report, and
9. Development of plan of care.

This service may be repeated on different days as necessary until the behavior identification assessment has been completed.

Documentation must contain the interpretation of results as well as the development of a treatment plan. The treatment plan should outline the provider's plan of care. Successive progress review treatment plan gains should be noted and modifications to the treatment plan should be recorded, as necessary. The assessment's total time or start and stop times should be noted in the medical record.

8-2.3 Adaptive behavior treatment

Individual treatment for ABA case supervision includes both direct and indirect supervision. Activities included in case supervision responsibilities include:

1. Direct supervision: The psychologist or behavior analyst is either engaged directly with the member or is directing a technician in implementing a modified protocol with the member, or
2. Indirect supervision: include activities involved in ongoing monitoring of member progress and revising protocols, preparing for assessment or treatment sessions, reviewing data, and writing progress notes.

The provider is responsible for retaining records of the time spent engaged in direct and indirect supervision responsibilities.

These services are delivered and overseen by a QHP specializing in behavior analysis and delivered by an assistant behavior analyst or technician(s). Services focus on treatment goals and targets established from a prior adaptive behavior assessment and include continuing and developing assessment and adjustment of those targets, goals, and protocols. Some of the objectives of this type of treatment include minimizing recurrent and/or other maladaptive behaviors and boosting communication, social, personal safety, and other adaptive functioning by breaking the larger category of adaptive skills into smaller, easy-to-measure units focusing on practicing a skill repeatedly until it becomes routine for the member.

These services are provided face-to-face or, when appropriate via telehealth, with the member or family, alone or in a group, and combine large amounts of varying procedures that require analysis and the adjustment of the motivation, circumstances, and setting, among other factors, and may occur in various settings.

Adaptive behavior treatment and group adaptive behavior treatment are administered by a technician under the direction of a QHP, utilizing a treatment protocol designed in advance. The QHP may or may not provide direction during the treatment. Group service requires that the services occur in groups of eight or smaller.

Adaptive behavior treatment with protocol modification is administered face-to-face with a single member. The QHP resolves one or more problems with

the protocol and may simultaneously direct a technician in administering the modified protocol while the member is present.

Family adaptive behavior treatment guidance and multiple-family group adaptive behavior treatment guidance are administered by a QHP face-to-face with a member's caregiver(s). The treatment guidance involves identifying potential treatment targets and training to implement treatment protocols designed to address deficient adaptive or maladaptive behaviors. This service requires that the training occur in groups of eight or smaller.

Group adaptive behavior treatment with protocol modification is administered by a QHP face-to-face with multiple members. During the session they monitor the needs of individual members and adjust the treatment techniques during the group sessions, as needed. In contrast to group adaptive behavior treatment by protocol, protocol adjustments are made in real time rather than for a subsequent service. This service requires that the training occur in groups of eight or smaller.

8-2.4 Alternative treatment service delivery models

Medicaid recognizes that adaptation in the service delivery model may be required to accommodate the member's individual treatment needs. See Chapter 12 Coding of this manual for specifics.

Requests that exceed the maximum allowed units, as indicated in Chapter 12 Coding, will be subject to secondary medical review and/or medical review committee unless the request is offset as defined above. The QHP must include justification supporting the medical necessity of the alternative treatment service delivery model or for requests that exceed the maximum allowed units with each prior authorization request.

8-3 Service delivery specifications

8-3.1 ABA treatment by assistant behavior analyst or behavior technician

ABA treatment programs must be designed and supervised by a QHP and are delivered by an assistant behavior analyst or behavior technician.

Under the supervision of a QHP, the assistant behavior analysts may:

1. Perform clinical and case management support
2. Assist in oversight of technicians
3. Provide direct intervention

8-3.2 Assessments for measuring outcomes

Medicaid requires assessments to be completed by a QHP. Assessments may be conducted utilizing standardized evidence-based assessment tools or non-standardized assessment tools which include a detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary caregiver(s), and preparation of a report.

8-3.3 Case supervision requirements

When a tiered service delivery model is utilized, the following supervisory activities are required:

1. The QHP is responsible for all aspects of clinical direction, supervision, and case management, including activities of the support staff. For example, assistant behavior analyst or behavior technician,
2. The QHP must have knowledge of:
   a) each treatment team member's ability to effectively carry out clinical activities before assigning them, and
   b) the member's needs and treatment plan. They must observe the technician implementing the plan, regardless of whether there is clinical support provided by an assistant behavior analyst or behavior analyst in training.

A QHP is required to supervise a minimum of 10 percent of the time the member is receiving direct services from a technician or assistant behavior analyst. At least 50 percent of the QHP’s supervision must be direct supervision.

When determined as medically necessary by the QHP, requests for an additional 10 percent of direct supervision may be requested through the prior authorization process. QHPs must include documentation supporting the

medical necessity of the request. Additional time approved for direct supervision cannot be used for indirect supervision.

8-3.4 Telehealth

When clinically appropriate, supervision of an assistant behavior analyst or behavior technician may occur via remote access technology.

Parent training services via remote technology are covered when it is clinically appropriate, per Utah Administrative Rule R414-42.

Documentation must substantiate the clinical appropriateness of telehealth services.

The provider may deliver services or supervise only one member or one group session at a time. Medicaid coverage requires synchronous delivery of services. This is comprised of real-time videoconferencing that occurs via two-way video and audio interactions.

The following services not covered when performed via telehealth:

1. Adaptive behavior treatment administered by a technician
2. Group adaptive behavior treatment administered by a technician
3. Group adaptive behavior treatment with protocol modification administered by a QHP

For more information concerning telehealth use for psychiatric diagnostic evaluations reference the Rehabilitative Mental Health and Substance Use Disorder (SUD) Services Provider Manual, Chapter 1-4 Scope of service.

8-3.5 Restrictive interventions

Although many persons with severe behavioral problems can be effectively treated without the use of restrictive interventions, these may be necessary on rare occasions. When restrictive interventions are medically necessary they must be performed in accordance with Utah Administrative Code Rule R539-4 - Behavior Interventions.

8-4 Service delivery settings

ABA services may be delivered in multiple settings on the same day. ABA services may be delivered in a variety of relevant naturally occurring settings in the home and community. Services may also be delivered in clinic or center-based settings where the environment can be more easily controlled for specific interventions, for coordination with other therapies, or where group-based services are provided.

8-4.1 School-based settings

ASD-related services identified on the child's individualized education plan (IEP), as required under the federal Individuals with Disabilities Education Act (IDEA), may be provided in school-based settings. ASD-related services that are listed on an IEP must be provided through the Medicaid School-Based Skills Development Services benefit. Refer to the School-Based Skills Development Services Provider Manual for information on this benefit. School based settings include charter schools funded through a Local Education Authority (LEA) but not privately funded schools.

Apart from the psychologist's or behavior analyst's participation in the child's annual IEP development meeting, the Medicaid agency shall not reimburse fee for service ABA services in school-based settings that are in addition to services listed on an IEP. If the psychologist or behavior analyst, in coordination with the child's family and school professionals, believe it is medically necessary for the psychologist or behavior analyst to participate in the child's IEP development meeting, the provider may bill for this specific service on a fee for service basis.

9 Non-covered services and limitations

9-1 Non-covered services

The following services are non-covered:

1. ABA services that are not primarily provided to ameliorate a behavioral or maladaptive behavior.
2. Any service that does not follow the established treatment plan.

3. ABA services rendered when measurable functional improvement is not expected or progress has plateaued with no further protocol modifications made to address deficits.
4. Experimental, investigational, or unproven practices as outlined in Section I: General Information, Chapter 9-3.3 Experimental, investigational, or unproven medical practices.
5. Custodial care services
    a) Custodial care is defined as care that is provided for the sole purpose to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety.
6. Respite care services
    a) Care provided primarily to give relief to, or during the absence of, the usual caregiver.
7. Coverage of costs associated with different settings in which ABA services are provided. Examples of settings that may have costs associated with them that are not covered by Medicaid include:
    a) Resorts
    b) Spas
    c) Therapeutic programs
    d) Camps
8. Time spent by the behavior analyst, behavior analyst in training, or technician charting or collecting data that is occurring separate from the time spent documenting direct observations that occur when the provider is working directly with the member.
9. Provider's time traveling and other associated costs to get to the member.

9-2 Limitations

Medicaid has established limitations of services based on standards of care. On occasion, members may require medically necessary services that surpass the quantity limitations established by Medicaid. In these instances, providers may request authorization for additional services. Refer to the Section I: General Information Provider Manual, Chapter 9-3.5 Quantity limits for additional information.

9-3 Exceptions to non-covered services

Requests for coverage of non-covered services will be reviewed on a case-by-case basis through the Medicaid exception process. Information concerning the exception process may be found in the Section I: General Information Provider Manual, Chapter 9-3.4 Exceptions when Medicaid will pay for non-covered procedures. Documentation must be submitted with the request that demonstrates medical necessity as defined in the Section I: General Information Provider Manual, Chapter 8-1 Medical necessity.

10 Prior authorization

General prior authorization information is provided in the Utah Medicaid Provider Manual, Section I: General Information, Chapter 10, Prior authorization. Incomplete requests will be returned to the providers for additional information. Code specific coverage, prior authorization requirements, and reimbursement rates may be found in the Coverage and Reimbursement Code Lookup.

10-1 Request for initial services

Upon the initiation of services, providers will be permitted a 10-business day grace period to submit a request for prior authorization of services. If providers are unable to obtain prior authorization during the grace period, then the authorization will start on the day that the request is completed.

Initial requests for services must include:

1. Prior authorization request form.
2. Copy of a written ASD diagnosis by a clinician who is authorized under the scope of their licensure to render a diagnosis.
3. An order (prescription) for ABA services from a licensed clinician authorized to prescribe ABA services under their scope of licensure and training.
    a) For ongoing services, a new order must be submitted annually
4. Copy of the ABA treatment plan that includes:
    a) Date of assessment(s)

b) Name and signature of QHP who conducted the assessment and developed the treatment plan
c) A copy of the assessment tool(s) used to assess functional skills and, if applicable, maladaptive behaviors
d) Summary of assessment results
   i. Baseline data must include the date range for the data represented and, where appropriate, comparisons against benchmarks of normally developing peers.
      - There are circumstances where baseline data may not be observed during the initial assessment. In these instances, the baseline data to meet this criterion can be obtained from assessment observation and parent/caregiver report. The expectation is that these baseline assessment estimates will be adjusted, and treatment goals revised as more accurate data is recorded during future therapy sessions.
e) Summary data from parent/caregiver from interviews
f) Identification and description of targeted skills
g) Identification and description of targeted maladaptive behaviors or a statement indicating if these are not present
h) Measurable treatment goals specific to the treatment plan period, including those intended to improve functional skills, decrease maladaptive behaviors (if applicable), and teach appropriate replacement behaviors
i) Method and frequency of implementing and assessing treatment protocols
j) Anticipated caregiver involvement in the treatment process
k) Anticipated coordination of care needs

5. Attestation of medical necessity by the psychologist or behavior analyst that ABA is medically necessary and appropriate to address the treatment goals of the member.
6. Individualized clinical recommendations of the number of weekly services, delineated by service code.

7. A description of the setting(s) in which services will be provided, including hours via remote technology.

10-2 Request for continued services

The request for the new certification period must be received within 10 business days of the re-certification period start date. If the request is received more than 10 days after the start of the new certification period, the authorization will begin on the day that the completed request and all required documentation is submitted. ABA reassessments and treatment plan updates must be conducted by a QHP.

Requests for continued services must include:

1. Completed ABA Services Prior Authorization Request Form
2. Copy of the treatment plan that includes:
   a) Date of reassessment or treatment plan update
   b) Name and signature of the QHP conducting the assessment
   c) Evaluation of progress toward treatment goals using objective, validated assessment methods that includes the following:
      i. Date that each treatment goal was started
      ii. Summary of progress toward functional skill goals
      iii. Summary of progress toward maladaptive behavior goals, or a statement indicating if these are not present
      iv. Data from the previous six month period should be measured using the same method throughout the member's episode of care. If data are unavailable, an explanation must be provided
      v. Data should be compared against baselines established at the initiation of care with the current provider, which should be dated and if re-baselining occurs, an explanation provided
      vi. Overall progress should be compared to benchmarks of normally developing peers using established instruments to show treatment progress in relation to initial assessments
   d) Name of standardized assessment instrument(s) used
   e) Specific strategies to generalize skills to settings and people that are meaningful to the member

   f) Specific strategies to move the member toward more focused interventions as a result of successful treatment and generalization
   g) Coordination of care activities during the previous authorization period, and
   h) Anticipated caregiver involvement in the treatment process
3. A description of treatment plan revisions that include:
   a) Description of treatment goals, if any, that were not accomplished during the previous authorization period, with explanation
   b) If there is inadequate progress toward meeting treatment goals or there is no demonstrable progress in the previous authorization period
      i. The psychologist or behavior analyst must assess the reasons for lack of progress and modify treatment interventions to achieve adequate progress
   c) Updated and new measurable treatment goals overall and specific to the treatment plan period
   d) Method and frequency of implementing and assessing treatment protocols
4. Clinical certification by the psychologist or behavior analyst that ABA is medically necessary and appropriate to address the treatment goals of the member
5. Individualized clinical recommendations of the amount of weekly services, delineated by service code
6. A description of the setting(s) in which services will be provided, including hours via remote technology
7. Projected duration of ABA treatment, and
8. A discharge plan, if treatment is expected to conclude within six months of the date of reassessment.

11 Billing

Refer to the Utah Medicaid Provider Manual, Section I: General Information, Chapter 11 Billing Medicaid, for detailed billing instructions.

11-1 Third party liability

Requirements for billing third parties are described in Section I: General Information, Chapter 11-5 Billing third parties.

When other insurance coverage is available and a provider under that insurance is available to deliver ABA services, those services must be exhausted prior to claims being submitted to Medicaid. Providers must satisfy available third-party insurance requirements so those benefits can be utilized.

If an ABA provider is not paneled with the private insurance and there is not out of network benefit, a transition to a provider enrolled with the private insurance must be facilitated within six months of the discovery of the insurance. Alternatively, the current provider may continue to deliver services under Medicaid reimbursement while they are actively seeking enrollment with the private insurance. This must be completed within 6 months of discovery of the insurance.

11-2 Medicaid as payment in full, client billing prohibited

A provider who accepts a member as a Medicaid patient must accept Medicaid payment as reimbursement in full. Refer to the Section I: General Information Provider Manual, Chapters 3-4, Medicaid as payment in full, client billing prohibited.

There are limited circumstances in which a provider may bill a Medicaid member. These circumstances may be found in the Section I: General Information Provider Manual, Chapter 3-5, Exceptions to prohibition on billing members.

Code specific information may be found in the Coverage and Reimbursement Lookup Tool.

11-3 Mental health evaluations and psychological testing

Mental health evaluations and psychological testing performed for the purpose of diagnosing developmental disorders must be reported with the UC modifier appended. These services are considered carved out of the MCE services and will be reimbursed on a fee for service basis.

11-4 Telehealth services

When reporting services delivered via remote access technology, the CMS 1500 claim form must include "Place of Service 02" to identify the service as delivered via telehealth. Refer to Chapter 8-3.4 Telehealth of this manual for additional information.

12 Coding

It is the responsibility of the provider to report the appropriate billing codes for services rendered.

The maximum allowed column is a description of average utilization over the authorization period. Medicaid recognizes that fluctuations in service utilization may vary from week to week. It is the provider's responsibility to track utilization to ensure that they do not exceed the total number of approved units over the authorization period.

12-1 ABA assessment coding

ABA assessments are reported using the procedure code described in the table below.

Code	Service	Who Attends	Maximum Allowed
97151	Behavior Identification Assessment Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and	QHP, Member and their Parent(s)/ Caregiver(s)	1 assessment per 26 Weeks (up to 24 units)

Code	Service	Who Attends	Maximum Allowed
	discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan		

12-2 Individual therapy codes

One-on-one ABA therapy is reported using the procedure codes described in the table below.

When a behavior analyst or assistant behavior analyst provides direct intervention under CPT codes 97153 or 97154, the provider must not bill for behavior analyst level services.

Procedure code 97155 must be reported for direct case supervision of the member. Indirect case supervision must be reported using HCPCS code H0032.

Direct and indirect case supervision services must be reported with the corresponding modifier to indicate the credentials of the clinician performing the supervision services. The supervision service modifiers are defined below:

1. HP – Psychologist or BCBA-D
2. HO – BCBA
3. HN – Behavior analyst in training or BCaBA

Code	Service	Who Attends	Maximum Allowed
97153	Adaptive behavior treatment by protocol	QHP, Member and their	780 Hours (3,120 units) per 26 Weeks

	Adaptive behavior treatment by protocol, administered by technician under the direction of a QHP, face-to-face with one patient, each 15 minutes	Parent(s)/ Caregiver(s)	(See Chapter 8-2.1, Alternative Service Delivery Models)
97155	Adaptive behavior treatment with protocol modification Adaptive behavior treatment with protocol modification, administered by QHP, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	QHP, Member, Technician and their Parent(s)/ Caregiver(s)	A total of 84 Hours (336 units) per 26 Weeks may be requested combined for codes 97155 and H0032. At least 50 percent of the supervision must be direct supervision, as specified in Chapter 8-3, Service Delivery Specifications.
H0032	Mental health service plan development by nonphysician A mental health service plan is developed for treating a patient, including modifying goals, assessing progress, planning transitions, and addressing other needs. This service is provided by someone other than a physician, who is a clinical,	QHP	A total of 84 Hours (336 units) per 26 Weeks may be requested combined for codes 97155 and H0032. At least 50 percent of the supervision must be direct supervision, as specified in Chapter

	professional, or other specialist, each 15 minutes		8-3, Service Delivery Specifications.
97156	Family adaptive behavior treatment guidance Family adaptive behavior treatment guidance, administered by QHP (with or without the patient present), face-to-face with guardian(s) /caregiver(s), each 15 minutes	QHP with Parent(s)/ Caregiver(s) Member may or may not be present	Recommended minimal requirement for parent training 3 episodes per 26 weeks (up to 4 units per episode) See Chapter 8-2.1, Alternative Service Delivery Models

12-3 Group treatment codes

Services provided in a group setting must be reported with the corresponding modifier to indicate the size of the group. Rates for group services are based on the size of the group. Group services claims submitted without a modifier will be denied. The group-size modifiers are defined below:

1. UN – 2 individuals
2. UP – 3 individuals
3. UQ – 4 individuals
4. UR – 5 individuals
5. US – 6 or more individuals

Code	Service	Who Attends	Maximum Allowed
97154	Group Adaptive Behavior Treatment by Protocol Group adaptive behavior treatment by protocol, administered by technician under the direction of a	QHP, Member and Group of Peers (Maximum	52 Episodes per 26 Weeks (up to 4 units per episode)

	physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes	of 8 Members)	
97157	Multiple Family Adaptive Behavior Treatment Guidance Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	QHP, Parents/ Caregivers (Member/ Members Not Present) (Training for a Maximum of 8 Parents/ Caregivers)	3 Episodes per 26 Weeks (up 4 units per episode)
97158	Adaptive Behavior Treatment Social Skills Group Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes	QHP, Member and Group of Peers (Maximum of 8 Members)	26 Episodes per 26 Weeks (up to 4 units per episode)

12-4 Alternative service hour combinations

Providers may request alternative service hour combinations that equal less than 30 hours/week of combined services for codes for individual and group therapy by a behavior technician. Combined requests for parent training and social skills groups by a BCBA may also be requested for less than 29 hours every 6-month authorization period.

12-5 Coding guidance

The following table assists in outlining the covered adaptive behavior treatment and the CPT codes reportable by each.

Type of Service	CPT Codes
Direct face-to-face treatment with the patient	97153, 97155
Direct treatment of patient(s) in group	97154, 97158
Family treatment guidance	97156, 97157

The following table offers coding guidance to providers and outlines the elements included with adaptive behavior treatment by protocol or with protocol modification.

	97153	97155
By Protocol	X	
With protocol modifications		X
QHP face-to-face with the patient		X
QHP are required to be onsite		X
Number of technicians	1	0-1
Deficient adaptive behavior(s), maladaptive behavior(s), or other impaired functioning secondary to deficient adaptive or maladaptive behaviors		X
Destructive behavior(s)		X

SECTION 2

Behavioral Health Services

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2 General Policy

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, note the specific link that is not working and the page number where the link is found.

For general information regarding Medicaid, refer to the *Section I: General Information* provider manual.

Behavioral health services are a covered benefit when the services meet the definition of medical necessity as defined in Utah Administrative Code R414-1-2. Behavioral health services are directed to the treatment of behavioral health disorders and provided directly to or directed exclusively toward the member or exclusively toward the treatment of the member.

2-1 Definitions

Accountable Care Organization (ACO) means a Utah managed care organization that contracts with the Department to provide medical services to its enrollees.

Behavioral Health Disorders: mental health disorders and substance use disorders (SUDs).

Behavioral Health Services: the services directed to the treatment of behavioral health disorders.

CPT manual: the Current Procedural Terminology CPT Professional Edition or CPT Professional Codebook published by the American Medical Association.

Fee-for-Service (FFS): Medicaid-covered services that are reported directly to and paid directly through FFS Medicaid based on an established fee schedule.

Habilitation Services: interventions for the purpose of helping individuals acquire new functional abilities. (See Rehabilitative Services definition below.)

Healthy Outcomes Medical Excellence (HOME): a voluntary managed care program for Medicaid members who have a developmental disability and mental health or behavioral challenges. HOME is a coordinated care program that provides its members with medical services, behavioral health services, and targeted case management services.

Institution for Mental Diseases (IMD): means the same as defined in 42 CFR 435.1010 "Institution for mental diseases".

Medically Necessary Services: means the same as defined in Utah Administrative Code R414-1-2(18).

Mental Health Therapist: means the same defined in the Mental Health Practice Act 58-60-102.

Prepaid Mental Health Plan (PMHP): the mental health and substance use disorder managed care plan operating under the authority of the Department of Health and Human Service's 1915(b) waiver that contracts with the Department to provide to its enrollee's mental health and substance use disorder services, or in one designated area of the State, mental health services only.

Rehabilitative Services: any medical or remedial services ordered by a physician or other licensed practitioner for maximum reduction of an individual's behavioral health disorder and restoration of the individual to their best possible functional level.

Utah Medicaid Integrated Care (UMIC) Plan: a Utah managed care organization that contracts with the Department to provide medical and behavioral health (i.e., mental health and substance use disorder services to its enrollees) HOME is not a UMIC Plan.

2-2 Early and Periodic Screening, Diagnostic, and Treatment

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a program for individuals under the age of 21 to receive preventive health care and all medically necessary services. The program's purpose is to find and treat health problems before they become more serious. Behavioral Health Services covered in this manual are available for the EPSDT population. To learn more, see the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services manual. To request reimbursement for a service that is not defined in this manual, providers may request the service be reviewed by the EPSDT Committee.

Providers must submit an authorization request at https://medicaid.utah.gov/prior-authorization/

Providers and members can also contact the member's managed care plan or a Health Program Representative at 1-866-608-9422 to get information about the EPSDT program.

3 Coding

As part of the Provider Agreement, enrolled providers agree to comply with and follow all guidelines of the National Correction Coding Initiative per *Section I: General Information,* Chapter 3 "Provider Participation and Requirements".

Utah Medicaid has some coding policies unique to Utah that are outlined in this manual. When specific guidance is not given Utah Medicaid follows the National Correction Coding Initiative. Providers are responsible for identifying and reporting the correct codes for all services rendered. Additional guidance on coding behavioral health services can be found in the Coverage and Reimbursement Code Lookup tool.

4 Provider Participation and Requirements

Refer to *Section I: General Information*, Chapter 3, "Provider Participation and Requirements."

4-1 Providers Qualified to Prescribe Behavioral Health Services

Behavioral health services must be prescribed by a mental health therapist as defined in Title 58-60-102, *Mental Health Professional Practice*.

4-2 Providers Qualified to Render Behavioral Health Services

All providers must only render services within their scope of practice and should consult with their licensing or certifying entities for their scope of practice. Qualified providers for some services are authorized through the Utah Medicaid State Plan, Utah's Medicaid Reform 1115 Demonstration and other Medicaid policies.

4-3 Other Trained Individuals

Other trained individuals may provide psychosocial rehabilitative services and supportive living, as defined in this manual, and other services as defined in the Managed Care Manual.

Before other trained individuals can report services, the hiring body must ensure the following minimum training requirements are met:

Individuals shall receive training on all administrative policies and procedures of the agency, and the program as applicable, including:

- Fraud, waste or abuse detection and reporting,
- HIPAA and confidentiality/privacy policy and procedures,

- Emergency/crisis procedures, and
- Other relevant administrative-level subjects.

Individuals shall also receive information and training in areas including:

- Philosophy, objectives, and purpose of the service(s) the individual will be delivering,
- Medicaid definition of the service(s) the individual will be delivering,
- Specific job duties,
- Treatment plans and development of treatment goals,
- Role and use of clinical supervision of the other trained individual,
- Population(s) served and the functional impacts of diagnoses that result in the need for the service,
- Healthy interactions with members to help them obtain goals,
- Management of difficult behaviors,
- Medications and their role in treatment,
- Any formal programming materials used in the delivery of the service (the individual shall understand their use and receive training on them as required), and
- Other relevant subjects as determined by the agency.

The hiring body shall maintain documentation of training including dates of training, agendas, and training/educational materials used. The supervising provider must ensure individuals complete all training within 60 calendar days of the hiring date, or for existing providers within 60 calendar days from the date of enrollment as a Medicaid provider.

5 Record Keeping

Providers must maintain records in accordance with relevant laws and statutes. Refer to Section I: General Information, Chapter 4, *Record Keeping.* Additionally, the provider must develop and maintain sufficient written documentation for each service or session to support the medical necessity and provision of the prescribed mental health service.

For services that are bundled, documentation must be completed for each service rendered and must meet the record keeping standards described in this manual.

Documentation must include:

- name of each service the member received,
- date, start and stop time, and duration of each service,
- setting in which each service was rendered. When services are provided via telehealth, the provider setting and a notation that the service was provided via telehealth must be made,
- record of what happened during the service including treatment goals addressed, and
- signature and licensure or credentials of the individual who rendered the service.

5-1 Time Rules

Utah Medicaid follows the time rules standards set by CMS. For services with 15-minute units follow the time rules below.

- Less than 8 minutes equals 0 units,
- 8 minutes through 22 minutes of service equals 1 unit,
- 23 minutes through 37 minutes of service equals 2 units,
- 38 minutes through 52 minutes of service equals 3 units,
- 53 minutes through 67 minutes of service equals 4 units, etc.…

6 Coding and Billing

Refer to *Section I: General Information*, Chapter 11 "Billing Medicaid" for detailed billing instructions. Utah Medicaid requires all enrolled providers to comply with all laws, rules, and regulations governing the Medicaid Program. As part of the Provider Agreement, all enrolled Medicaid providers agree to follow all guidelines of the National Uniform Billing Code when billing for Medicaid services. Refer to *Section I: General Information*, Chapter 3 "Provider Participation and Requirements" for Provider Agreement information.

For per diem bundled service codes, at least one behavioral health service must be rendered to the member to report the bundled code.

6-1 Telehealth Services

When reporting services delivered via telehealth refer to *Section I - General Information*, Chapter 8-4.2 "Telehealth" for additional information.

6-2 Third Party Liability

Requirements for billing third parties are described in *Section I: General Information*, Chapter 11-5 "Billing Third Parties."

6-3 Medicaid as Payment in Full, Member Billing Prohibited

A provider who accepts a member must accept Medicaid payment as reimbursement in full. Refer to *Section I: General Information Provider Manual*, Chapters 3-4 "Medicaid as Payment in Full, Client Billing Prohibited" and Chapter 3-5 "Exceptions to Prohibition on Billing Members" for exceptions to billing members.

7 Treatment Plan

Based on data from evaluation(s), when behavioral health services are deemed medically necessary, a mental health therapist is responsible for the development of an individualized treatment plan in collaboration with the member. A mental health therapist is also responsible to conduct reassessments/treatment plan reviews with the member, as clinically indicated, to ensure the member's treatment plan is current and accurately reflects the member's goals and needed behavioral health services. Initial treatment plans and any subsequent treatment plan review and updates must also be documented.

The treatment plan must include the following:

1. measurable treatment goals including the date each treatment goal is added to the treatment plan,
2. the specific treatment methods that will be used to meet the measurable treatment goals,
3. a projected schedule for service delivery, including the expected frequency and duration of each treatment method,
4. the licensure or credentials of the individuals who will furnish the medically necessary services, and
5. the signature and licensure or credentials of the mental health therapist who developed the treatment plan.

8 Behavioral Health Services

8-1 General Information

Behavioral health services must be provided to or directed exclusively toward the treatment of the Medicaid member.

Behavioral health services may be provided to members with a dual diagnosis of a mental health disorder, substance use disorder, intellectual disability, developmental disorder, or related condition. Services should be directed toward the treatment or remediation of the diagnosis.

For applied behavioral analysis (ABA) policies for treating autism spectrum disorder (ASD), refer to the *Autism Spectrum Disorder Services* provider manual.

The following descriptions of services provide general information, provider requirements, limitations, and coding/billing guidelines for Medicaid covered services. Services with specific Utah regulations include pertinent information. For services without unique Utah rules, general information is included, and providers should refer to the CPT Manual or the National Correct Coding Initiative (NCCI) for information.

8-2 Psychiatric Diagnostic Evaluation

8-2.1 General

Psychiatric diagnostic evaluations are an integrated biopsychosocial assessment performed for the purpose of assessing and determining diagnoses. These evaluations include the assessment of the patient's psychosocial history, current mental status, review, and ordering of diagnostic studies followed by appropriate treatment recommendations. In certain circumstances information may be obtained from family members, guardians, or significant others in lieu of the patient.

Additional provider requirements apply when evaluations may be used to qualify a Medicaid member to receive Medicaid-covered autism spectrum disorder (ASD)-related services. For information on these requirements and on ASD-related services, refer to the *Utah Medicaid Provider Manual for Autism Spectrum Disorder Related Services* for EPSDT Eligible Individuals.

For information and requirements regarding psychiatric diagnostic evaluations for individuals with a chronic pain management service and evaluations required prior to certain medical and surgical procedures, refer to the Utah Medicaid Provider Manual for *Physician Services*, 8-15.1 “Evaluations and Psychological Testing”.

8-2.2 Provider Participation

Psychiatric diagnostic evaluations must be performed by a licensed mental health therapist. Psychiatric diagnostic evaluations with medical services must be performed by a licensed provider acting within their scope of practice.

Psychiatric diagnostic evaluations performed for physical health purposes (including prior to medical procedures), or for diagnosing intellectual or development disabilities, or organic disorders, the services are paid directly by FFS Medicaid and not by ACOs, PMHPs or UMIC Plans. To ensure correct adjudication of the claim use the UC modifier with the procedure code for these services.

8-2.3 Limitations

Psychiatric diagnostic evaluations are not reimbursable when requested by a court, the Department of Health and Human Services (DHHS), Division of Child and Family Services, solely for the purpose of

determining if a parent is able to parent and should therefore be granted custody or visitation rights, or whether the child should be in some other custodial.

8-2.4 Coding and Billing

Utah Medicaid uses 15-minute units for reporting of psychiatric diagnostic evaluations. See Time Rules in Chapter 5-2 of this manual.

90791	Psychiatric diagnostic evaluation	Per 15 minutes
90792	Psychiatric diagnostic evaluation with medical services	Per 15 minutes

8-3 Mental Health Assessment by a Non-Mental Health Therapist

8-3.1 General

Mental health Assessment by a Non-Mental Health Therapist is when a qualified provider participating in a in multi-disciplinary team assists in the psychiatric diagnostic evaluation process by gathering psychosocial information including information on the individual's strengths, weaknesses, and needs, and historical, social, functional, psychiatric, and other information. The provider may also assist the member to identify treatment goals. The information obtained is provided to the qualified provider who will perform the psychiatric diagnostic evaluation assessment, reassessment, or treatment plan review. Information also may be collected through in-person or telephonic interviews with family/guardians or other sources as necessary.

8-3.2 Provider Participation

The following individuals may provide a mental health assessment when they are under the supervision of a licensed mental health therapist and are participating as part of a multi-disciplinary team:

- licensed social service worker
- substance use disorder counselor licensed as an advanced substance use disorder counselor (ASUDC), certified advanced substance use disorder counselor (CASUDC), certified advanced substance use disorder counselor intern (CASUDC-I), substance use disorder counselor (SUDC), certified substance use disorder counselor (CSUDC), or certified substance use disorder counselor intern (CSUDC-I)
- licensed behavioral health coach
- licensed registered nurse
- licensed practical nurse
- licensed registered nursing apprentice
- individual who has obtained a qualifying bachelor's degree and is actively engaged in meeting the Department of Professional Licensing requirements to obtain licensure as a Social Service Worker in accordance with State law
- individual enrolled in a qualified substance use disorder education program who is exempted from licensure in accordance with State law, and under DOPL-required supervision.

8-3.3 Limitations

This service is meant to accompany psychiatric diagnostic evaluations. If a psychiatric diagnostic evaluation is not conducted after this service is performed, this service may be reported if all the documentation requirements in the Record Keeping Chapter are met and the reason for non-completion of the psychiatric diagnostic evaluation is documented.

If the provider conducting the psychiatric diagnostic evaluation obtains all the psychosocial information directly from the Medicaid member, only that service is reported. The provider does not report this service.

8-3.4 Coding and Billing

H0031	Mental health Assessment by a Non-Mental Health Therapist	15-minute units

8-4 Psychological Testing

8-4.1 General

Medicaid provides coverage for psychological testing as a comprehensive evaluation to assess the presence, type, and severity of a mental illness or disorder. This includes administering psychological tests that are specifically chosen to meet a member's clinical needs. The service also encompasses the interpretation of test results and the preparation of detailed reports as integral components of the psychological assessment process. Provider Participation

Licensed providers acting within their scope of practice may report this service.

8-4.2 Limitations

For more information on psychological testing for physical health purposes, see the Utah Administrative Code R414-10, *Physician Services*, and the *Physician Services provider manual*, Chapter 8-15.1 – "Evaluations and Psychological Testing".

Additional provider requirements apply when testing may be used to qualify a member to receive covered ASD-related services. For information on these requirements and on ASD-related services, refer to the *Autism Spectrum Disorder Services* provider manual.

8-4.3 Coding and Billing

Refer to the CPT manual for psychological testing codes. Psychological testing performed for physical health purposes, including prior to medical procedures, or for diagnosing intellectual or development disabilities, or organic disorders, the services are paid directly by FFS Medicaid and not by ACOs, PMHPs or UMIC Plans. To ensure correct adjudication of the claim, use the UC modifier with the procedure code.

8-5 Psychotherapy

8-5.1 General

Medicaid covers psychotherapy when used for the treatment for mental illness and behavioral disturbances. The provider, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development so that the member may be restored to their best possible functional level. Services are based on measurable treatment goals identified in the treatment plan.

8-5.2 Provider Participation

Psychotherapy must be provided by a licensed mental health therapist. Group psychotherapy may be cofacilitated by licensed mental health therapist and another licensed provider acting within their scope of practice. Psychotherapy with evaluation and management services must be provided by a provider acting within their scope of practice.

8-5.3 Limitations

Group psychotherapy is limited to 12 patients in attendance unless a co-provider is present, then group psychotherapy may not exceed 16 patients in attendance.

Multiple-family group psychotherapy is limited to 12 families in attendance unless there is a co-provider, then groups may not exceed 16 families in attendance.

If the number of patients or families in attendance exceeds the limit, then the group may not be reported for any of the Medicaid members.

8-5.4 Coding and Billing

Utah Medicaid uses 15-minute units when reporting group and family psychotherapy.

90846	Family Psychotherapy - without patient present	per 15 minutes
90847	Family Psychotherapy - with patient present	per 15 minutes
90849	Multiple-Family Group Psychotherapy	per 15 minutes
90853	Group Psychotherapy	per 15 minutes

8-6 Psychotherapy for Crisis

8-6.1 General

Psychotherapy for crisis is an urgent assessment of a crisis state, a mental status exam, and disposition. It includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention for a member in high distress.

8-6.2 Provider Participation

A licensed mental health therapist acting within their scope of practice may provide this service.

8-7 Pharmacologic Management

8-7.1 General

Pharmacologic management service entails reviewing and monitoring the patient's prescribed medication(s) and medication regimen to manage a behavioral health condition. Reviewing and monitoring includes evaluation of dosage, the effect the medication(s) is having on the patient's symptoms, and side effects. Any of the following may also be included in the service: prescription of medications to treat the patient's behavioral health condition, providing information (including directions for proper and safe usage of medications), and/or administering medications as applicable.

8-7.2 Provider Participation

A licensed physician or other qualified provider acting within their scope of practice.

8-7.3 Coding and Billing

Pharmacologic management is reported using the appropriate Evaluation and Management code. When reporting this pharmacologic management service, use the CG modifier with the Evaluation and

Management code. The CG modifier signifies that the service was a behavioral health pharmacologic management service as opposed to a medical Evaluation and Management service.

8-8 Nurse Medication Management

8-8.1 General

Behavioral health nurse medication management is nurse medication management includes reviewing and monitoring the member's prescribed medication(s) and medication regimen to manage a behavioral health condition. Reviewing and monitoring includes evaluation of dosage, the effect the medication(s) is having on the member's symptoms, and side effects.

8-8.2 Provider Participation

A licensed provider acting within their scope of practice.

8-8.3 Limitations

Distributing medications (i.e., handling, setting out or handing medications to members) is not a covered service and may not be reported.

Administration of medications is not covered under this service.

Specimen collection, including urinalysis (UA), is not covered under this service.

8-8.4 Coding and Billing

Nurse medication management is reported using the Evaluation and Management code listed below. When reporting this service, use the CG modifier with the Evaluation and Management code listed below. The CG modifier signifies that the service was a behavioral health service as opposed to a medical service.

99211CG	Nurse medication management	Per encounter

8-9 Therapeutic Behavioral Services

8-9.1 General

Therapeutic behavioral services are behavioral interventions to assist members with specific identified behavior problems. The service may be provided to an individual, family, or group. Individuals receiving this service must be referred by a mental health therapist as part of the assessment and treatment planning process; members must continue with individual mental health treatment in conjunction with therapeutic behavioral services.

8-9.2 Provider Participation

The following providers may report this service:

- licensed mental health therapist,
- licensed social service worker under the supervision of a licensed mental health therapist,
- individual who has obtained a qualifying bachelor's degree and is actively engaged in meeting DOPL requirements to obtain licensure as a social service worker in accordance with state law, and is under the supervision of a licensed mental health therapist,
- licensed registered nurse,
- licensed ASUDC or licensed SUDC under the general supervision of a licensed mental health therapist,

- licensed CASUDC or licensed CASUDC-I under direct supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 who is qualified to provide supervision, or a licensed ASUDC qualified to provide supervision,
- licensed CSUDC or licensed CSUDC-I under direct supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 who is qualified to provide supervision, or a licensed ASUDC or a licensed SUDC who are qualified to provide supervision,
- licensed behavioral health coach,
- registered nurse apprentice who is exempted from licensure in accordance with State law, and under required supervision, and
- individual enrolled in a qualified substance use disorder counselor education program, who is exempted from licensure in accordance with State law, and under DOPL-required supervision.

8-9.3 Limitations

Groups are limited to 12 patients in attendance unless a co-provider is present, then groups may not exceed 24 patients in attendance.

Multiple family therapeutic behavioral services groups are limited to 12 families in attendance, unless there is a co-provider, then may not exceed 16 families in attendance.

If the number of patients or families in attendance exceeds the limit, then the group may not be reported for any of the Medicaid members.

Co-providers must meet the provider qualifications outlined in the ‘Qualified Providers’ section above.

8-9.4 Coding and Billing

H2019	Individual/Family Therapeutic Behavioral Services	per 15 minutes
H2019HQ	Group Therapeutic Behavioral Services	per 15 minutes

8-10 Psychosocial Rehabilitative Services

8-10.1 General

Psychosocial rehabilitative services (PRS) are services provided to an individual or group and are designed to restore the member(s) to his or her optimal possible functional level. This service is aimed at maximizing the member’s basic daily living and life skills, increasing compliance with the medication regimen as applicable, and reducing or eliminating symptomatology that interferes with the member’s functioning.

8-10.2 Provider Participation

- licensed mental health therapist,
- licensed social service worker under the supervision of a licensed mental health therapist,
- individual who has a qualifying bachelor’s degree and is actively engaged in meeting DOPL requirements to obtain license as a social service worker in accordance with state law, and is under the supervision of a licensed mental health therapist,
- licensed registered nurse,
- licensed practical nurse under the supervision of a licensed registered nurse, or a licensed mental health therapist,

- licensed ASUDC or licensed SUDC under the general supervision of a licensed mental health therapist,
- licensed CASUDC or licensed CASUDC-I are under direct supervision of a licensed mental health therapist,
- licensed CSUDC or licensed CSUDC-I under direct supervision of a licensed mental health therapist,
- other trained individual (but not including foster parents or other proctor parents) under the supervision of a licensed mental health therapist, a licensed social service worker, or a licensed registered nurse, or a licensed ASUDC or a licensed SUDC when the service is provided to individuals with a SUD,
- licensed behavioral health coach,
- certified behavioral health technician,
- registered nurse apprentice who is exempted from licensure in accordance with state law, and under DOPL-required supervision,
- individual enrolled in a qualified substance use disorder counselor education program, who is exempted from licensure in accordance with State law, and under DOPL-required supervision,

8-10.3 Limitations

PRS groups are limited to 12 or fewer patients per provider, with a maximum of 36 patients. If the number of patients participating in the group exceeds the maximum of 36 patients, the group session may not be reported for any of the Medicaid members.

Intensive PRS groups are limited to five patients per provider, with a maximum of ten patients per intensive PRS group. Intensive PRS groups are planned, structured groups, independent from other PRS groups. They are designed to address the clinical needs of patients who, if in a regular PRS group, would be distracting to other group members and/or require more individualized attention, including one on one, to maintain their focus on their clinical issues and treatment goals. Intensive PRS groups cannot be coded based solely on the number of patients in attendance.

The psychiatric diagnostic evaluation or other clinical documentation must document the need for an intensive PRS group, the member's diagnoses, severity of symptoms and behaviors, and why an intensive PRS group is required. The treatment plan must prescribe intensive PRS and contain goals to ameliorate the symptoms and behaviors that necessitate intensive PRS group.

The following are not to be reported under this service:

- activities in which providers are not present and actively involved helping members regain functional abilities and skills,
- routine supervision of members, including routine 24-hour care and supervision of members (or members' children) in residential settings. Routine supervision includes care and supervision-level providers who may have informal, sporadic interactions with a member that are helpful; however, these types of interactions do not constitute a reportable structured, pre-planned psychosocial rehabilitative individual or group session. Individual and group PRS must be provided in accordance with a formal schedule for the member and must be documented in accordance with the requirements in the 'Record' section below. Otherwise, intermittent unplanned communications with the member are part of the routine supervision and are not reportable,
- activities in which providers perform tasks for the member, including activities of daily living and personal care tasks (e.g., grooming, and personal hygiene tasks, etc.),

- time spent by the member in the routine completion of activities of daily living, including eating meals, doing chores, etc.,
- habilitation Services,
- job training, job coaching and other vocational activities, and educational services and activities such as lectures, presentations, conferences, other mass gatherings, etc.,
- social and recreational activities, including but not limited to routine exercise, farming, gardening, and animal care activities, etc. Although these activities may be therapeutic for the member, and a provider may obtain valuable observations for processing later, they do not constitute reportable activities. However, time spent before and after the activity addressing the members' skills and behaviors related to the member's rehabilitative goals is allowed,
- routine transportation of the member or transportation to the site where a psychosocial rehabilitative service will be provided, and
- any type of childcare (including therapeutic childcare).

8-10.4 Group Psychosocial Rehabilitative Services Provided in Licensed Day Treatment Programs, Licensed Residential Treatment Programs, and Licensed or Unlicensed Day Treatment Programs in Schools

For each date of participation in the program, documentation must include:

- name of each group in which the member participated (e.g., anger management, interpersonal relations, etc.),
- date, start and stop time, and duration of each group, and
- setting in which each group service was rendered (e.g., day treatment program). When services are provided via telehealth, the provider setting and a notation that the service was provided via telehealth must be made.

When services are provided in one of these programs, one summary note for each unique type of psychosocial rehabilitative group the member participated in during the immediately preceding two-week period must be prepared at the close of the two-week period. The required summary note may be written by the provider who conducted the group, or by a provider who is most familiar with the member's involvement and progress across groups.

The summary note must include:

- name of the group,
- treatment goal(s) addressed in the group and the member's progress toward treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers, and
- signature and licensure or credentials of the individual who prepared the documentation. If a co-leader is present for the group, the note must contain the co-leader's name and licensure or credentials.

8-10.5 Coding and Billing

H2014	Individual Psychosocial Rehabilitative Services	per 15 minutes
H2017	Group Psychosocial Rehabilitative Services	per 15 minutes
H2017U1	Group Psychosocial Rehabilitative Services – Intensive	per 15 minutes

8-11 Peer Support Services

8-11.1 General

Peer support services are specialized therapeutic interactions that are performed by individuals who are current or past recipients of behavioral health services. These individuals are trained and certified to provide support and assistance to individuals in their recovery and integration into the community. The goal is to provide understanding and coping skills and empowerment through mentoring and other supports so that individuals with severe and persistent mental disorders can cope with stress and achieve personal wellness.

Peer support services are provided to an individual or in group settings. For children, services are provided to their parents or legal guardians or other responsible caregivers, as appropriate to the child's age.

8-11.2 Provider Participation

Peer Support Services must be delivered by a peer support specialist who is certified through the Office of Substance Use and Mental Health (SUMH) certification process as outlined in Utah Administrative Code R523-5 or R523-6.

8-11.3 Limitations

Peer support service groups with a ratio greater than 1:8 are not reportable for any Medicaid member in the group.

Peer support services must be referred by a licensed mental health therapist and must document in the record which licensed mental health therapist recommended peer support services.

8-11.4 Coding and Billing

H0038	Individual Peer Support Services	Per 15 minutes
H0038HQ	Group Peer Support Services	Per 15 minutes

8-12 Assertive Community Treatment and Assertive Community Outreach Treatment

8-12.1 General

Assertive Community Treatment (ACT) and Assertive Community Outreach Treatment (ACOT) are community-based programs that offer treatment and support services for people with serious and persistent mental illnesses. Their goal is to help members live independently in their chosen communities, rather than relying on hospitals. ACT and ACOT teams provide services in-person and in community settings, including inpatient and outpatient facilities.

8-12.2 Provider Participation

Assertive Community Treatment (ACT) teams must meet Utah Administrative Code R523-22-5 guidelines to report ACT services. Assertive Community Outreach Treatment (ACOT) teams must meet the Office of Substance Use and Mental (SUMH) Assertive Community Outreach Treatment for Clients with the Most Serious and Persistent Mental Illnesses Program Guidelines in order to report ACOT services.

8-12.3 Coding and Billing

ACT and ACOT services are reimbursed on a per month bundled payment basis and the member must receive at least one behavioral health service per billing period. Only one unit of service can be reported each month, and services must be reported only for the month in which at least one service was provided.

A prorated charge is reported when a member enters or discharges from the ACT or ACOT caseload in the middle of a month and does not receive ACT or ACOT services for the entirety of the month. The per diem rate is determined by multiplying the monthly rate by 12 then dividing it by 365. The prorated rate is then multiplied by the number of days of service for the prorated month. Providers report the days of service, one unit, and the prorated charge.

H0040	Assertive Community Treatment	Per month

8-13 Mobile Crisis Outreach Teams

8-13.1 General

Mobile Crisis Outreach Teams (MCOT) offer a community-based intervention to members experiencing a crisis. MCOTs go to homes, schools, shelters, work, or anywhere else in the community where a member is experiencing a crisis.

8-13.2 Provider Participation

MCOTs that meet the standards in Utah Administrative Code R523-18 may report this service.

8-13.3 Coding and Billing

H2000	Comprehensive multidisciplinary evaluation	Per diem

8-14 Clinically Managed Residential Withdrawal Management

8-14.1 General

Clinically Managed Residential Withdrawal Management, sometimes referred to as “social detox”, is a service provides 24-hour supervision, observation, and support for members who are intoxicated or experiencing withdrawal. It emphasizes peer and social support rather than medical and nursing care. Details about this service can be found in *The American Society of Addiction Medicine (ASAM) Criteria* guidelines.

8-14.2 Provider Participation

A program that is licensed through DHHS Office of Licensing as a social detoxification facility and meets *ASAM Criteria* guidelines for this level of care may report this service.

8-14.3 Limitations

Programs must ensure that that members have access to fully integrated comprehensive addiction treatment services which may be through formal affiliation with other providers and programs.

This service is reportable on hospital admission and discharge dates.

8-14.4 Coding and Billing

H0012	Alcohol and/or drug services, sub-acute detoxification	Per diem

8-15 Medically Managed Outpatient Treatment

8-15.1 General

Medically Managed Outpatient Treatment, sometimes referred to as "outpatient detox", is a medically organized outpatient service which may be provided in an outpatient setting such as a healthcare clinic, office setting, or addiction treatment facility by a licensed professional. The primary purpose of the service is to provide medically supervised, withdrawal management, and referral services based on the member's needs. These services are provided in regularly scheduled timeframes and intervals set by the licensed provider once the member has been assessed and it is determined treatment at the outpatient level of care is appropriate.

8-15.2 Provider Participation

A program that is licensed through the Utah Office of Licensing as a Medically Managed Outpatient Treatment facility and meets *The ASAM Criteria* guidelines for this level of care.

8-15.3 Limitations

Programs may only report the per diem bundled service code for dates on which at least one included service is provided to the member. This service is reportable on hospital admission and discharge dates.

8-15.4 Coding and Billing

H0014	Alcohol and/or drug services-Ambulatory Detoxification (with or without extended on-site monitoring)	Per diem

8-16 Behavioral Health Receiving Centers

8-16.1 General

Behavioral Health Receiving Centers (BHRC) are 24/7 community centers designed to support individuals experiencing any type of behavioral health crisis. These centers are staffed by a team that includes psychiatrists, registered nurses, mental health therapists, and peer counselors. The team provides care for those in mental health or substance use crises. At BHRCs, individuals are assessed, stabilized, and can be monitored in a recliner for up to 23 hours.

8-16.2 Provider Participation

BHRCs must be licensed by the DHHS Office of Licensing, be an outpatient hospital, or be included under a hospital's license. All facilities must meet treatment and staffing requirements specified in Utah Administrative Code R523-21.

8-16.3 Coding and Billing

S9485	Crisis intervention mental health services,	Per diem

8-17 Psychiatric Hospitals Considered Institutions for Mental Disease

8-17.1 General

Treatment in a psychiatric hospital considered to be an Institution for Mental Disease (IMD) is covered when medically necessary for up to 60 days for members ages 21 through 64. Prior authorization is

required. No more than 60 calendar days will be authorized per treatment episode. If treatment exceeds 60 days, no part of the stay is eligible for reimbursement.

For members ages 21 and under, stays in IMD facilities are covered as long as the stay is medically necessary. No prior authorization is required.

If the member is enrolled in a PMHP, UMIC Plan or HOME, refer to the plan for their prior authorization requirements.

For information on psychiatric hospital licensing, coverage, and limitations please refer to the *Hospital Services Manual*, Chapter 8-11, Mental Health Services.

8-18 Mental Health Residential Treatment

8-18.1 General

Mental health residential treatment provides a 24-hour group living environment for members, with mental health disorders.

8-18.2 Provider Participation

Providers must be licensed by DHHS Office of Licensing as a licensed residential treatment program and meet the requirements in Utah Administrative Code R501-19. For facilities that are IMDs, accreditation from The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) is also required.

8-18.3 Programs with 16 or fewer beds

For members 21 years of age or older, providers report a per diem code. For members under 21 years of age, providers report the individual services rendered.

8-18.4 Programs with 17 or more beds (Institutions for Mental Diseases)

Programs with 17 or more beds are Institutions for Mental Diseases (IMDs). Utah Medicaid only allows the reporting of services for members 21-64 years of age in IMDs. Prior authorization is required.

Mental health residential treatment in an IMD is limited to 60 days per episode of care, regardless of medical necessity. If a treatment episode exceeds 60 days, then none of the days of the treatment episode of care are reportable or reimbursable.

Mental health residential treatment programs that are IMDs must also meet the following standards:

- Programs must have the capacity to address co-morbid physical health conditions during short-term stays.
- Programs are responsible for ensuring appropriate transitions to other levels of outpatient mental health services, either by directly providing the level of care needed or by coordinating the transition to the needed level of care with another provider.
- Programs must have a process to assess the housing situation of the member transitioning to the community from the program and to connect the member who may experience homelessness upon discharge, or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services.
- Programs must have protocols in place to ensure contact is made with each discharged member within 72 hours of discharge and to assist the member with accessing follow-up care by contacting the community-based provider they were referred to.

8-18.5 Prior Authorization for Mental Health Residential Treatment in Programs that are IMDs

Prior authorization (PA) requests may be approved for up to seven (7) calendar days per PA request or at a time. Members may receive only one initial admission PA per treatment episode in which no clinical documentation is necessary. If a PMHP, UMIC plan, or HOME program has given a non-clinical PA and the member's enrollment changes to FFS during the treatment episode, or vice versa, additional PA requests must be a clinical PA request(s). No more than 60 calendar days may be authorized per treatment episode regardless of medical necessity.

If the member is enrolled in a PMHP, UMIC Plan or HOME, refer to the plan for their prior authorization requirements.

8.18.5.1 Initial Admission PA Request

An initial admission PA request must be submitted no later than two (2) business days after the date of admission. No supporting documentation is required.

8.18.5.2 Ongoing/Continued Stay PA Request

An ongoing/continued stay PA request must include the anticipated discharge date in the 'documentation' section and 'remarks' section that supports medical necessity for continued stay. The submission must be no earlier than four (4) calendar days of (and including) the first requested date of service indicated on the PA request. The clinical documentation must be submitted no later than the first requested date of service indicated on the PA request.

8.18.5.3 Transition Days

If the provider determines that medical necessity for continued stay is not met, the provider may request up to seven (7) calendar transition days to allow time to transition the member to the medically necessary level of care. Providers must complete the PA request submission and ensure that the 'remarks' section indicates that the request is for transition days and must submit the PA request no later than the first date of service requested on the PA request. If the PA team determines that the clinical documentation submitted with a continued stay (clinical) PA request does not support continued stay criteria, the PA team may authorize up to seven (7) calendar days to allow time to transition the member to the medically necessary level of care.

8.18.5.4 Member Absence from the Program

If a member is absent from a program for three (3) calendar days or less, providers must request a modification to the current PA request by completing and submitting a 'modification form'. Providers must include in the comment or remark section the dates the member was absent from the program.

If a member is absent for more than three (3) calendar days, providers must request a new non-clinical PA. Providers must include in the 'remark' section or 'comment' section, including the date the member left the program are included.

8.18.5.5 Modification Requests

If a modification on an authorization is required, the provider must complete and submit the modification request form and any supporting documentation for the existing prior authorization request no later than 10 days after the admission date. Anything submitted after 10 days will not be considered timely and will result in a denial.

8-18.6 Coding and Billing

Facilities may only report the per diem bundled service codes for dates when at least one of the following services are provided:

- psychiatric diagnostic evaluation,
- psychotherapy (individual/group/family),
- injectable administration of a drug,
- nursing assessment, case management,
- mental health assessment,
- peer services,
- training/skills development,
- community support services,
- psychosocial rehabilitative services,
- therapeutic behavioral services,
- or targeted case management.

H0017	Mental Health Residential Treatment IMD Program, ages 21-64	Per diem
H2013	Mental Health Residential Treatment Program non-IMD, 21 years of age and older	Per diem
Individual service codes	Mental Health Residential Treatment Program non-IMD, under 21	

8-19 Substance Use Disorder Residential Treatment

8-19.1 General

Substance use disorder (SUD) residential treatment provides specialized treatment in a 24-hour group living environment for individuals with substance use disorders.

8-19.2 Provider Participation

Providers must be licensed by DHHS Office of Licensing and meet the requirements in Utah Administrative Code R501-19.

8-19.3 Limitations

Prior authorization (PA) is required for all members receiving substance use disorder residential treatment.

SUD residential treatment is limited to members ages 12 and older.

This service is reportable on hospital admission and discharge dates.

8-19.4 Prior Authorization for Substance Use Disorder Residential Treatment Programs

PA requests for adolescent members ages 12 through 18 may be approved for up to 30 calendar days per request. PA requests for adult members 19 years of age or older may be approved for up to 60 calendar days per request. Members may receive one initial PA per treatment episode, without the submission of accompanying medical documentation. If a PMHP, UMIC Plan, or HOME program has given an initial PA and the member's enrollment changes to FFS during the treatment episode, additional ongoing/continued stay PA requests must be submitted.

For more information on PA submissions for SUD providers please see the PRISM Prior Authorization (PA) Facilitator Guide for Providers for SUD training document.

8.19.4.1 Initial Admission PA Request

An initial admission PA request must be submitted no later than 2 business days after the date of admission. No supporting documentation is required with this request.

8.19.4.2 Ongoing/Continued Stay PA Request

An ongoing/continued stay PA request must include a completed reassessment and treatment plan review using ASAM criteria and must be submitted no earlier than seven (7) calendar days of (and including) the first requested date of service indicated on the PA request. The reassessment and treatment plan review must be no later than the first date of service requested on the PA request form.

8.19.4.3 Transition Days

If the provider determines that medical necessity for continued stay is not met, the provider may request up to seven (7) calendar transition days through the standard clinical PA request process to allow time to transition the member to the appropriate ASAM level of care. When Medicaid determines the clinical documentation does not support the need for continued stay, seven (7) transitional calendar days may be authorized to allow time for the transition of the member to the medically necessary ASAM level of care.

8.19.4.4 Member Absence from the Program

If a member is absent from a program for three (3) calendar days or less, providers must request a modification to the current PA request by completing and submitting a 'modification request form'. Providers must ensure the 'remarks' or 'comments' section, include the dates the member was absent.

If a member is absent for more than three (3) calendar days, providers must request a new non-clinical PA. Providers must ensure the 'remarks' or 'comments' section, include the date the member left the.

8.19.4.5 Modification Requests

If a modification to an authorization is required, the provider must complete and submit the modification request form and any supporting documentation for the existing prior authorization request no later than 10 calendar days after the admission date. Anything submitted after 10 calendar days will not be considered timely and will result in a denial.

8-19.5 Coding and Billing

Facilities may only report the per diem bundled service codes for dates when at least one of the following services are provided: Psychiatric diagnostic evaluation, psychotherapy (individual/group/family), injectable administration of a drug, nursing assessment, case management, mental health assessment, peer services, training/skills development, community support services, psychosocial rehabilitative services, therapeutic behavioral services, or targeted case management.

H0018	Substance use disorder residential treatment, IMD	Per diem
H2036	Substance use disorder residential treatment, non- IMD	Per diem

8-20 Supportive Living

8-20.1 General

Supportive living service involves 24-hour staff who create a safe and supportive environment for members. This service is provided directly to members through residential support, crisis intervention, community integration, and ensuring safety and security. It focuses on improving members' living situations, addressing safety concerns, helping resolve interpersonal issues with other residents, and

preventing or managing emergencies to help members reach their best possible functional level. This service does not cover the costs of other covered services or room and board.

8-20.2 Provider Participation

Facilities must be licensed by DHHS Office of Licensing and meet the requirements in Utah Code 62A-2-101(38). This service may be provided by an Other Trained Individual as defined in Chapter 3-1.3 of this manual and other certified and licensed providers.

8-20.3 Limitations

- Costs do not include room and board.
- Supportive living may not be reported when a per diem bundled behavioral health treatment code is reported (codes H0012, H0018, H2036, H0017, or H2013) as supportive living costs are included in the bundled payment rates.

8-20.4 Coding and Billing

H2016	Supportive Living	Per diem

8-21 Recreational Therapy

8-21.1 General

Recreational therapy is a person-centered process that uses recreation activities to improve the physical, cognitive, social, behavioral, emotional, or spiritual well-being of a person with an illness or a disability.

8-21.2 Provider Participation

Recreational therapy services can only be reported by a master therapeutic recreation specialist, a therapeutic recreation specialist, or a therapeutic recreation technician as authorized by Title 58-40, Recreational Therapy Practice Act.

8-21.3 Limitations

A licensed mental health therapist must refer a member for recreational therapy services. The referral must be documented in the behavioral health treatment plan and in the recreational therapy treatment plan.

Recreational therapy can only be reported when provided in the following settings:

- general acute hospital,
- youth residential treatment facility,
- behavioral health program,
- intermediate care facility,
- assisted living facility,
- skilled nursing facility,
- nursing home,
- psychiatric hospital, or
- mental health agency.

8-21.4 Coding and Billing

H2032	Activity Therapy	Per 15 minutes
H2032HQ	Group Activity Therapy	Per 15 minutes

8-22 Methadone Administration Services

8-22.1 General

Methadone administration services are delivered to a member for detoxification from opioids and/or maintenance treatment. Overall treatment must be delivered, which should include counseling/therapy, case review, and medication monitoring. Members may obtain methadone administration services from any Medicaid-enrolled Opioid Treatment Program. However, related outpatient behavioral health services are covered under PMHPs, UMIC Plans and HOME.

8-22.2 Provider Participation

Facilities must be licensed through the DHHS Office of Licensing and certified by the federal Substance Abuse and Mental Health Services Administration in accordance with 42 C.F.R. 8.11.

8-22.3 Coding and Billing

This service is reimbursed through FFS Medicaid and multiple dates of service for take home dosing may be billed on the same line.

H0020	Methadone administration and/or service (provision of the drug by a licensed program)	Per diem

9 Non-covered Services

The following may not be reported:

- Habilitation services are not reportable as mental health or substance use disorder services,
- Community based services such as Alcoholics Anonymous,
- Driving under the influence (DUI) classes or court ordered only programming,
- Evaluations for the sole purpose of determining custodial arrangements or parental custody or visitation rights, are not medically necessary and are not covered,
- Job training, job coaching, vocational, and educational services,
- Social and recreational activities, and
- Routine transportation of the member or transportation to a site where services will be provided.

10 Procedure Code Table

The following table is not an all-inclusive table of Utah Medicaid covered services. This table is for assistance with unique Utah coding policies, modifiers, Medically Unlikely Edit (MUE), and time rules associated with these codes.

Utah Medicaid bypasses CMS' National Correct Coding Initiative (NCCI) MUEs set for the following codes and instead uses the reporting unit specified in the table below for these codes: H0006, H0031, 90791, 90792, 90846, 90847, 90849, and 90853.

SERVICE	CODE	MODIFIER	DESCRIPTION
Psychiatric Diagnostic Evaluation	90791		Psychiatric Diagnostic Evaluation - per 15 minutes

	90792		Psychiatric Diagnostic Evaluation with Medical Services - per 15 minutes
Mental Health Assessment by a Non-Mental Health Therapist	H0031		Mental Health Assessment by a Non-Mental Health Therapist – per 15 minutes
Psychological Testing	CPT Codes		Psychological Testing and Neuropsychological Testing codes
		UC	When performed for physical health purposes, including prior to medical procedures, or for the purpose of diagnosing intellectual or development disabilities, or organic disorders.
Group and Family Psychotherapy	90846		Family Psychotherapy - without patient present – per 15 minutes
	90847		Family Psychotherapy - with patient present – per 15 minutes
	90849		Multiple-Family Group Psychotherapy - per 15 minutes per member
	90853		*Group Psychotherapy* - per 15 minutes per member
Pharmacologic Management Services	E/M codes	CG	The CG modifier signifies that the service was a behavioral health pharmacologic management service as opposed to a medical E/M service.
Nurse Medication Management	99211	CG	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician
Therapeutic Behavioral Services	H2019		Individual/Family Therapeutic Behavioral Services - per 15 minutes
	H2019	HQ	Group Therapeutic Behavioral Services - per 15 minutes per Medicaid patient
Psychosocial Rehabilitative Services	H2014		Individual Psychosocial Rehabilitative Services - per 15 minutes

	H2017		Group Psychosocial Rehabilitative Services - per 15 minutes per member
	H2017	U1	Group Psychosocial Rehabilitative Services – Intensive – 15 minutes per member
Peer Support Services	H0038		Individual Peer Support Services - per 15 minutes
	H0038	HQ	Group Peer Support Services - per 15 minutes per member
Assertive Community Treatment (ACT) and Assertive Community Outreach Treatment (ACOT)	H0040		Assertive Community Treatment, per month
Mobile Crisis Outreach Team (MCOT)	H2000		Comprehensive multidisciplinary evaluation, per diem
Clinically Managed Residential Withdrawal Management	H0012		Sub-acute detoxification (social detox)– per diem
Behavioral Health Receiving Centers	S9485		Crisis intervention mental health services, per diem
Mental Health Residential Treatment	H0017		17 or more beds (IMD) – member is 21 to 65 years of age – per diem
	H2013		16 or fewer beds - member is 21 years of age or older – per diem
	CPT Codes or H codes		16 or fewer beds – member is under 21 years of age
Substance Use Disorder Residential Treatment	H0018		17 or more beds (IMD) Behavioral health; short-term residential (non-hospital residential treatment program), without room and board – per diem
	H2036		16 or fewer beds

			Alcohol and/or drug treatment program, per diem
Supportive Living	H2016		Comprehensive community support services, per diem
Recreational Therapy	H2032		Individual recreational therapy assessments, treatment plan formulation, and recreational therapy interventions – per 15 minutes
	H2032	HQ	Group recreational interventions – per 15 minutes
Methadone administration services	H0020		Methadone administration and/or service (provision of the drug by a licensed program) – per diem

Utah Medicaid Provider Manual

Dental, Oral Maxillofacial, and Orthodontia Services

Division of Integrated Healthcare

Updated November 2023

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1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General information.

1-1 Dental services

Dental services, whether furnished in the office, a hospital, a skilled nursing facility, or elsewhere, means covered services performed within the scope of the Medicaid dental provider's license as defined in Title 58, Occupations and Professions. This includes services to treat disease, maintain oral health, and treat injuries or impairments that may affect a member's oral or general health. In addition, orthodontics is defined as a corrective procedure for functionally handicapping conditions.

According to Medicaid's policies and procedures, all services must maintain a high standard of quality and be provided within the reasonable limits of those customarily available and provided to most persons in the community.

In addition to this provider manual, reference Utah Administrative Code Title R414. Health Care Financing, Coverage and Reimbursement Policy, for more information on Utah Medicaid Policy. For specific information regarding Dental, Oral and Maxillofacial Surgeons and Orthodontia Services see Utah Administrative Code R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia. Coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

References: 42 CFR §§440.100, 440.120, 440.225, 440.50, 483.55; and Administrative Rule R414-49.

2 Health plans

For more information about fee for service and managed care, refer to Section I: General Information, Chapter 1-7.

For more Information about dental plans, refer to Section I: General Information, Chapter 2-10.

Managed care plans are not responsible for covering the following Medicaid State Plan or waiver services. These services are "carved-out services" and should be reported directly to Medicaid on a fee for service basis:

Any dental service for a Medicaid eligible member who is:

1. a non-pregnant adult, except for an EPSDT enrollee;
2. in the custody of the Department of Human Services and covered by Foster Care Medicaid;
3. in a nursing home or an intermediate care facility;
4. enrolled in Utah's Premium Partnership for Health Insurance (UPP);
5. Facility charges for hospital and ambulatory surgical centers;
6. Medical and dental surgical services that include general anesthesia performed at a hospital or ambulatory surgical center;
7. Emergency services performed in an emergency department of a hospital or an urgent care facility;
8. Services performed at Indian Health Services, any tribal facility, or an Urban Indian facility;
9. Services performed at the Utah State Hospital or Utah State Developmental Center; and
10. Surgical repair services performed by a dentist or oral surgeon for craniofacial anomalies, cleft lip, or palate.

3 Provider participation and requirements

Refer to Section I: General Information, Chapter 3, Provider participation and requirements.

4 Record keeping

Refer to Section I: General Information, Chapter 4, Record keeping.

5 Provider sanctions

Refer to Section I: General Information, Chapter 5, Provider sanctions.

6 Member eligibility

Refer to Section I: General Information, Chapter 6, Member eligibility, to verify a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Eligible Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member responsibilities

For information on member responsibilities, including establishing eligibility and co-payment requirements, refer to Section I: General Information, Chapter 7, Member responsibilities.

8 Programs and coverage

For information on policy regarding dental, oral and maxillofacial surgeons and orthodontia coverage, see Utah Administrative Code R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia. For general information on Medicaid programs, refer to Section I: General Information, Chapter 8, Programs and coverage, and Utah Medicaid Provider Manuals Parent Directory. Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

For Medicaid members that are enrolled as Targeted Adult Medicaid (TAM) members undergoing substance use disorder (SUD) treatment, aged, or blind and disabled, dental services must be provided through the University of Utah School of Dentistry (UUSOD) or their associated state-wide provider network. Providers must be paneled

with the UUSOD for dental services to be covered for the TAM SUD, aged, or blind and disabled populations.

For provider network access questions, see Dental Coverage and Plans on the Medicaid website, or contact the UUSOD at (801) 587-7174.

8-1 Definitions

Definitions of terms used in multiple Medicaid programs are in Section I: General Information, Chapter 1-9, Definitions and Utah Administrative Code R414-1. Utah Medicaid Program. Definitions particular to Dental Services are found in Utah Administrative Code R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia Definitions.

8-2 Endodontics

8-2.1 Completed root canal

A root canal is to be reported after the canals has been completely obturated with the final filling. Reporting for services that have not been completed is considered fraud.

8-2.2 Billing the member for incomplete root canal

A dental provider cannot submit a claim to Medicaid for a completed therapeutic pulpotomy when a Medicaid member has the first stage endodontic procedure performed and fails to return for subsequent appointments.

If a written agreement was obtained from the member in advance of treatment, the provider may bill the member for the non-covered pulpal debridement to relieve acute pain before conventional root canal therapy.

The agreement must fulfill all four conditions described in the provider manual, Section I: General Information, Chapter 3-5, Exceptions to prohibition on billing members, non-covered services, and also the following:

1. The non-covered service, pulpal debridement may only be reported if the member fails to complete endodontic treatment and the required agreement is in place.
2. The provider must refund the fee to the member if the root canal is completed and reported to Medicaid.
3. A dental provider who fails to comply precisely with the Medicaid process for billing a member is disqualified from billing the patient.

8-3 Prosthodontics

8-3.1 Dentures

Denture services require written prior authorization.

Upper dentures and lower dentures are limited to once every five years. For example, a member that receives an immediate upper denture within the last five years would not be eligible for complete or partial upper dentures within the same five-year period, the same being applicable to lower dentures.

Complete maxillary and mandibular dentures may be allowed for the replacement of permanent teeth under the following conditions when the patient is either:

1. edentulous
2. has a dental or medical condition that indicates extraction of remaining teeth, or
3. documentation of prior appliance

Partial dentures may be allowed when the following criteria are met;

1. Prior authorization was obtained before fabricating the partial denture.
2. There must be an anterior tooth missing, or the partial denture must restore mastication ability.
3. If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if they have two maxillary and two mandibular posterior teeth on the same side in occlusion.
4. There must be at least one posterior tooth or canine present with adequate bone support on each side of the arch.

5. Medicaid will cover a partial denture if a complete denture opposes it and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch.
6. The provider must send the following:
    a) Mounted periapical x-rays or Panorex
    b) Documentation of the teeth to be replaced

Dental prophylaxis is available for adults and children with dentures through CDT codes D1110 and D1120, respectively. Any enrolled Medicaid dental provider may provide services. All other denture services require written prior authorization.

Additional information on coverage requirements and limitations of denture services is found in the Coverage and Reimbursement Lookup Tool at: http://health.utah.gov/stplan/lookup/CoverageLookup.php.

8-3.2 Loss of eligibility

A member may lose their Medicaid eligibility before the completion of prosthodontic services. In such instances, Medicaid permits reporting the date of service based on:

1. The date of impression related to the prosthodontic service, or
2. The date the member had their teeth extracted to receive prosthodontic services and has not yet received impressions.

When reporting prosthodontic services rendered under one of these circumstances, providers must:

1. Report the claim with CDT code D5899 in conjunction with the designated prior-authorized prosthodontic code.
2. Submit substantiating documentation, including an attestation of having completed prosthodontic services before reporting the claim.

This process does not permit any exceptions to PA requirements. Prosthodontic PAs are for one year from the date of issuance. If the services

have not been completed within the PA time frame and a member has lost eligibility, the related claim will be denied.

8-4 Emergency services

Emergency dental care services are reported globally and include necessary laboratory and preoperative work, placement of sutures, packing, removal of sutures, and office calls.

8-5 Sedation and general anesthesia

Medicaid requires providers to abide by the current American Dental Association (ADA) "Guidelines for the Use of Sedation and General Anesthesia by Dentists" when performing sedation permitted within their scope of training/licensing. When sedation is provided by another licensed dentist, anesthesiologist, or certified registered nurse anesthetist, the same requirements apply.

If a member is EPSDT eligible, the provider must also abide by the current American Academy of Pediatric Dentistry (AAPD) clinical guidelines, "Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures."

The member's medical record must reflect adherence to ADA or AAPD guidelines. Documentation must show that there was no other equally effective, more conservative, and less costly level of sedation suitable for the member. Medicaid covers only those services that are medically necessary under Utah Administrative Code R414-1-2(18), which states:

"Medically necessary service" means that:

1. it is reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap; and

2. there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

These guidelines apply to all members, including those with special needs.

Ambulatory surgical centers (ASC) billing for dental services shall use code 41899. Refer to the Coverage and Reimbursement Lookup tool at: http://health.utah.gov/stplan/lookup/CoverageLookup.php.

For information related to billing for services related to sedation, see Chapter 11 Billing Medicaid.

8-5.1 Oral and intramuscular sedation

Medicaid covers intramuscular and intraoral injections for sedation only. Behavior management is not covered. Orally administered medications for sedation are covered under the Medicaid pharmacy program by prescription only.

8-6 Orthodontia

Orthodontia services are available to eligible Medicaid members who have a handicapping malocclusion due to congenital disabilities, accidents, disease, or abnormal growth patterns, of such severity that they cannot masticate, digest, or benefit from their diet. Orthodontic treatment is limited to one per lifetime.

Prior authorization is required for orthodontia. Send pre-treatment models and photographs, panoramic x-rays, and requested codes on a completed prior authorization form.

Medicaid uses the J.A. Salzmann Handicapping Malocclusion Assessment Record to determine the severity of the malocclusion. Per policy, a tooth must be rotated 30 degrees or more to be included in the assessment. The completed assessment record is used to calculate an index number ("Salzmann Scoring Index"). Members must have a Salzmann Scoring Index of 30 or more to qualify for orthodontia.

Comprehensive orthodontic treatment is a global service that includes banding and adjustments. It is reported at the time of banding. Orthodontic retention is reported upon completion of treatment.

Orthodontia services for Indian Health Services (IHS) are limited to 36 visits for comprehensive treatment and two visits for orthodontic retention. Claims are adjudicated and reimbursed at the all-inclusive rate (AIR).

8-6.1 Non-covered orthodontic services

The following services are non-covered:

1. Limited orthodontic and removable appliance therapies
2. Re-banding or multistage orthodontic treatment
3. Removable appliances in conjunction with the fixed banded treatment
4. Habit control appliances
5. Orthodontic services for cosmetic or esthetic reasons
6. Dental surgical procedures that are cosmetic even when performed in conjunction with orthodontia
7. Treatment of any temporomandibular joint condition or dysfunction
8. Conditions in which radiographic evidence of bone loss has been documented

Medicaid requires that a licensed orthodontic specialist and a licensed maxillofacial oral specialist be used to treat combined orthodontic/surgical cases. Reimbursement will not be made to general dentists that perform orthodontic or surgical treatment for combined orthodontic/surgical cases.

8-7 Craniofacial anomalies

The following codes may be allowed with prior authorization approval for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) members with craniofacial anomalies, cleft lip or palate:

1. D5936- obturator prosthesis, interim
2. D5952- speech aid prosthesis, pediatric
3. D5988- surgical splint
4. D8210- removable appliance therapy

5. D5999- unspecified maxillofacial prosthesis, by report designated for nasal stent/nasal stent activator
6. D8999- unspecified orthodontic procedure, by report designated for rapid palate expander

These services are carved out of the Managed Care Entities and billed directly to Medicaid as fee for service. Criteria include substantiating the medical necessity of services by describing the medical condition, dentist's treatment plan, and schedule, and radiographs fully depicting existing teeth and associated structures.

8-8 Silver diamine fluoride

Silver diamine fluoride (SDF) is a liquid substance used to help prevent tooth cavities (or caries) from forming, growing, or spreading to other teeth. Medicaid covers SDF for treatment of primary dentition for EPSDT-eligible and pregnant members when:

1. Used for treatment of dental caries
2. May be applied once per tooth every 6 months

Medicaid does not cover SDF for caries prevention or dental hypersensitivity.

Additional coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

8-9 Dental hygienists

Dental hygienists enrolled as Medicaid providers may directly report claims for certain dental services provided independently in a public health setting. Public health setting is defined in the Dentist and Dental Hygienist Practice Act as:

1. an individual's residence, if the individual is unable to leave the residence;
2. a school, as part of a school-based program;
3. a nursing home;
4. an assisted living or long-term care facility;
5. a community health center;
6. a federally qualified health center; or

7. a mobile dental health program that employs a dentist

For a hygienist to be directly reimbursed, the hygienist must work under a written agreement or under the general supervision of a dentist. Hygienists may also perform services independently, without a written agreement or general supervision of a dentist, under the criteria defined in Utah Administrative code 58-69-801(5).

All dental services provided must fall within the scope of practice for a dental hygienist as defined in the Dentist and Dental Hygienist Practice Act. The dental hygienist must also have a federally assigned National Provider Identifier (NPI) number.

Dental services that may be reported and billed directly by a hygienist are limited. Refer to the Coverage and Reimbursement Lookup Tool for additional information concerning CDT code coverage for dental hygienists. All other dental services provided in a public health setting may only be reported by an authorized dental provider.

9 Non-covered services and limitations

Certain services are non-covered by Medicaid because medical necessity, appropriateness, and cost-effectiveness cannot be readily determined or justified for medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

For more information on non-covered services and limitations, see Utah Administrative Code R414-1. Utah Medicaid Program; Utah Administrative Code R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia; and Section I: General Information, Chapter 9, Non-covered services and limitations.

10 Prior authorization

Prior authorization is obtained by submitting a request for the specific codes of services requested and attaching clinical documentation to support the need or justification for the services requested. When a service requires prior authorization, it is the responsibility of all associated providers to verify whether or not prior

authorization has been obtained. Dental and anesthesia providers may require prior authorization as well as the facility where the procedure is to be performed.

If a dental code requires prior authorization, the procedure must be authorized by Medicaid before the service being provided. However, there are limited circumstances in which a provider may request authorization after service is rendered. These limitations are described in Section I: General Information, Chapter 10-3 Retroactive authorization.

Refer to Section I: General Information, record keeping and prior authorization chapters for further information.

11 Billing Medicaid

Dental services may be reported using the ADA J430 Dental claim form (same as ADA Dental Claim Form- J431, J432, J433, J434). Medicaid can only accept up to 18 procedure code lines per claim form.

Medicaid accepts dental claims electronically in the ANSI X12N 837d format, version 5010. For additional information concerning electronic reporting, see Section I: General Information, Electronic data interchange.

11-1 Reporting supernumerary teeth

Medicaid supports the nomenclature approved by the ADA for identifying supernumerary teeth.

Please report using the following tooth identifiers for supernumerary teeth:

Upper Right Deciduous Teeth Upper Left

Tooth #	A	B	C	D	E	F	G	H	I	J
Supernumerary #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Lower Right	Deciduous Teeth					Lower Left				
Tooth #	T	S	R	O	P	Q	N	M	L	K
Supernumerary #	TS	SS	RS	OS	PS	QS	NS	MS	LS	KS

Upper Right			Permanent Teeth			Upper Left										
Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
“Super “ #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Lower Right			Permanent Teeth			Lower Left										
Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
“Super “ #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

11-2 Dental spend-ups

There are limited dental services where a Medicaid member may choose to upgrade a covered dental service to a non-covered service, which is considered a dental spend-up. However, the member must be willing to assume responsibility for the difference in the covered and non-covered services fees. Refer to R414-49 for the limited services that may be used as a dental spend-up. In addition, when authorized through EPSDT, utilization review, or hearing processes, other covered services may be used as a spend-up.

When a member requests a service not covered by Medicaid, the provider may bill the Medicaid member when all four conditions of Section I: General Information, Exceptions to prohibition on billing members, non-covered services, are met.

The provider cannot mandate or insist the covered procedure be upgraded. The member makes the choice. Further, the provider as a guarantee of payment by the member may not hold the member's Medicaid member card, nor may any other restrictions be placed upon the member.

The amount paid by the member is the difference between the provider's usual and customary charge for the non-covered service and the provider's usual and customary charge for the covered service.

The member is not responsible for paying the difference between the Medicaid payment for the covered service and the usual and customary fee for the requested upgraded service.

When providing an upgraded service, providers report the covered code and charges on the first line. Then, in the description box, indicate it was an upgraded service and reference the upgraded code; this shows that the member has signed a memo of understanding of the payment responsibility for the service. The memorandum of understanding must be kept in the provider's medical record for the client.

11-3 Anesthesiologists and certified nurse anesthetists

Anesthesia providers, CRNA or anesthesiologists, billing for dental services shall use code 00170 with the appropriate "P" modifier (physical status) and the actual anesthesia time in minutes. For electronic submissions, report anesthesia minutes using the MJ qualifier. For paper claims, report anesthesia minutes in Box 24G of the CMS-1500 (08/05) claim form by putting an "M" before the number of minutes.

11-4 Timely filing

A claim must be submitted to Medicaid within 365 days from the date of service. For more information on timely filing, refer to Section I: General Information, Chapter 11-6.5, Time limit to submit Medicaid claims.

12 Coding

Medicaid recognizes guidelines in current editions of established coding manuals or other standard literature. However, those guidelines are adopted only as they are consistent with the application to Utah Medicaid policy. The established dental

coding guidance material consists of the Code on Dental Procedures and Nomenclature (CDT Code) published by the American Dental Association.

For coverage and reimbursement information for specific procedure codes, see the Coverage and Reimbursement Code Lookup. Generally, the fees represented on the Coverage and Reimbursement Code Lookup are only for fee for service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.).

13 Miscellaneous information

13-1 Targeted adult Medicaid members with substance use disorders

Dental services are available to eligible TAM members actively receiving treatment in a SUD program as defined in Utah State Code Section 62A-2-101, licensed under Title 62A, Chapter 2, Licensure of programs and facilities.

Before performing dental services for TAM receiving treatment actively in a SUD program, the UUSOD will verify that the member is receiving active treatment for the SUD. The UUSOD will submit a SUD treatment verification form to Medicaid for each eligible TAM member.

For additional information regarding the TAM program, refer to Utah Administrative Code R414-31. Targeted Adult Medicaid.

13-2 Dental incentive programs

13-2.1 Dental providers in urban counties

As an incentive to improve member access to dental services in urban counties (Weber, Davis, Salt Lake, and Utah counties), dental providers willing to see 100 or more distinct members during the next year will be reimbursed at billed charges, or 120 percent of the established fee schedule, whichever is less. An agreement for the enhanced payments must be signed and received by Medicaid before the increase is effective.

13-2.2 Dental providers in rural counties

Dentists outside of the Wasatch front (including all counties except Salt Lake, Weber, Davis, and Utah counties) automatically receive a 20% increase in reimbursement. This increase encourages dentists in rural areas to treat eligible Medicaid members and improve access for members residing outside the Wasatch front areas.

13-2.3 Additional information

The increases outlined in chapters 13-2.1 and 13-2.2 are mutually exclusive.

A dentist in one of the four Wasatch Front counties can get a 20% increase meeting the requirements of paragraph A. Dentists in other counties will receive a 20% increase regardless of the number of Medicaid patients served.

Bill your usual and customary fee for a dental service provided to a Medicaid client.

If you have signed the Medicaid dental agreement, you will receive either 120% of the amount listed on the reimbursement schedule or the amount you billed for the service provided, whichever amount is less.

If you wish to sign up for the 20% incentive, you may fax a completed copy of the agreement to Medicaid at 1-801-536-0471.

14 Resource table

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

For information regarding:	
Administrative Rules	• Utah Administrative Code Table of Contents • Dental, Oral and Maxillofacial Surgeons and Orthodontia. R414-49. • Medicaid Policy for Experimental,

	Investigational or Unproven Medical Practices. R414-1A. • Physician Services. R414-10
General information including: • Billing • Fee for service and managed care • Member eligibility • Prior authorization • Provider participation	• Section I: General Information • Claims • Managed Care: Accountable Care Organizations • Utah Medicaid Prior Authorization Administrative Rules • Eligibility Requirements. R414-302. • Medicaid General Provisions. R414-301. • Program Benefits and Date of Eligibility. R414306. • Utah Medicaid Program. R414-1.
Information including: • Anesthesia fee resources • Coverage and reimbursement resources • National correct coding initiative • Procedure codes with accompanying criteria and limitations	• Office of Coverage and Reimbursement Policy • Coverage and Reimbursement Code Lookup • The National Correct Coding Initiative in Medicaid
Information including policy and rule updates: • Medicaid Information Bulletins (Issued bimonthly) • Medicaid Provider Manuals	• Utah Medicaid Official Publications • Utah State Bulletin

• Utah State Bulletin (Issued on the 1st and 15th of each month)	
Laboratory services	• Social Security Act §1833 - Payment of Benefits • PART 493—LABORATORY REQUIREMENTS • Clinical Labs Center • Clinical Laboratory Improvement Amendments (CLIA) and Medicare Laboratory Services • CMS Clinical Laboratory Improvement Amendments (CLIA) • State Operations Manual • How to Obtain a CLIA Certificate
	• State Laboratories
Medicaid forms including: • Hearing Request • Hospice Prior Authorization Form • PA Request	• Utah Medicaid Forms
Modifiers	• Section I: General Information
Patient (Member) Eligibility Lookup Tool	• Eligibility Lookup Tool
Pharmacy	• Drug Criteria Limits • Medicaid Pharmacy Program • OTC Drug List • Pharmacy Provider Manual • Medicaid Policy for Pharmacy Program. R414-60.

Prior authorization	• Prior Authorization Form • Utah Medicaid Prior Authorization
Provider portal access	• Provider Portal Access
Provider training	• Utah Medicaid Provider Training
Other	• Medicaid.gov • RHC-FQHC Provider Manual • Women, Infants and Children (WIC)
References including: • Social Security Act • Code of Federal Regulations • Utah Code	• 42 CFR 440.50 • Social Security Act 1905(a) • Social Security Act 1861 (r) • Utah Annotated Code Title 58
Tobacco cessation resources	• Utah Tobacco Quit Line (1-800-QUIT-NOW) • Way to Quit

Utah Medicaid Provider Manual

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

Division of Integrated Healthcare

Updated November 2024

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1 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit policies

1-1 General overview

The mission of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is to ensure that individuals under the age of 21, who are enrolled in Medicaid, receive age-appropriate screening, preventive, and treatment services that are medically necessary to correct or ameliorate identified conditions. In other words, the goal is to provide the right care to the right child at the right time in the right setting. The broad scope of the EPSDT program supports a comprehensive approach to high-quality healthcare and patient outcomes.

It is important to note that the services outlined throughout this manual are of no cost to the EPSDT eligible member, with some exceptions made for EPSDT members ages 18-20. For additional information concerning co-pay requirements for EPSDT members aged 18 years or older refer to Utah Administrative Rule R414-1 and Attachment 4.18A.

Before billing an EPSDT member for any costs, all required criteria must be met.

1-1.1 Early and periodic

The EPSDT benefit helps eligible members receive quality health care as early as possible to correct or enhance health outcomes through early detection.

Early prevention further supports the overarching goal of the EPSDT program by helping ensure the identification, diagnosis, and treatment of conditions before they become more complex and costly to treat. This is accomplished through the emphasis of preventive and comprehensive care. It is important that EPSDT members receive all recommended preventive services and any medical treatment needed to promote healthy growth and development.

Assessment of children's health at age-appropriate intervals is an essential component of the EPSDT benefit. Infants, children, and adolescents should visit a healthcare provider regularly. To help encourage frequent and effective healthcare interventions, there are multiple state and federal programs that coordinate outreach on behalf of EPSDT members. These include:

1. Baby Watch Early Intervention Program
2. Birth to 5: Watch Me Thrive!

3. Case managers
4. Children with Special Health Care Needs
5. Local health departments
6. Managed healthcare outreach programs
7. School-based services
8. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

In alignment with the standards defined by the American Academy of Pediatrics (AAP), Utah Medicaid has adopted the Recommendations for Preventive Pediatric Health Care guidelines that outline when screenings should occur.

Bright Futures, as developed by the AAP, is a tool providers should use when planning appropriate care and screenings for EPSDT members. The Bright Futures initiative helps healthcare providers and families understand the types of care that infants, children, and adolescents should receive and when they should receive it, which, in turn, leads to prevention-based, family focused, and developmentally oriented care.

In further support of this initiative, the American Academy of Pediatric Dentistry (AAPD) has published the Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents for dental related care.

It is important to note that EPSDT members may receive additional check-ups and screenings, beyond the periodicity schedules, when a condition or problem is suspected.

The families of EPSDT members are encouraged to seek early and repeated well-child health care visits for their children. These visits should start as early as possible, ideally at birth, and continue throughout childhood and adolescence. These preventive services should be pursued as early as possible, even in cases where an EPSDT member may be older than the recommended age.

1-1.2 Screening

Health screenings provide physical, mental, developmental, dental, hearing, vision, and other tests to detect potential problems or conditions in pediatric patients. EPSDT members should receive regular well-child check-ups of their physical and mental health, growth, development, and nutritional status. A well-child check-up should include:

1. A comprehensive health and developmental history,
2. Physical health assessments,
3. Behavior health assessments,
4. Age-appropriate immunizations,
5. Vision and hearing tests,
6. Dental exams,
7. Laboratory tests, including blood lead level assessments at certain ages, and
8. Health education, including anticipatory guidance.

Screenings are also often completed within public schools and other community locations. PCPs should encourage parents/responsible caregivers to share results from school and community screenings during appointments, which may include a formal referral for additional testing.

1-1.3 Diagnostic

Screenings may lead to the performing of diagnostic tests to follow up when a health risk is identified. When a well-child check-up or other visit to a health care professional shows that a child or adolescent may potentially have a health problem, follow-up diagnostic testing and evaluations must be provided. This includes testing related to the diagnosis of physical health, mental health, substance use, vision, hearing, and dental problems.

Providers are responsible for assisting EPSDT member(s) with appropriate referrals to a specialty provider when additional diagnostic services are required because of screening/assessment findings.

1-1.4 Treatment

Under the EPSDT benefit, medically necessary healthcare services are covered for treatment of physical and mental illnesses or other conditions discovered through clinical decision making and diagnostic procedures. Treatment should be based on the need to correct or ameliorate the member’s physical or mental condition. EPSDT members are eligible for medically necessary treatment even when the screening occurs outside of the provider’s office, e.g. at school or in other setting.

Primary care providers (PCP) of EPSDT members should oversee any coordination of care needs required by their patient. Care coordination in the PCP setting involves organizing patient care activities and sharing information with relevant participants concerned with a patient's healthcare to achieve safer and more effective outcomes.

Care coordination promotes the delivery of high-quality and high-value healthcare, while meeting the medical needs of EPSDT members. Care coordination may include the initiation of care management, medication management and reconciliation between multiple providers, sharing of diagnostic results and assessments, and the compiling of medical records into a single repository.

1-2 Exceptions for non-covered services

When an EPSDT member requires medically necessary services, those services may be covered by Medicaid, even if the requested service is not typically covered under the Medicaid benefit.

Necessary health care, diagnostic services, treatment, or other measures to correct or ameliorate defects, physical or mental illness or conditions are available based on medical necessity. Prior authorization is required before providing these services. Exceptions are considered through the prior authorization and/or utilization review process, which is accessed through either submitting a request for prior authorization or submitting a hearing request in response to an adverse benefit determination.

Refer to Chapter 2, Prior Authorization, for additional information concerning documentation and submission requirements for the exception process.

1-3 Outreach, prevention, and appointment assistance

Medicaid contracts with local health departments (LHD) to aid EPSDT members and their family/responsible care givers with scheduling appointments, follow-up care, and education.

Refer to Chapter 1-4.5, Local Health Departments and Targeted Case Management for Early Childhood, for additional information.

In addition, providers are encouraged to provide or arrange for all the appropriate EPSDT services for each child. These services should occur at each age level in a timely manner,

and proper documentation and reporting of the services must be included in the patient record.

1-4 Additional state/federal programs

This chapter includes information concerning several state and federal programs available to EPSDT members. Providers are encouraged to refer EPSDT members to these programs, where applicable.

1-4.1 Baby Watch Early Intervention Program

The Baby Watch Early Intervention Program (BWEIP) focuses on enhancing early growth and development in infants and toddlers. This program includes children birth through age 3, who have not yet entered the public school system, and who have developmental delays or disabilities. BWEIP provides individualized support through the rendering of certain Medicaid covered services and training to children and their families. For additional information concerning BWIEP refer to the Individuals with Disabilities Education Act Part C (IDEA).

As children enter into the public school system they transition from the BWEIP to the School-Based Skills Development Program. The services delivered by each are adapted to meet the needs of the EPSDT member. For more information about the services and procedures associated with this program, refer to the Baby Watch Early Intervention Program.

1-4.2 Birth to 5: Watch Me Thrive

Birth to 5: Watch Me Thrive! encourages healthy child development, universal developmental and behavioral screenings for young children, and support for the families and providers who care for them. For more information concerning this program see the following websites:

1. Office Of Early Childhood Development
2. A Compendium of Screening Measures for Young Children

1-4.3 Children with Special Health Care Needs

The Children with Special Health Care Needs (CSHCN) program works to improve the health and quality of life for children with special health care needs. This is achieved through early screening, early detection, data integration, care coordination,

education, intervention, and family training. This is accomplished through the Title V Maternal and Child Health Block Grant.

CSHCN activities focus on reduction of preventable death, disability, and illness in children due to chronic and disabling conditions by promoting family-centered coordinated care.

To learn more, see Children with Special Health Care Needs and the programs it supports.

Provider and families may also refer to Health Resources & Services Administration - Children and Youth with Special Health Care Needs (CYSHCN) and the Centers for Disease Control and Prevention – Children and Youth with Special Healthcare Needs in Emergencies for additional information.

1-4.4 Foster care

For information concerning individuals in foster care please refer to the following resources:

1. Section I: General Information, Chapter 8-2.10 Custody medical care program (Children in foster care).
2. Foster Care Medicaid
3. Independent Living and Transitioning From Foster Care
4. Young Adults Formerly in Foster Care: Challenges and Solutions
5. Custody Medical Program

1-4.5 Local Health Departments (LHD) and targeted case management for early childhood

The Division of Integrated Healthcare (DIH) contracts with Local Health Departments (LHD) to provide outreach services to families.

Services provided through the LHDs include:

1. Information for EPSDT eligible individuals, including adults who are pregnant, concerning EPSDT services available to the member, such as age-appropriate screenings, well child visits, and immunizations.
2. Setting appointments or arranging screening services

3. Arranging (through referral) for corrective treatment for medical and mental health conditions discovered through EPSDT screenings.
4. Missed appointment follow-up contact.

Children born to women enrolled in Medicaid become eligible for a Targeted Case Management Service focused on childhood development. Parents/responsible guardians may contact an LHD in their area to see if an EPSDT member should receive or would benefit from Targeted Case Management Services.

Refer to the Targeted Case Management for Early Childhood provider manual for additional information.

1-4.6 Managed healthcare outreach programs

Medicaid contracts with managed care plans, referred to as Managed Care Entities (MCEs), to coordinate care for EPSDT members. Screenings, care management, special healthcare needs and disease management, assistance in finding and scheduling care with a primary care or specialty provider, and pre/post-natal care are some of the many services coordinated by the MCEs.

Refer to the Managed Care page located on the Medicaid website for additional information on how to contact a managed care plan.

1-4.7 School-based services

The School-Based Skills Development Program allows public schools and charter schools to provide special education services to some EPSDT members starting upon entry into the school system. These services are delivered within the school setting and are tailored to each EPSDT member as stated in their Individualized Education Plan (IEP). Medicaid reimburses the school for certain covered services included in a student's IEP. For additional information please refer to the Individuals with Disabilities Education Act Part B (IDEA).

To learn more about the services and procedures associated with this program, refer to the School-Based Skills Development Manual.

1-4.8 Special supplemental nutrition program for Women, Infants, and Children (WIC)

The Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutrition and breastfeeding services and supplemental foods to pregnant

women, mothers, infants, and children up to their 5th birthday. WIC offers families personalized one-on-one nutrition consultation, a wide array of nutrition education, individualized breastfeeding support, and referrals to other public health programs. Pregnant and postpartum women, infants, and children under 5 years of age who are current Medicaid members are eligible to participate in the WIC program.

Providers and members are encouraged to visit Utah Women, Infants, and Children (WIC) for additional information.

1-5 General coverage

Throughout this chapter the different services available for EPSDT members will be outlined, including the extent of eligibility requirements, coverage, limitations, restrictions, and authorization criteria required where applicable. Each chapter may also include information related to relevant screening services, diagnostics, and treatments for conditions related to the specific service.

Medicaid coverage includes the following types of services:

1. Audiology
2. Behavioral
    a) Autism Spectrum Disorder (ASD)
    b) Developmental delays
    c) Mental Health
    d) Substance use disorders (SUD)
    e) Tobacco cessation
3. Dental
4. Fertility preservation
5. Genetic testing
6. Home based services
    a) Home Health
    b) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
    c) Personal Care
    d) Private Duty Nursing (PDN)
    e) Hospice

   f) Physical Therapy (PT)/Occupational Therapy (OT)/Speech-language Pathology (SLP)
7. Inpatient services
8. Integrated healthcare
9. Interpretive services
10. Laboratory and radiology services
11. Nursing and long-term care services
12. Medications and pharmacy
13. Primary care services
   a) Family planning
   b) Preventive services
   c) PCP services
   d) Vaccines/immunizations – Vaccines for children (VFC)
   e) Well-child check-ups
14. Transportation
15. Vision

1-6 Audiology – hearing services

Audiology services are a covered benefit for EPSDT members when determined to be medically necessary.

Medicaid covers diagnostic examinations, assessments for a hearing aid(s) and, when appropriate, a hearing aid or assistive listening device. Medicaid also covers repairs of hearing aids.

Diagnostic audiology evaluations require an order from a QHP that include the procedures that may be used for a hearing aid assessment and any other diagnostic tests appropriate for the specific diagnosis.

For members enrolled in a managed care entity (MCE), providers may need to obtain a prior authorization (PA) or referral from the MCE before visiting an audiologist or other QHP for evaluation and/or treatment. FFS Medicaid members may also require a PA for certain services. To determine which service requires a PA, refer to the Coverage and Reimbursement Lookup.

State funding, other than Medicaid, may also support audiology services through Early Intervention for ages 0 to 3 years.

The following audiological services are covered for EPSDT members who are at risk for hearing impairment:

1. Preventive care
2. Screening
3. Evaluation
4. Diagnostic testing
5. Hearing aid evaluation
    a) Ear mold services, fitting, orientation, and follow-up
6. Audiologic habilitation includes but not limited to:
    a) Speech
    b) Hearing
    c) Gestural communication

1-6.1 Hearing observation and screening

The first two years of life are a critical period for language acquisition. The AAP recommends observation and screening services designed to detect hearing loss in infants before 3 months of age, with appropriate intervention no later than 6 months of age. Screening tests vary according to age and should be part of EPSDT screening services. Refer to the Bright Futures/AAP periodicity schedule for recommended screening ages and related guidance.

In addition, the Joint Committee on Infant Hearing's Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs contains recommendations to help identify children who need early and more frequent assessments.

For additional information concerning reimbursement policy for audiology services refer to the Utah State Plan, Attachment 4.19-B.

1-6.1.1 Newborn hearing screening

Every infant should be provided with a physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments. Newborns that do not pass the newborn hearing screen should be referred to an audiologist, or other QHP, for additional evaluation to determine the extent of hearing loss, as well as possible causes.

For more information on newborn hearing screening refer to Utah Administrative Code R398-2. Newborn Hearing Screening and the Utah Department of Health and

Human Services Early Hearing Detection and Intervention Program. For specific code coverage refer to the Coverage and Reimbursement Code Lookup.

1-6.1.2 Hearing screening of older children

Hearing screenings for EPSDT members should be performed according to the Bright Futures/AAP periodicity schedule.

Hearing screenings completed within public schools are not covered by Medicaid. These screening efforts should not be duplicated unless the child is at risk and the situation warrants additional screening. Screening results from the school should be documented in the member's medical records. Parents/caregivers should be encouraged to share results from school screenings during appointments, which may include a formal referral for additional testing.

1-6.2 Hearing referral standards

When a chronic hearing deficit is suspected or has been confirmed by the EPSDT member's PCP or other QHP, a referral to a specialist, such as an audiologist or otolaryngologist, should be arranged at an appropriate time.

1-6.3 Hearing aids/assistive listening devices

Hearing aids require PA. If a hearing aid assessment is recommended, an order from a QHP is required. If the subsequent hearing test shows a change in hearing thresholds or the need for a new hearing aid, a PA must be obtained before proceeding with the hearing aid refitting. The hearing aid may be provided by an audiologist, other QHP, or by a durable medical equipment (DME) provider enrolled with Medicaid.

1. Hearing aids must be guaranteed by the manufacturer for a period of at least one year.
2. The initial ear mold, fitting of the hearing aid on the EPSDT member, and necessary follow-up procedures (i.e. conformity evaluation, counseling, adjustments, testing batteries, etc.) are part of the global rate and will not be reimbursed separately.
    a) The global rate covers a period of 12 months.
3. If a follow-up examination results in a recommendation for a different model of hearing aid, the original aid must be exchanged for another aid within 60 days of the follow up examination.

4. The provider who supplies the hearing aid must accept the return of a new hearing aid within 60 days if the prescribing QHP determines that the hearing aid does not meet the medical need and requires exchange.
5. Audiology related service costs for EPSDT members who reside in an ICF/ID facility are included in the per diem rate paid to the facility. It is the responsibility of the ICF/ID facility, as defined in the Utah State Plan, Attachment 4.19-D Nursing Home Reimbursement, to provide reimbursement to the provider for these services.
    a) Exception: The hearing aid appliance is considered ancillary to the per diem rate and may be reported to Medicaid via fee for service (FFS) separately
6. Hearing aids may be replaced every three years when medically appropriate.
    a) When requesting a replacement hearing aid, a new medical examination, QHP order, and audiology evaluation is required.
    b) Exceptions to the 3-year usage limit can be made by following the process outlined in Chapter 1-2 for Non-covered services.

Hearing aid repair

Hearing aids are reimbursed as a purchase only, except in cases where a temporary hearing aid is needed during repairs. When a repair is medically indicated, Medicaid reimburses for a hearing aid rental as part of the total reimbursement for the repair.

If the repair requires the hearing aid to be returned to the original manufacturer, the provider will be reimbursed the cost indicated on the manufacturer's original invoice plus an additional $15. If the repair is completed by the provider directly, the provider may report the dispensing fee related to cost for time, acquisition cost for parts, plus an additional $15.

Dispensing fees

With PA, a dispensing fee may be reimbursed once per hearing aid for the operational lifetime of that hearing aid. This dispensing fee may only be requested outside of the services included as part of the 12-month global reimbursement period upon the provision of the initial hearing aid.

Dispensing fees include:

1. Adjusting the hearing aid to the recipient, including necessary programming on digital and digitally programmable hearing aids
2. Instructing and counseling the recipient on use and care of the hearing aid
3. Fitting and modifications of the hearing aid
4. Freight, postage, delivery of the hearing aid
5. Maintenance, cleaning, and servicing outside the first year of ownership.

Prior authorization requirements

Prior authorization requirements for hearing aids and assistive listening devices are as follows:

1. A physician or other QHP order, stating the EPSDT member has a medical indication for a hearing aid or assistive listening device.
2. The results of a comprehensive audiometric exam performed by the audiologist or other QHP to identify the type of hearing loss (i.e., conductive loss, sensorineural loss, or mixed loss)
3. Speech testing that includes:
    a) speech reception thresholds
    b) speech discrimination scores
    c) pure tone average
4. Audiogram documentation that includes details from the hearing evaluation test, including decibel loss for both right and left ears at hearing thresholds 250, 500, 1000, 2000, 4000 and 8000 Hz
    a) Monaural hearing aids may be requested if the hearing test indicates an average hearing loss in one ear of 30 dB or greater, based on a high frequency PTA specially calculated for frequencies 1000, 2000, and 4000 hertz.
    b) Binaural hearing aids may be requested for members who:
        i. Exhibit an average hearing loss of 25 dBs, based on a high frequency PTA specially calculated for frequencies 1000, 2000, and 4000 in both ears; OR
        ii. The recipient is blind, and a monaural hearing aid may be contraindicated.
5. The type of hearing aid(s) requested; monaural or binaural, and the respective medical code(s).

1-7 Developmental, social, behavioral, and mental health

Medicaid covers the detection, surveillance, screening, and assessment of infants and children for diagnosis and monitoring of developmental and behavioral health disorders. Utah Medicaid covers standardized and evidence-based developmental surveillance tools. Providers are encouraged to utilize age-appropriate diagnostic criteria for young children, such as the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5).

PCPs can provide an array of behavioral health support including screenings and treatment for depression, anxiety, PTSD (Post-Traumatic Stress Disorder), substance use disorders, peripartum mood disorders, eating disorders, and intimate partner violence. PCPs should coordinate care with qualified mental health professionals such as therapists and psychiatrists, for members with complex mental health needs that may require a multidisciplinary team approach.

Suicidal patients are more likely to see a primary care physician than a psychiatrist in the months preceding their death. Primary care physicians are therefore in a unique position to identify at-risk individuals and possibly intervene.

PCPs should determine whether the members depression and/or suicidal ideation should be managed solely by the PCP or be referred for tertiary psychiatric care (and the urgency of the latter). All persons with clear-cut active suicidal ideation should be sent to an appropriate hospital for urgent psychiatric care.

1-7.1 Developmental checks

Developmental checks are important for the early detection and diagnosis of developmental delay in all children. Developmental surveillance should occur during every health visit to identify the risk of developmental delay, paying particular attention to children four to five years of age who are preparing to enter elementary school. Parents or responsible caregivers should be interviewed, and any concerns or issues should be further investigated as medically indicated.

The American Academy of Pediatrics (AAP) recommends developmental surveillance focused on the following six components:

1. Eliciting parent and caregiver concerns
2. Obtaining a developmental history

3. Observing the child
4. Identifying risks, strengths, and protective factors
5. Maintaining a record
6. Sharing opinions and findings

1-7.1.1 Children younger than five years old

Providers should perform developmental screenings at 9-, 18-, and 30-month visits. Medicaid utilizes guidance from the Bright Futures initiative to set a periodicity schedule for developmental screenings of EPSDT members.

1-7.2 Autism spectrum disorder screenings

Medicaid covers autism spectrum disorder (ASD) screenings at 18- and 24-months when medically indicated. Screenings must use a standardized, validated autism screening tool at the child's periodic visits. When an autism screen identifies a child as being at risk for ASD, a diagnostic evaluation should follow. See the Utah Medicaid Autism Spectrum Disorder Services provider manual for information on evaluation, treatment processes, and requirements for PAs.

1-7.3 Tobacco, alcohol, or drug use assessment

Substance use during adolescence may result in long lasting consequences including involvement in the criminal justice system, physical or behavioral issues, or poor school performance. Medicaid encourages the use of scientifically valid screening tools for adolescent children to assess substance use disorder risk. Some recommended screening and assessment tools from the National Institute on Drug Abuse (NIDA) include but are not limited to:

1. Screening to Brief Intervention (S2BI)
2. Brief Screener for Alcohol, Tobacco, and other Substance Use (TAPS)
3. Drug Abuse Screen Test (DAST-10)

1-7.4 Depression and suicide risk screening

According to the AAP, periodic screening by providers reduces the likelihood of misdiagnosis or prolonged suffering of mental health conditions in adolescence. The following screening tools are recommended by the AAP to identify youth with risk factors for depression or suicidality:

1. Patient Health Questionnaire 9: Modified for Teens
2. Columbia Depression Scale

3. Ask Suicide-Screening Questions (asQ).

In instances where screenings determine an EPSDT member is at high risk for depression or suicidal thoughts or behaviors, the provider should complete further evaluation to determine the need for referral and provide adequate behavioral health resources. Providers should educate youth and their caregivers on the National Crisis Line (988) and make referrals to appropriate mental health providers.

1-7.5 Maternal depression screening

Maternal depression can have a strong impact on parenting and child outcomes, primary care health providers can contribute to their pediatric patients' health and support by screening and assisting mothers with referrals for depression.

Maternal Depression screening should be performed at the child's 1-, 2-, 4-, and 6-month EPSDT visit.

Medicaid recommends the Edinburgh Postnatal Depression Scale (EPDS-10 or EPDS-2) but will accept other evidence-based screening tools for the monitoring and identification of depression in new mothers.

Screening by the pediatric provider, accompanied by referral and intervention protocols play an important role in linking mothers experiencing mental health issues with the appropriate interventions. Medicaid encourages providers to refer mothers with suspected mental health needs for assessment and treatment as necessary.

Refer the child's mother to the mental health plan listed on the member's Medicaid identification card. If no plan is listed on the Medicaid card, refer the mother to an enrolled Medicaid mental health provider in the mother's home area. Mental health services, at a minimum, include diagnosis and treatment for mental health conditions. Refer to the Behavioral Health Services provider manual, the Physician Services provider manual, and the Coverage and Reimbursement Code Lookup for policy information related to mental health services.

1-8 Primary care services

Primary care providers (PCPs) are essential healthcare professionals who play a critical role in maintaining the health and well-being of EPSDT members. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care. A PCP can discover potential health problems early and provide needed intervention before health problems become severe. Members

who engage in early and regular screening, diagnostic and treatment services, coordinated through a PCP, will spend less time in the hospital and less money on medical costs over time due to early intervention and management of medically necessary services.

The following preventative care, screenings, history, measurements, and physical examination should be completed as part of each EPSDT visit where indicated. Refer to the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org for additional information.

1-8.1 Preventive and screening services

Screenings (periodic comprehensive child health assessments) are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of EPSDT members that include the following:

1. Comprehensive health and developmental history, including assessment of physical and mental health development
2. Physical examination, including a comprehensive physical exam at each EPSDT visit
3. Measurements at each EPSDT visit including:
    a) Weight/height
        i. Weight/length for each visit through 18-months
    b) Head circumference at each visit through 24-months
    c) Blood pressure beginning at 3-years of age
    d) Body mass index (BMI) beginning at age 2.
4. Developmental/behavioral health assessments/screenings including:
    a) Developmental screening at 9-, 18-, and 30-month visits
    b) Developmental surveillance
    c) Autism spectrum disorder screening at 18- and 24-months when medically indicated
    d) Behavioral/social/emotional assessments as medically indicated
    e) Tobacco, alcohol or drug use assessments beginning at age 11
    f) Depression and suicide risk screening beginning at age 12
    g) Maternal depression screening should be performed at the child's 1-, 2-, 4-, and 6-month EPSDT visit
5. Appropriate vision assessment or screenings

6. Appropriate hearing assessment or screenings
7. Administration of or referral to any laboratory tests, procedures or immunizations appropriate for age and risk factors
8. Dental assessments/screenings
    a) Oral health risk assessment, including oral observation and examination at the 6-, 9-, and 12-month EPSDT visit.
    b) Dental screening services furnished by direct referral to a dentist for children beginning at 3-years of age
9. Anticipatory guidance/health education

Each of these screening services is described more fully in the following sources:

1. Bright Futures
2. AAP Periodicity Schedule
3. Recommended Immunization Schedule for Children and Adolescents provided by the Centers for Disease Control and Prevention (CDC).

1-8.1.1 Newborn hearing screening

As authorized by Utah Administrative Rule R398-2. Newborn Hearing Screening: Early Hearing Detection and Intervention (EHDI) Program, if the hospital performing the newborn delivery is an inpatient hospital, the auditory screening is included as part of the DRG reimbursement methodology. If the hospital performing the newborn delivery is a rural hospital/critical access hospital or the delivery occurs in a non-hospital setting, the audiologists may bill Medicaid for the auditory screening.

1-8.1.2 Lead screenings

The CDC and the AAP recommend a lead risk assessment and a blood lead level test for all Medicaid eligible children between the ages of 6-months and 72-months. All children within this time frame are considered at risk for lead poisoning and should be screened.

In cooperation with the Utah Lead Coalition, Medicaid is dedicated to supporting increased member health outcomes by providing ongoing guidance for screenings related to the detection of lead toxicity. Ongoing provider and member education will bring about early identification of people who have had exposure to lead as well as prompting advanced treatments to reduce the enduring effects of untreated lead poisoning.

While lead toxicity can affect all age groups, children remain highly vulnerable to the effects of lead toxicity with the possibility of lifelong ramifications if left untreated. Member education for the prevention of lead exposure and testing to identify those that have had exposure is of the utmost importance to prevent adverse outcomes related to lead poisoning.

As such the Utah Lead Coalition has many valuable resources related to identifying those persons who are at higher risk of exposure to lead, standards in testing for lead poisoning, what treatments are available for those who have lead poisoning, and prevention of ongoing exposure to sources of lead.

Providers are encouraged to utilize the resources and guidance available through the Utah Lead Coalition website as well as those published by the CDC "Childhood Lead Poisoning Prevention," the Unites State Environmental Protection Agency (EPA) "Lead," and the AAP "Lead Exposure and Lead Poisoning."

1-8.1.3 Anemia

Anemia is defined as a reduction in one or more of the major red blood cell (RBC) measurements obtained as a part of the complete blood count (CBC): hemoglobin concentration, hematocrit, or RBC count. A low hemoglobin concentration and/or low hematocrit are the parameters most widely used to diagnose anemia. Evaluation for anemia is one of the most common concerns in clinical practice.

The purpose of screening for anemia is to diagnose and treat correctable nutritional anemia, such as iron deficiency anemia. Providers should follow current clinical standards for diagnosis of anemia based upon the age of the child.

The risk assessment or screening for anemia should be performed as appropriate, beginning at 4-months of age, in accordance with recommendations in the Bright Futures/AAP periodicity schedule.

All children must be tested for anemia at 1-year of age.

Sickle cell disease

Sickle cell disease (Hemoglobin SS Disease) is an inherited sickle cell disorder that affects the structure of red blood cells. Sickle cell disorders affect approximately 100,000 people in the United States. 1 in 365 African American and 1 in 16,300

Hispanic American births. 1 in 13 African American babies are born with sickle cell trait.

Screening for sickle cell disease should occur as part of the newborn screenings. If an infant tests positive for sickle cell disease the American College of Medical Genetics and Genomics (ACMG) recommends that providers:

1. Inform the family of the newborn screening result.
2. Ascertain clinical status (newborns are expected to be asymptomatic).
3. Evaluate the newborn (assess for splenomegaly and send CBC).
4. Administer prophylactic penicillin.
5. Consult with sickle cell specialist immediately with in person follow up by no later than 12 weeks of age.
6. Coordinate confirmatory diagnostic testing and management as recommended by specialist.
7. Provide family with basic information about Hemoglobin S/S or Hemoglobin S/Beta Zero (β0) Thalassemia including the need for urgent evaluation if fever of ≥ 38.5°C (101°F), or signs of stroke or splenic sequestration.
8. Refer for genetic counseling.
9. Report final diagnostic outcome to newborn screening program.

Additional information, treatment guidelines and resources for sickle cell disease can be found in the following sources:

1. Department of Health and Human Services
2. Centers for Disease Control and Prevention (CDC)

1-8.1.4 Dyslipidemia

Clinical evidence suggests that atherosclerosis begins in childhood and that early atherosclerosis is associated with the presence and intensity of identified risk factors that lead to vascular disease events, such as myocardial infarction, stroke, peripheral arterial disease, and ruptured aortic aneurysm, later in life.

To assist in the effort to prevent cardiovascular disease in childhood and adolescence, dyslipidemia screening must be performed once during each of these age-range visits:

1. Between the 9-year and 11-year visits

2. Between 17-year and 21-year visits

In addition, the Bright Futures/AAP periodicity schedule indicates intervals for performing a risk assessment, beginning at 24-months of age, to determine whether further action is required.

The National Heart, Lung, and Blood Institute provides additional guidance titled Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents . This guidance is designed to assist providers in reducing the risk factors associated with cardiovascular (CV) disease in children and adolescents and provide an important, up-to-date evidence-based framework for implementation of interventions in primary care offices and specialty clinics.

1-8.1.5 Tuberculosis

Information published by the AAP indicates that the most reliable tuberculosis control program is based on aggressive, expedient contact investigations, rather than routine skin test screening. The AAP recommends that an assessment of risk of exposure to tuberculosis be included in the 1-, 6-, 12- and 24-month visit as well as in all annual visits beginning at age 3.

Only children deemed to have increased risk of exposure to persons with tuberculosis should be considered for tuberculin (Mantoux) skin testing.

The frequency of such skin testing should be according to the degree of risk of acquiring tuberculosis infection, as detailed below. Routine tuberculin skin testing of children with no risk factors and residing in low-prevalence communities is not indicated.

1. Children for whom immediate skin testing is indicated:
   a) Children with contact to persons with confirmed or suspected infectious tuberculosis, including contact to family members or associates in jail or prison in the last five years.
   b) Children with radiographic or clinical findings suggest tuberculosis.
   c) Children immigrating from endemic areas, such as Asia, Africa, the Middle East, and Latin America
   d) Children with travel histories to endemic countries or significant contact with indigenous persons from such countries
2. Children who should be tested annually for tuberculosis:

a) Children infected with human immunodeficiency virus (HIV)
b) Incarcerated adolescents

3. Children who should be tested every two to three years:
   a) Children exposed to the following individuals who are: HIV-infected, homeless, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults, and migrant farm workers.

Children who have no risk factors but who reside in high-prevalence regions and children whose histories for risk factors are incomplete or unreliable should be considered for tuberculin skin testing at 4- to 6-years old and 11- to 16-years old. The decision to test should be based on the local epidemiology of tuberculosis in conjunction with advice from regional tuberculosis control officials.

Family investigation is indicated whenever a tuberculin skin test result of a parent converts from negative to positive (indicating recent infection). Children of healthcare workers are not at increased risk of acquiring tuberculosis infection unless the workers' tuberculin skin test results convert to positive, or the workers have diagnoses of tuberculosis disease.

The skin test interpretation guidelines for indurations of 5, 10, and 15 mm in diameter remain appropriate for decisions about contact investigations, tuberculosis control measures and preventive therapy.

Providers are encouraged to utilize the treatment guidelines and resources published by the Centers for Disease Control and Prevention.

1-8.1.6 Sexually transmitted diseases

All sexually active adolescents must be considered at high risk for most sexually transmitted infections (STIs). The Bright Futures/AAP periodicity schedule suggests performing a risk assessment for STIs annually, beginning at 11- to 21-years of age, to determine whether testing is appropriate.

1-8.2 Family and medical history

Providers must obtain and document a comprehensive family and medical history as part of the EPSDT screening process.

1-8.2.1 Measurements

The following measurements must be performed during each EPSDT exam:

1. Height or length (birth through 18 months)
2. Weight
3. Head circumference (birth through 2 years)
4. Body mass index (BMI) (beginning at 2 years)
5. Blood pressure (beginning at 3 years; or earlier for infants and children with specific risk conditions)

1.8.2.2 Height, weight, and head circumference

Providers should refer to the CDC, National Center for Health Statistics (NCHS), for information concerning height, weight, and head circumference percentile standards. If a significant deviation is discovered during assessment, the provider must conduct further evaluation and, if necessary, make appropriate referrals.

1-8.2.3 Body mass index

Providers should calculate and plot children's BMI annually, beginning at age two. The Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report is recommended to provide screening guidelines.

1-8.2.4 Blood pressure

Medicaid requires that blood pressure be measured and documented as part of each screening for children 3-years of age and older.

The American Academy of Pediatrics (AAP) publishes current percentile charts of normal blood pressure readings for various ages. Any significant deviation is a basis for further evaluation and, if necessary, a referral to a specialist.

1-8.3 Physical examinations

A complete physical exam must be provided as part of each EPSDT screening. Providers must communicate the scope and nature of the physical examination to be performed to the EPSDT member and the parent/responsible caregiver.

Suspect or positive findings from the examination must be documented and communicated with the member and/or parent/responsible caregiver. If additional

diagnostics or revisions to the plan of treatment are needed, those must be documented and communicated as well. Providers are responsible for overseeing referrals and communicating necessary appointments with the member and parent/caregiver.

1-9 Vaccines and immunizations

Immunizations should be provided or arranged for each child according to the schedule recommended by the AAP. Every EPSDT visit should be an opportunity to update and complete a child's immunizations.

1-9.1 Vaccines for children program

The Vaccines for Children (VFC) program makes available, at no cost to providers, certain vaccines for administration to members 18-years old and younger.

If a vaccine is available through the VFC program, Medicaid will not reimburse the use of a non-VFC vaccine (referred to as "private stock" vaccine) for members 18-years old and younger. Immunizations will only be eligible for a dispensing fee with no reimbursement for the immunization. Providers that are not currently enrolled in the VFC program are encouraged to enroll in the VFC program to ensure members do not experience a disruption in care.

See the Centers for Disease Control (CDC) Vaccine Price List for information on what vaccines are covered under the VFC program. For general information concerning the VFC program, including provider enrollment information, see the Vaccines for Children (VFC Provider Information page.

For additional information regarding reimbursement policy for vaccines, refer to Utah Administrative Rule R414-60. Medicaid Policy for Pharmacy Program, section 7. Reimbursement.

1-10 Well-child check ups

Infants, children, and adolescents should receive regular well-child check-ups of their physical and mental health, growth, development, and nutritional status. A well-child check-up includes:

1. A comprehensive health and developmental history,
2. Physical health assessments,
3. Behavior health assessments,

4. Age-appropriate immunizations,
5. Vision and hearing tests,
6. Dental exam,
7. Laboratory tests, including blood lead level assessments at certain ages, and
8. Health education, including anticipatory guidance.

1-11 Dental

Among the many dental conditions affecting EPSDT members, dental caries (tooth decay) is the preeminent concern in the context of Medicaid services because of its substantial prevalence in the low-income population. Tooth decay continues to be the single most common chronic disease among U.S. children, even though it is highly preventable through early and sustained home care and regular professional preventive services.

EPSDT members should begin to receive oral health risk assessments by six months of age by a pediatrician or other QHP. Dental services for children, at a minimum, include preventive dental services such as preventive dental examinations, prophylaxis, topical fluoride applications, and appropriate prescriptions for fluoride supplements, fluoride treatments, and sealants. In addition, the following services are included:

1. relief of pain and infections
2. restoration of teeth
3. maintenance of oral health

The Recommended Dental Periodicity Schedule, is a summary of EPSDT dental periodicity requirements. The schedule has been adopted from the AAPD's recommendations for dental services for the target population (ages 0-21).

Orthodontic treatment is provided in cases of severe malocclusions and requires prior authorization.

Refer to the Dental, Oral Maxillofacial, and Orthodontia Services provider manual and the Coverage and Reimbursement Code Lookup tool for additional coverage information.

1-11.1 Referrals

The EPSDT member should be referred to a dental provider as follows:

1. Make the initial referral by six months of age, if determined necessary by a QHP, and yearly thereafter
2. Make the referral if the child is at least four years old and has not had a complete dental examination by a dental professional in the past 12-months
3. Make the referral at any age if the oral inspection reveals cavities, infection, or significant abnormality

1-11.2 Recommended dental services

Fluoride varnish reduces the incidence of dental caries. Fluoride varnish minimizes the risk of inadvertent fluoride consumption and is easy to use on very young children. It forms a deposit on the dental enamel that slowly releases a high concentration of fluoride ions into the dental enamel. It is effective in preventing tooth decay and remineralizes tooth damage caused by the decaying process. Fluoride varnish may be applied to a child's teeth at regular 4- to 6-month intervals starting with primary tooth eruption and continuing through age 4.

1-11.3 Well-child (EPSDT) procedure codes for fluoride varnish

Medicaid covers application of dental fluoride varnish as an optional service for children birth through 4-years as part of a well-child exam. Claims for the application of dental varnish must be submitted using the appropriate CPT code (see Chapter 6 Coding for a list of applicable CPT codes) for the corresponding visit and the appropriate CPT code to indicate the application of fluoride varnish during the visit.

For more information, training, or technical advice on the application of the varnish, contact the Oral Health Program at the Utah Department of Health and Human Services at (801) 273-2995. For more information related to claims, payments, or billing codes contact Medicaid information at (801) 538-6155.

1-12 Family planning

Family planning services means diagnostic, treatment, drugs, supplies, devices, and related counseling related to family planning methods to prevent or delay pregnancy.

Refer to the Utah Medicaid State Plan, Attachment 3.1-A & B, Attachment #4c Family Planning Services and Supplies for additional information.

1-13 Federally Qualified Healthcare Centers (FQHC) and Rural Health Clinics (RHC)

Services provided at FQHCs and RHCs are primarily outpatient health care services, including routine diagnostic and laboratory services provided by physicians, nurse practitioners, certified nurse midwives, or physician assistants.

Refer to the Rural Health Clinics and Federally Qualified Health Centers provider manual for additional information.

1-14 Fertility preservation

Fertility preservation services are covered for members undergoing gonadotoxic cancer treatments or other medically necessary treatment that are expected to render them permanently infertile (excluding voluntary sterilization) either pre or post treatment. Qualifying members must meet the following criteria:

1. The member is post-pubertal through 40 years of age.
2. Diagnosis by a qualified healthcare professional (QHP) of a condition requiring treatment which, in the QHP's professional judgment, may pose a substantial risk of sterility or lead to iatrogenic infertility (infertility caused by treatment).
3. The member's current state of health is sufficient to undergo fertility preservation procedures.
4. The member has received infertility counseling as well as psychotherapy, when medically indicated.
5. Collection and storage of embryos, eggs or sperm is consistent with established medical practices or professional guidelines published by the American Society of Reproductive Medicine (ASRM) or the American Society of Clinical Oncology (ASCO).

1-14.1 Coverage

Collection and storage of embryos, reproductive tissues, eggs, and sperm must use collection and storage processes that are consistent with established medical practices or professional guidelines published by the ASRM or the ASCO.
Coverage includes the following fertility preservation services:

1. Mature oocyte cryopreservation
2. Ovarian tissue cryopreservation
3. Ejaculated/surgically extracted sperm cryopreservation

4. Embryo cryopreservation

1-14.2 Limitations

1. Reimbursement for cryopreservation storage is covered as a single payment and includes up to a five-year storage increment.
    a) Post cryopreservation procedures for use of eggs, sperm, or embryos are not covered.
    b) Additional five-year storage increments may only be requested for member's that retain Medicaid eligibility.

1-14.3 Non-covered services

1. Cryopreservation of embryos or eggs or sperm for fertility preservation purposes other than chemotherapy or other treatments that may render an individual infertile.
2. Cryopreservation of embryos or eggs or sperm for reciprocal IVF
3. Sperm storage/banking for males requesting this service for convenience or "back-up" for a fresh specimen.

For additional code specific policy information providers may refer to the Coverage and Reimbursement Code Lookup.

1-15 Genetic testing

Genetic tests are laboratory studies of human deoxyribonucleic acid (DNA), chromosomes, genes or gene products to diagnose the presence of a genetic variation associated with a high risk of having or transmitting a specific genetic disorder.

Genetic testing must be medically necessary and ordered by a Medicaid enrolled provider, within the scope of their practice.

1. Providers must be able to counsel clients on the particular genetic test ordered and the results of that test, as it applies to the member, in consultation with a genetic specialist as needed.

2. If a provider is unable to counsel a member regarding pre- and post-genetic testing, they must refer the member to a provider capable of providing genetic counseling prior to ordering the test.

Genetic testing is medically necessary for EPSDT members when there is a reasonable expectation based on family history, risk factors, and/or symptomatology that a genetically inherited condition exists, and any of the following clinical scenarios also exist:

1. Clinical presentation fits a well-defined syndrome for which a specific or targeted gene test is available; or
2. A definitive diagnosis cannot be made based on history, physical examination, pedigree analysis, and/or standard diagnostic studies or tests; or
3. There is a clinical syndrome with a broad number of potential diagnoses, and without a specific diagnosis, the medical management will include unnecessary monitoring, testing, hospitalizations, and/or medical setbacks; or
4. There is a clinical syndrome with a broad number of potential diagnoses, and a specific diagnosis will determine prognosis and appropriate medical management.

Genetic testing may require PA. Specific coverage on CPT or HCPCS codes are found in the Coverage and Reimbursement Code Lookup.

Coverage of genetic testing by Medicaid is determined by using an evidence-based criteria tool and clinical decision making.

Documentation requirements

Documentation to support the recommendation(s) for testing must address the following:

1. Specific risk factors, the clinical scenario, and/or family history that supports the need for the requested test(s); and
2. Clinical examination and conventional diagnostic testing have not contributed to the determination of a specific diagnosis; and
3. The results of the genetic test may influence the medical management of a suspected condition.

Where criteria do not exist, submission of publicly accessible data from peer-reviewed, scientific literature and/or national databases that addresses the clinical validity, predictive value, and/or medical benefit(s) of the specific diagnostic genetic test(s) should be submitted.

1-15.1 Next Generation Sequencing (NGS)

Identifying a molecularly confirmed diagnosis promptly for an individual with a rare genetic condition can have a variety of health outcomes, including:

1. Guiding prognosis and improving clinical decision-making that can improve clinical outcome by application of specific treatments as well as withholding of contraindicated treatments for certain rare genetic conditions.
2. Surveillance for later-onset comorbidities.
3. Eliminating lower-yield testing, and additional screening(s) that may later be proven unnecessary once a diagnosis is achieved.
4. Reducing the financial and psychological impact of diagnostic uncertainty.
5. Next-generation sequencing (NGS) includes genetic testing options such as whole exome sequencing (WES) and whole genome sequencing (WGS) and can detect the most significant variant types, meaning genetic alterations with sufficient evidence to classify as pathogenic.

1-15.2 Whole Exome Sequencing (WES)

WES focuses on the genomic protein coding regions (exons). It is a cost-effective, widely used NGS method that requires fewer sequencing reagents and takes less time to perform bioinformatic analysis compared to WGS. Although the human exome represents only 1-5% of the genome, it contains approximately 85% of known disease-related variants.

WES is considered medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorders in EPSDT-eligible members when all of the following criteria are met:

1. After all other appropriate diagnostic testing has been performed, and the member remains undiagnosed (e.g., targeted single-gene testing, panel testing, MRI, etc.), and
2. Results of such testing are expected to influence medical management and clinical outcomes directly.

1-15.3 Whole Genome Sequencing (WGS)

WGS, in contrast to WES, may detect larger deletions or duplications, triple repeat expansions, and pathogenic variants in deep intronic regions; regulatory regions that are outside of the coding regions; and untranslated gene regions.

WGS is considered medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorders in members aged less than one year of life and currently admitted to a Neonatal Intensive Care Unit (NICU) or other intensive care setting, when all of the following prior authorization criteria are met:

1. Test is ordered by one of the following provider types, who has evaluated the member and family history, and recommends and/or orders the test:
   a) Neonatologist or intensivist in collaboration with a medical geneticist or certified genetic counselor.
   b) The member has been evaluated by a board-certified clinician with expertise in clinical genetics and counseled about the potential risks of genetic testing.
   c) Pre- and post-test counseling is performed by an American Board of Medical Genetics or American Board of Genetic Counseling certified genetic counselor.
2. Clinical indications:
   a) Absence of definitive diagnosis based on standard clinical workup.
   b) Unclear disease identity based on member's phenotype, or the member has phenotypic characteristics outside of, or in addition to, what has been established for the disease.
   c) A genetic etiology is the most likely explanation for the phenotype or clinical scenario, or the affected individual is faced with invasive procedures or testing as the next diagnostic step (e.g., muscle biopsy.)
   d) No other causative circumstances (e.g., environmental exposures, injury, infection) can explain the symptoms.

8-15.4 Non-covered services

Diagnostic genetic testing, for the sole convenience of information to identify specific diagnoses for which the medical management of the member is not anticipated to be altered.

Additional types of diagnostic genetic testing that are non-covered include:

1. Experimental and/or investigational (excluding members who are participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the "Consolidated Appropriations Act, 2021")
2. Tests for screening purposes only (excluding newborn screening as defined in Utah Administrative Code R398-2. Newborn Hearing Screening), including:
   a) preimplantation genetic diagnosis (PGD); or
   b) prenatal genetic screening; or
   c) in the absence of signs and/or symptoms
3. Tests, for the member or family members, performed solely for the purposes of genetic counseling, family planning, or health screening
4. Tests for research to find a rare or new gene not previously identified or of unclear clinical significance
5. Direct-to-consumer (DTC) genetic tests
6. Tests of a member's germline DNA to benefit family member(s), rather than the member being tested
7. Establishment of paternity
8. Genetic testing is considered not medically necessary when performed entirely for non-medical reasons (e.g., a general interest in genetic test results)

1-16 Home services

1-16.1 Home health

Medicaid covers skilled nursing and home health aides for EPSDT members. Home health services are medically necessary, part-time, intermittent health care services provided in settings defined by 42 CFR Part 440.70 when the services are medically necessary, cost-effective, and consistent with the member's medical need.

Refer to the Home Health Services provider manual for additional information.

1-16.2 Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)

Medicaid may approve medically necessary medical supplies and durable medical equipment for EPSDT eligible members. For information on Medical Supplies and Durable Medical Equipment service, refer to the Medical Supplies and Durable Medical Equipment Manual.

1-16.3 Personal care

The purpose of personal care is to provide supportive care to members in their place of residence, maximize independence, and prevent premature or inappropriate institutionalization. Supportive care offers a range of assistance services that enable persons with disabilities (cognitive or physical) and acute or chronic conditions to perform tasks associated with activities of daily living (ADLs) or instrumental activities of daily living (IADL).

Refer to the Personal Care Services provider manual for additional information.

1-16.4 Private Duty Nursing

Private Duty Nursing (PDN) service is a program intended for the prevention of prolonged institutionalization of an EPSDT member. Refer to the Home Health Services, Chapter 8-11 Private Duty Nursing (PDN) for additional information.

1-16.5 Hospice

EPSDT members who elect hospice services do not forfeit curative care that would otherwise be available to them through the Medicaid State Plan. Refer to Hospice Care Services, Chapter 8-9.2 Election of hospice for additional information.

1-16.6 Physical and occupational therapy

Refer to Physical Therapy and Occupational Therapy Services, Chapters 1-2 General Policy, 9-2.1 Physical therapy limitations, and 9-2.2 Occupational therapy limitations for additional information concerning expanded services for the EPSDT program.

1-17 Speech Language Pathology

Speech language pathology (SLP) services include examination, diagnosis, and treatment of speech/ communication disabilities and related factors of individuals with certain voice, speech, hearing, and language disorders. These services treat problems associated with accident, injury, illness, or birth defect. Nonorganic or organically based SLP articulatory deviations, voice disorders, language impairments, or dysfluencies may be included in the treatment plan in some specific instances.

SLP therapy evaluations should consider audiological issues and other physical (organic) conditions restricting proper speech and language development. These

issues, along with interventions must be addressed in a comprehensive treatment plan.

SLP therapy services must be ordered by a QHP and be provided by a speech-language pathologist.

SLP therapy services may require PA. Refer to the Coverage and Reimbursement Lookup for additional information.

1-17.1 SLP evaluation

EPSDT members are allowed one speech evaluation per year.

1-17.2 Covered SLP services

State funds, other than Medicaid, support speech and language therapy through Early Intervention for ages 0 to 3 years.

SLP services provided either through Early Intervention or U.S. Department of Education's Individuals with Disabilities Education Act (IDEA) are designed to assist parents/responsible caregivers to prepare a child, that qualifies for these services, for education when a speech or language disorder is present.

1. Services for children ages 2 years through 5 years are covered, if the child's speech or language deficit is at, or greater than one and one-half standard deviations below the mean as measured by an age-appropriate standardized test for articulation, phonology, fluency or language OR if using percentile score is at or below the 7th percentile. One and one-half standard deviations below the mean equals a standard score of 78.
2. Services for children eligible for preschool through age 20 are available through the educational system, but additional Medicaid services may be approved if the EPSDT member's speech or language deficit is at, or greater than two standard deviations below the mean as measured by an age-appropriate standardized test for articulation, phonology, fluency or language OR if using percentile score is at or below the 2nd percentile. Two standard deviations below the mean equals a standard score of 70.
3. SLP services for EPSDT members under age 2 are not covered unless a specific medical diagnosis is present and medical documentation supports the medical need and efficacy of early intervention for speech therapy. Such early intervention is required to meet medical necessity criteria, as defined in the

[Section I: General Information](#) provider manual, Chapter 8-1 *Medical Necessity*. If testing is possible, documentation must demonstrate that the child's speech or language deficit is at, or greater than one and one-half standard deviations below the mean as measured by an age-appropriate standardized test for articulation, phonology, fluency, or language OR if using percentile score, is at or below the 7th percentile.

4. Services for voice anomalies such as pitch, tone, or quality, are limited to velopharyngeal inadequacies due to cleft palate, submucous cleft palate, congenital short palate, palatopharyngeal paresis/paralysis, neuromuscular diseases (myasthenia gravis, multiple sclerosis, ALS, etc.).
5. Services for voice disturbances related to vocal cord pathology or vocal cord dysfunctions are limited to 5 visits. This includes vocal cord nodules, polyps, web, mucosal edema, or granulomatosis or vocal cord dysfunctions of paralysis/paresis, hyper and hypokinesis, laryngeal dystonia, or paradoxical vocal fold dysfunction.
6. Therapeutic services for training the EPSDT member in the use of a speech generating device are a covered service when medically necessary.
7. All therapeutic services are limited to a combined total of 24 sessions in a 6-month period.

1-17.3 Plan of care required

A written plan of care established by the speech-language pathologist is required. The plan of care must include:

1. Patient/member information and history
2. Current medical findings
3. Diagnosis
4. Previous treatment (if applicable)
5. Planned treatment
6. Anticipated goals
7. The type, amount, frequency and duration of the services to be rendered
8. Scores of appropriate tests that measure the disability or dysfunction must be submitted with the plan of care annually

1-17.4 SLP limitations

SLP services are limited as described below.

1. Home health speech therapy is limited to EPSDT members that are unable to leave the home for outpatient speech therapy.
2. Communication disabilities solely associated with behavioral, learning, and/or psychological disorders are non-covered, unless documented as part of a comprehensive medical treatment plan.
3. Treatment for clients who have reached maximum potential for improvement or who have achieved the stated goals, or test above the stated threshold requirements for treatment.
4. SLP treatment for speech/ communication disabilities caused by a cerebral vascular accident (CVA) or traumatic brain injury (TBI) which manifest more than six months after onset.

1-17.5 SLP non-covered services

The following services are not Medicaid benefits, except when related to accident, illness, birth defect, or injury:

1. Recipients with no documented evidence of capability or measurable improvement
2. Residents of an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) (included in the per diem resident rate)
3. Non-diagnostic, non-therapeutic, routine, repetitive or reinforcing procedures, such as practicing word drills or using a communication board, such as a PECS, or picture board or other procedures that may be carried out effectively by the member, family, or care givers
4. Continued training beyond the initial instruction to use a communication board, such as a PECS, or picture board
5. Self-correcting dysfunctions that are within normal limits for the recipient's age. For example: slow speech development, developmental dysfluencies, or developmental articulation errors
6. Dysfluencies such as stuttering or stammering or rhythm abnormalities
7. Articulation problems, such as "lisping" or the inability to provide certain consonants

1-17.6 Speech augmentative communication devices

Speech augmentative communication devices are covered in accordance with the Coverage and Reimbursement Code Lookup.

1-17.7 Voice prosthetics and voice amplifiers

Voice prosthetics and voice amplifiers are covered in accordance with the Coverage and Reimbursement Code Lookup. A speech-language pathologist may provide necessary training for utilization of the device.

18-1 Inpatient services

Inpatient hospital services are available to EPSDT members with surgical, medical, diagnostic, or level of care needs that require the availability of specialized diagnostic and therapeutic services, and close medical supervision of care and treatment directed toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain.

Refer to the Hospital Services provider manual for additional information.

1-18.1 Inpatient intensive physical rehabilitation services

Inpatient intensive physical rehabilitation services cover acute conditions from birth through any age and are available one time per event.

EPSDT members with chronic conditions may be considered for age-appropriate developmental training. Refer to the Hospital Services provider manual, Chapter 8-6 Inpatient hospital intensive physical rehabilitation services for additional information.

1-19 Interpretive services

Effective communication between EPSDT members and providers is essential in improving health outcomes and achieving optimal health care outcomes. As Medicaid continues to experience soaring growth in individuals who don't use English as a primary language, qualified medical interpreters are increasingly critical in filling this important patient need.

Refer to Section I: General Information, Chapter 3-8 Medical interpretive services for additional information concerning interpretive services for EPSDT members.

Medicaid also offers a Guide to Medical Interpretive Services. The guide lists member eligibility requirements, contractors, languages offered, and information required from the provider.

1-20 Laboratory and radiology services

Laboratory and radiology tests provide important information about a member's health. Medically necessary laboratory and radiology services are covered for EPSDT members to assist providers with diagnosis of diseases and conditions, monitoring treatments for a disease, or to check the condition of organs and body systems. Providers are encouraged to facilitate or arrange all appropriate services for each EPSDT member at each age level in a timely manner, and properly document and report the services.

1-21 Nursing and long-term care facilities

Refer to the Long Term Care Services provider manual.

1-22 Medications and pharmacy

Under the EPSDT program, all medically necessary medical treatment, including medications is a covered service. The Centers for Medicare and Medicaid Services (CMS) guidance document "EPSDT: A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents" informs that states must provide children with the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions.

As noted above, the EPSDT program covers physical and mental health and substance use disorder services, regardless of whether these services are provided under the State Plan and regardless of any restrictions that states may impose on coverage for adult services, as long as those services could be covered under the State Plan including medication management which would fall under the Medicaid pharmacy benefit. Please refer to the Pharmacy Services provider manual for further information.

Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices are covered by the Vaccines for Children Program.

The EPSDT benefit does not require coverage of treatments, services, or items including pharmaceuticals that are experimental or investigational. Such services

and items may, however, be covered at the state's discretion if it is determined that the treatment or item would be effective to address the EPSDT member's condition.

1-23 Outpatient physical therapy and occupational therapy

Refer to the Physical Therapy and Occupational Therapy Services provider manual for additional information concerning outpatient therapy services.

1-24 Chiropractic services

Coverage of chiropractic services is limited to spinal manipulation. Chiropractors performing manual manipulation of the spine may use manual devices. However, no additional payment is available for use of the device, nor does Medicaid recognize an extra charge for the device itself. No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered.

Specific coverage on CPT or HCPCS codes may be found in the Coverage and Reimbursement Code Lookup.

1-25 Transportation

Medicaid may provide reimbursement for non-emergency medical transportation (NEMT) if the member is currently eligible for EPSDT services and they do not have access to transportation to receive needed medical care.

Medical transportation is not available for services provided by non-enrolled medical practitioners or for non-covered services. Members may be asked to verify medical appointments associated with transportation services. Medicaid may not reimburse for all transportation services.

Available options for NEMT services are based on the member's medical needs and include:

1. Utah Transit Authority (UTA);
2. Paratransit;
3. Modivcare;
4. Ambulance services; and
5. Potential reimbursement for personal car mileage.

To maintain cost effectiveness while providing necessary services to EPSDT members, utilization is restricted to available services near the member's place of residence.

Note: To access medical transportation services, members must discuss transportation needs with a Department of Workforce Services (DWS) eligibility worker. DWS eligibility workers can assist the member in finding the most cost effective and efficient options available to the member.

Approval for NEMT uses the following hierarchy for NEMT utilization:

1. Personal Transportation Reimbursement
2. Members who live within UTA or Cedar Area Transportation Services (CATS) boundaries should utilize "fixed bus route" services or UTA's TRAX light rail
   a) "Fixed bus routes" refers to buses that operate on a predetermined route according to a predetermined schedule.
3. If a member cannot use UTA or CATS, but they still live within established boundaries for those services, the member can apply for UTA Paratransit transportation or CATS "Dial-A-Ride" services.
4. Members who live outside the boundaries of the UTA/CATS service areas or who are unable to use the previously mentioned services for medical reasons can utilize the contracted NEMT broker, Modivcare, for transportation services.
5. If the member exceeds established weight limits and cannot obtain the use of a manual wheelchair for Modivcare services, then NEMT ambulance services are available for member use.

For additional information, including personal transportation reimbursement, applications for services, and service limitations for the above NEMT services, please reference the Medical Transportation Manual, the Utah Medicaid NEMT website, or the DHHS Medical Policy Manual, Chapter 651 Non-Emergency Medical Transportation.

1-26 Vision services

The AAP emphasizes that eye examinations and vision assessments are critical for the detection of conditions that often result in visual impairment, signify serious systemic disease, lead to problems with school performance, and, in some cases, threaten the child's life. Undetected vision problems occur in 5%–10% of preschool children. The

most serious of these problems is amblyopia, a loss of visual acuity and binocular vision that becomes irreversible after 5 years old.

Each EPSDT screening must include a visual observation with an external eye examination and a risk assessment or screening for visual acuity. See the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule for timing of required screenings.

Refer to the AAP Policy Statement Visual System Assessment in Infants, Children, and Young Adults by Pediatricians and Procedures for the Evaluation of the Visual System by Pediatricians for additional information.

Vision services include vision screenings, examinations, diagnosis, and treatment for defects in vision, including eyeglasses.

1-26.1 Screening for visual acuity

A visual acuity screen is recommended at ages 3-, 4-, and 5-years of age. Instrument-based screening may be used to assess risk at ages 12- and 24-months, in addition to the well visits at 3 through 5 years of age.

Visual acuity screening procedures and passing criteria should be followed as advised in the AAP publication, Procedures for the Evaluation of the Visual System by Pediatricians.

1-26.2 Vision referral standards

Referrals to an appropriate eye or vision specialist must be made when screening methods or parent/caregiver reports indicate that further diagnostics are warranted by a specialist. An EPSDT member may also be referred if parent/responsible guardian reports warrant a referral.

1-26.3 Corrective lenses

Corrective lenses are medically necessary to prevent permanent visual loss due to a number of eye conditions. These conditions may include, but is not limited to:

1. high or asymmetric refractive error,
2. strabismus,

3. amblyopia,
4. aphakia,
5. pseudophakia,
6. congenital ocular anomalies,
7. neurologic disorders,
8. medication side effects,
9. and for protection in cases where the member has only one well-functioning eye

A change in prescription or replacement due to normal lens wear is also considered medically necessary.

Covered lenses include single vision, bifocal, trifocal, with or without slab-off prism, in clear glass or plastic.

Separate charges for glasses fitting are not reimbursable. Fitting fees are included in the reimbursement rate for the provided items.

1-26.4 Frames

Medicaid provides one standard plastic or metal frame. If the lens prescription changes, the same frame must be used when possible. Medicaid covers one pair of eyeglasses every 12-month period.

If a member requires lenticular lenses, deluxe frames will be allowed with a PA.

1-26.5 Eyeglass replacement

Eyeglasses are covered once every 12-months. When eyeglass replacement is needed prior to the end of the 12-month limit, prior authorization is required. Replacement lenses are covered and do not require PA. If the lenses alone need replacing, the provider must use existing frames.

The following prior authorization criteria must be met for eyeglass replacement requests:

1. There is a change in correction of 0.5 diopters or greater in either sphere or cylinder power in either eye.
2. A vision examination shows that a change in eyeglasses is medically necessary.
3. A change in the member's head size warrants a new pair of eyeglasses.

4. The recipient has experienced agitation or irritation from the frame material from the previous pair of eyeglasses.
5. The original pair is lost, broken, or irreparably damaged; the dispensing provider must submit a narrative explaining the reason for replacement with the prior authorization request.

1-26.6 Contact lenses

Contact lenses require PA.

1. Contact lenses may be covered under the following circumstances:
   a) Visual acuity cannot be corrected to 20/70 with glasses
   b) The refractive error is greater than +- 8D
   c) An eye disease or disorder exists that is not correctable with glasses, such as aphakia, keratoconus, nystagmus, or severe corneal distortion
2. Reimbursement of contact lenses includes fitting, measurement, member education, and follow-up care.

1-26.7 Low vision aids

Low vision aids or materials, such as magnifiers and lamps, may be covered. These items require PA.

1-26.8 Billing members for non-covered upgrades

With few exceptions, a provider may not bill a Medicaid member, as the Medicaid payment is considered payment in full. Exceptions may include a member request for a service that is not medically necessary and therefore not covered. Examples of services considered not medically necessary include, but are not limited to:

1. upgraded frames
2. tinted or transitional lenses
3. progressive lenses

A Medicaid member may choose to upgrade a covered vision service to a non-covered service, such as transitional lenses or brand-name frames. However, the member must be willing to assume financial responsibility for the difference in the covered and non-covered services fees.

When a member requests a product or service not covered by Medicaid, the provider may bill the Medicaid member when all four conditions of Section I: General Information, Chapter 3-5 Exceptions to prohibition on billing members, are met.

The provider cannot mandate or insist the covered product or service be upgraded. The member makes the choice. Further, the provider, as a guarantee of payment by the member, may not hold the member's Medicaid member card, nor impose any other restrictions upon the member.

The amount paid by the member is the difference between the provider's usual and customary charge for the non-covered service and the provider's usual and customary charge for the covered service.

The member is not responsible for paying the difference between the Medicaid payment for the covered service and the usual and customary fee for the requested upgraded service.

If providing upgraded services, report the Medicaid covered code and charges on the first line of the claim form. On the second line, bill the non-covered code, including the modifier “GX” (HCPCS “GX” modifier description: Notice of liability issued, voluntary under payer policy) and the charges on the second line. This indicates that the member has signed an agreement of understanding of the payment responsibility for the upgrade(s). The code with the GX modifier will be non-payable. The agreement of understanding must be kept in the provider’s medical record for the member.

Example:

A member is provided with frames for prescription eyeglasses, reported by the provider using HCPCS V2020. Medicaid reimburses HCPCS V2020 at a rate of $63.82. The customary charge for frames by the provider is $80. The member chooses an upgraded eyeglass frame valued at $120. In this example, the provider would:

1. Report HCPCS V2020 with the $80 charge on the first line of the claim
2. Report HCPCS V2020 with the GX modifier and a charge of $40 on the second line of the claim
3. Medicaid would reimburse the provider $63.82 for the first line and provide no payment for the second line of the claim

4. Per the agreement signed by the member, the provider could then bill the remaining $40 to the member directly for the upgraded product.

Note that the provider may not bill the member for the $16.18 difference between the $63.82 reimbursement rate from Medicaid and the $80 customary charge from the provider, as the reimbursement from Medicaid is considered payment in full.

1-26.9 Non-covered vision services

The following services are not covered vision services for Medicaid:

1. Additional glasses, such as reading glasses, safety glasses, distance glasses, or “spare glasses”
2. Extended wear contact lenses
3. Contact lenses for moderate visual improvement and/or cosmetic purposes
4. Sunglasses, tints, or any other mechanism such as light-sensitive lenses that “darken” or photo grey lenses
5. Oversized, exclusive, or specially designed lenses
6. Special cataract lenses, unless medically necessary. Only clinical cataract lenses are covered.
7. No-line bifocal lenses and no-line trifocal lenses
8. Replacement of glasses that are broken or lost due to abuse and neglect of the member
9. Repairs due to member neglect or abuse
10. Medications dispensed in an office
11. Screening examination to determine if member has an eye problem
12. Corneal Topography
    a) With a non-covered service (e.g., radial keratotomy, Lasix eye surgery)
    b) As a screening examination
    c) Separate from evaluation & management ophthalmological services
    d) Optical Coherence Tomography (OCT) (An ultrasonic method to evaluate ocular structures which is considered investigational)

1-27 Telehealth services

Refer to the [Section I: General Information](#) provider manual, Chapter 8-4.2 Telehealth.

2 Prior authorization

Prior authorization requests for EPSDT services must be in writing and include all applicable information listed below:

1. The provider's acquisition cost for the service or item.
    a) Note: The acquisition cost, or purchase price, is the amount paid by the provider for an asset or product, either through purchasing the product directly from a manufacturer or the cost incurred by the provider to manufacture the product, Acquisition cost is not the manufacturer's suggested retail price (MSRP). Submissions that include only MSRP information for items will be returned, without processing, for the needed acquisition cost.
2. Photocopy of any durable medical equipment item(s) requested.
3. Current comprehensive evaluation of the individual's condition, completed by the appropriate therapist, that includes the diagnosis, general medical history, therapy treatment history, age, height, weight, capabilities, prognosis, specific limitations, and the purpose for any durable medical equipment that is requested.
4. Letter from the physician describing medical necessity, including the diagnosis, the medical reason for the request, the medical condition that justifies the request, and the portion of the medical history that applies to the specific request. The letter must be member specific, indicate the reasons the physician is recommending the service or equipment, whether the item or service has been provided previously, and whether the service or equipment would contribute to preventing a future medical condition or hospitalization.

All providers involved in the diagnosis, evaluation, or treatment of the member should communicate directly and work together as a team to evaluate the most appropriate services for the EPSDT member.

For additional information concerning prior authorization refer to PRISM Prior Authorization training.

2-1 Exceptions to prior authorization requirements and non-covered services

Coverage may be available for EPSDT eligible members when a service is not covered by Medicaid. Prior authorization requests for EPSDT services must be in writing and include all applicable information listed below:

1. The provider's acquisition cost or usual and customary charges for the item(s) or service.
    a) The acquisition cost, or purchase price, is the amount paid by the provider for an asset or product, either through purchasing the product directly from a manufacturer or the cost incurred by the provider to manufacture the product, Acquisition cost is not the manufacturer's suggested retail price (MSRP). Submissions that include only MSRP information for items will be returned, without processing, for the needed acquisition cost.
2. Photocopy of any durable medical equipment item(s) requested, if applicable
3. Current comprehensive evaluation of the child's condition, completed by the appropriate qualified healthcare professional, that includes all applicable medical documentation to establish the medical necessity of the requested item or service,
4. Letter from the physician describing the member specific medical necessity for the product/service, including the diagnosis, pertinent medical history, and any previous or current medical interventions utilized in treatment.

All providers involved in the diagnosis, evaluation, or treatment of the member should communicate directly and work together as a team to evaluate the most appropriate services for the member.

3 Health plans

For more information about Managed Care Entities (MCE), refer to Section I: General Information, Chapter 2, Managed care entities.

If a Medicaid member is enrolled in an MCE, the Division of Integrated Healthcare (DIH) will not pay a claim unless it is for a carved-out service. A carved-out service is a service that is covered by Medicaid but not covered by an MCE. Services that are carved out from an MCE

differ depending upon the type of MCE. Refer to Section I: General Information, Chapter 2-6 MCE carve-out services for additional information.

3-1 Mental health plans

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information, Chapter 2-8, Prepaid mental health plans, and the Behavioral Health Services provider manual. A list of MCEs and PMHPs that Medicaid has contracted with to provide health care services is found on the Medicaid website.

For members enrolled in a PMHP, requests for services related to mental health conditions will be referred to the PMHP.

3-2 Dental plans

For more Information about dental plans, refer to Section I: General Information, Chapter 2-10, Dental plans.

MCEs are not responsible for covering the following Medicaid State Plan or waiver services. These services are “Carved-Out Services” and should be reported directly to Medicaid on a fee-for-service basis:

1. A non-pregnant adult member, except for an EPSDT enrollee,
2. A member in the custody of the Department of Health and Human Services (DHHS) and covered by Foster Care Medicaid,
3. A member that resides in a nursing home or an intermediate care facility, or
4. Enrolled in Utah’s Premium Partnership for Health Insurance (UPP),
5. Facility charges for hospital and ambulatory surgical centers,
6. Dental surgical services that include general anesthesia performed at a hospital or ambulatory surgical center,
7. Emergency dental services performed in an emergency department of a hospital or an urgent care facility,
8. Services performed at Indian Health Services facilities, any tribal facility, or an Urban Indian facility,
9. Services performed at the Utah State Hospital or Utah State Developmental Center,
10. Surgical repair services performed by a dentist or oral surgeon for craniofacial anomalies, cleft lip, or palate.

3-3 Healthy Outcomes Medical Excellence (HOME) Program

For more information concerning the HOME program, refer to Section I: General Information, Chapter 2-9, HOME.

HOME is a coordinated care program that provides services normally covered by the ACOs and the PMHPs. HOME is not responsible for pharmacy services. When members enroll in HOME, they are disenrolled from their ACO and PMHP.

4 Member eligibility

It is the responsibility of the provider to verify the member's eligibility prior to every service. For additional information regarding member eligibility refer to Section I: General Information, Chapter 6, Member eligibility.

EPSDT services are available to all members enrolled in Traditional Medicaid from birth until the member's 21st birthday.

Children born to women enrolled in Medicaid are eligible for the EPSDT benefit but must be enrolled in Medicaid, themselves, to receive benefits.

Note: Historically, individuals aged 19 through 20 who were enrolled in Non-Traditional Medicaid did not qualify for EPSDT services. On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan ended, and members formerly enrolled in the NTM plan were provided the same benefits as the Traditional benefit plan starting on January 1, 2024. Information regarding NTM services will remain in the Utah Medicaid Provider Manuals until January 1, 2025, for reporting and eligibility purposes.

5 Additional policy resources

Refer to the Section I: General Information manual for additional policy information concerning:

1. Provider participation and requirements
2. Record keeping
3. Provider sanctions
4. Member responsibilities

6 Coding

All Utah Medicaid claims require diagnosis codes and procedure codes. The appropriate diagnosis code must be entered on all claims. Procedure codes are dependent on the type

of service and claim type. Medicaid recognizes guidelines in current editions of established coding manuals or other standard literature. However, those guidelines are adopted only as far as they are consistent with application to Utah Medicaid policy. The established coding guidance materials consist of the following:

1. Healthcare Common Procedure Coding System (HCPCS)
2. Physicians' Current Procedural Terminology (CPT) Manual
3. Healthcare Common Procedure Coding System, HCPCS Level II
4. Healthcare Common Procedure Coding System, HCPCS Level III
5. International Classification of Diseases (ICD), Clinical Modification (CM), and Procedural Coding System (PCS)
6. Revenue Codes (Uniform Billing Codes-UB-04)

Refer to Section I: General Information, Chapter 11 Billing Medicaid and Chapter 12 Coding for additional reporting instructions. It is the responsibility of the provider to review Medicaid coverage policy for the procedure or service and request prior authorization (PA) or submit documentation for manual review. Refer to the Medicaid Coverage and Reimbursement Lookup for additional code specific information and fee schedule information.

7 Local Health Departments (LHD)

Bear River Health Department	***Central Utah Health Department***
655 East 1300 North Logan, UT 84341-2570 Office: 435 792-6541 Office Fax: 435 792-6600	70 Westview Drive Richfield, UT 84701-1868 Office: 435 896-5451, ext. 322 Office Fax: 435 896-4353
Davis County Health Department	***Salt Lake County Health Department***
22 S. State Street Clearfield, UT 84015-1043 Office: 801 525-5202 Office Fax: 801 525-5210	2001 South State Street, S3-700 PO Box 144575, Salt Lake City, UT 84114-4575 Office: 385 468-4150 Office Fax: 385 468-4109
San Juan Health Department	***Southeast Health Department***
196 East Center Blanding, UT 84511 Office: 435 678-2723 Office Fax: 435 678-3309	28 South 100 East Price, UT 84501-3002 Office: 435 637-3671 Office Fax: 435 637-1933
Southwest Health Department	***Summit County Health Department***
620 South 400 East #400 St. George, UT 84770 Office: 435 986-2588	650 Round Valley Dr., Suite 100 Park City, UT 84060 Office: 435 333-1504

Office Fax: 435 628-6425	Office Fax: 435 333-1580
Tri-County Health Department	***Utah County Health Department***
133 South 500 East Vernal, UT 840787-2728 Office: 435 247- Office Fax: 435 781-0536	151 S University Ave. #1610 Provo, UT 84601 Office: 801 851-7050 Office Fax: 801 851-7055
Wasatch County Health Department	***Weber Morgan Health Department***
55 South 500 West Heber City, UT 84032-1918 Office: 435 657-3257 Office Fax: 435 654-2705	477 23rd Street Ogden, UT 84401-1507 Office: 801 399-7235 Office Fax: 801 399-7256
Tooele County Health Department	
151 North Main Street Tooele, UT 84074-2141 Office: 435 277-2303	

8 Definitions

Definitions of terms used in multiple Medicaid programs can be found in Section I: General Information, Chapter 1-9, Definitions and Utah Administrative Code R414-1. Utah Medicaid Program. Definitions particular to the EPSDT program are found in Utah Administrative Code R414-71. Early and Periodic Screening, Diagnostic, and Treatment Program. Section 2. Definitions.

EPSDT member is an enrolled Medicaid member, including infants, children, and adolescents, under the age of 21.

EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

Responsible caregiver is defined as a person over 18 who is acting at the bequest or employment of a parent, guardian, durable power of attorney or legal next of kin of the minor child or dependent adult and who could be expected to provide adequate safety and supervision

Primary Care Provider (PCP) includes doctors, nurse practitioners, and physician assistants. They often maintain long-term relationships with members and advise and treat a range of health-related issues. They may also coordinate a member's care with specialists.

Qualified Healthcare Professional (QHP) is an individual who is qualified by education, training, and licensure who performs a professional service within their scope of practice and independently reports that professional service.

8-1 Abbreviations/initializations

AAP - American Academy of Pediatrics
AAPD - American Academy of Pediatric Dentistry
ACMG - American College of Medical Genetics and Genomics
ADL - Activities of Daily Living
ASCO - American Society of Clinical Oncology
ASD - Autism Spectrum Disorder
ASRM - American Society of Reproductive Medicine
BMI - Body Mass Index
BWEIP - Baby Watch Early Intervention Program
CDC - Centers for Disease Control and Prevention
CPT - Current Procedural Terminology
CSHCN - Children with Special Health Care Needs Program
DHHS - Department of Health and Human Services
DIH - Division of Integrated Healthcare
DMEPOS - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DNA - deoxyribonucleic acid
EHDI - Early Hearing Detection and Intervention Program
EPSDT - Early and Periodic Screening, Diagnostic and Treatment
FFS – Fee For Service
FQHC - Federally Qualified Health Centers
HCPCS - Healthcare Common Procedural Coding System
HOME - Healthy Outcomes Medical Excellence Program
IADL - instrumental Activities of Daily Living
ICF/IF - Intermediate Care Facility for persons with Intellectual Disability
IDEA - Individuals with Disabilities Act
IEP -Individualized Education Plan
LHD - Local Health Department
MCE - Managed Care Entities
MRI - Magnetic Resonance Imaging

NCHS - National Center for Health Statistics
NEMT - Non-Emergency Medical Transportation
NGS - Next Generation Sequencing
NICU - Neonatal Intensive Care Unit
NIDA - National Institute on Drug Abuse
OT - Occupational Therapy
PA - Prior Authorization
PCP - Primary Care Providers
PCS - Personal Care Services
PDN - Private Duty Nursing
PMHP - Prepaid Mental Health Plans
PT - Physical Therapy
QHP - Qualified Healthcare Professional
RHC - Rural Health Clinics
SPL - Speech-language Pathology
SUD - Substance Use Disorder
UTA - Utah Transit Authority
VFC - Vaccines for Children Program
WES - Whole Exome Sequencing
WGS - Whole Genome Sequencing
WIC - Women, Infants and Children Program

9 Resources

For information regarding:	
Administrative Rules	• Utah Administrative Code Table of Contents • Dental, Oral and Maxillofacial Surgeons and Orthodontia. R414-49. • Medicaid Policy for Experimental, Investigational or Unproven Medical Practices. R414-1A. • Transplant Services Standards. R414-10A. • Eligibility Requirements. R414-302. • Medicaid General Provisions. R414-301. • Program Benefits and Date of Eligibility. R414-306.

	• Utah Medicaid Program. R414-1
General information including: • Billing • Fee for service and managed care • Member eligibility • Prior authorization	• Section I: General Information • Claims • Managed Care: Accountable Care Organizations • Utah Medicaid Prior Authorization webpage • Patient (Member) Eligibility Lookup Tool
Additional information including: • Anesthesia fee resources • Coverage and reimbursement resources • Procedure codes with accompanying criteria and limitations • National correct coding initiative	• Coverage and Reimbursement webpage • PRISM Coverage and Reimbursement Code Lookup • The National Correct Coding Initiative in Medicaid
State Policy and Rule updates	• Utah Medicaid Official Publications • Utah Medicaid Provider Manuals • Medicaid Information Bulletins (MIB) ○ published Special Interim MIBs • Utah State Bulletin
Provider resources	• Healthcare Providers webpage • Utah Medicaid Provider Manuals • Medicaid Information Bulletins • PRISM Portal Access • Patient (Member) Eligibility Lookup Tool • Utah Medicaid Prior Authorization • Utah Medicaid Provider Training
Other helpful information	• Bright Futures • Periodicity Schedule • Immunization Schedule for Children and Adolescents • Targeted Case Management-Early Childhood (ages 0-4) Manual • Baby Your Baby • CDC Vaccines for Children Program. • Women, Infants and Children (WIC) • Utah Lead Coalition

Federal government resources	• Social Security Act, section 1905 (a) • Code of Federal Regulations ○ Title 42. Chapter IV. Subchapter C. Part 441. Subpart B. • Medicaid.gov

Utah Medicaid Provider Manual

Home and Community Based Services Waiver for Individuals with an Acquired Brain Injury

Division of Integrated Healthcare

Updated July 2020

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1 General policy

1. Under Section 1915(c) of the Social Security Act, a state may request approval through the federal Centers for Medicare and Medicaid Services (CMS) to “waive” certain statutory requirements in order to use Medicaid funds for an array of home and community-based services (HCBS) provided to eligible recipients as an alternative to institutional care. The State of Utah has provided Medicaid-reimbursed home and community-based waiver services to individuals with an acquired brain injury since October 1, 1995. The Division of Integrated Healthcare (DIH) received approval from CMS through a waiver renewal process to continue operating the Home and Community-Based Services Waiver for Individuals with an Acquired Brain Injury (ABI waiver) through June 30, 2019. The approval includes:

   a) The waiver of comparability requirements in subsection 1902(a)(10)(B) of the Social Security Act. In contrast to Medicaid State Plan service requirements, under a waiver of comparability, the state is permitted to provide covered waiver services to a limited number of eligible individuals who meet the level of care criteria for Medicaid reimbursement in a nursing facility (NF).

      Waiver services need not be comparable in amount, duration or scope to services covered under the State Plan. However, each year the state must demonstrate that the waiver is a cost-effective or a “cost-neutral” alternative to institutional NF services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded NF services.

   b) The waiver of institutional deeming requirements in section 1902(a)(10)(C)(I)(III) of the Social Security Act. Under the waiver of institutional deeming requirements, the state uses more liberal

eligibility income and resource calculations when determining recipients' Medicaid eligibility.

2. The State Medicaid Agency (SMA) has ultimate administrative oversight and responsibility for the ABI waiver program. The day to day operations have been delegated to the Department of Human Services (DHS), Division of Services for People with Disabilities (DSPD), through an interagency agreement with the SMA. This agreement and the State Implementation Plan (SIP) describe the responsibilities that have been delegated to DSPD as the Operating Agency (OA) for the waiver program.

1-1 Acronyms and definitions

For purposes of the ABI waiver, the following acronyms and definitions apply:

ABI	Acquired brain injury
CBIA	Comprehensive brain injury assessment
CMS	Centers for Medicare and Medicaid Services
DHS	Department of Human Services
DIH	Division of Integrated Healthcare
DHHS	Department of Health and Human Services
DSPD	Division of Services for People with Disabilities
HCBS	Home and Community-Based Services
MAR	Maximum allowable rate
NF	Nursing facility
NOA	Notice of action
OA	Operating agency
PCSP	Person centered support plan
PHI	Personal and Protected Health Information
PII	Personal Identifiable Information
RAS	Request for additional services
RFP	Request for proposal
SIP	State Implementation Plan
SMA	State Medicaid Agency

1-2 CMS approved State Implementation Plan

1. The CMS approved SIP for the ABI waiver serves as the state's authority to provide HCBS to the target group under its Medicaid plan. The SIP and all attachments constitute the terms and conditions of the program.
2. This manual does not contain the full scope of the SIP. To understand the full scope and requirements of the ABI Waiver, providers should refer to the SIP. In the event provisions of this manual are found to be in conflict with the SIP, the SIP will take precedent.

2 Service availability

Home and community-based waiver services are covered benefits only when provided to an individual:

1. With an acquired brain injury who has established eligibility for state matching funds through DHS in accordance with UCA 62A-5;
2. Who has been determined to meet the eligibility criteria defined in the current CMS approved ABI Waiver SIP pursuant to a written Person Centered Support Plan (PCSP); and
3. Pursuant to a written Person Centered Support Plan (PCSP).

2-1 Eligibility for ABI waiver services

1. Home and community-based waiver services are covered benefits only for a limited number of eligible Medicaid recipients who require the level of care provided in a NF, or the equivalent care provided through the ABI waiver. In determining whether the applicant has mental or physical conditions that meet this level of care requirement, the individual responsible for assessing level of care shall document that the applicant meets the criteria as established in Utah Administrative Rule 414-502-3.
2. The individual responsible for the assessment will also document that the applicant meets the following additional targeting criteria:
   a) 18 years of age or older;
   b) Diagnosed with an ABI defined as being injury related and neurological in nature which may include cerebral vascular accident and brain injuries that have occurred after birth;

c) As a result of the ABI, received a qualifying International Classification of Diseases code diagnosis from the most recent revision of the classification, clinical modification, as outlined in Division Directive 1.40 - Qualifying Acquired Brain Injury Diagnoses; and
d) Obtained an eligible score on the Comprehensive Brain Injury Assessment (CBIA) as outlined in Utah Administrative Rule 539-1-8(1)(c).

3. The ABI waiver cannot serve individuals:
   a) Whose functional limitations are due solely to mental illness, substance abuse, personality disorder, hearing impairment, visual impairment, learning disabilities, behavior disorders, aging process, or individuals with deteriorating diseases such as multiple sclerosis, muscular dystrophy, Huntington's chorea, ataxia, or cancer;
   b) Who have suffered congenital brain injury or brain injuries induced by birth trauma; and/or
   c) Who have been diagnosed with an intellectual disability.
4. If a person is eligible for more than one of the waivers operated by DSPD, the Division will educate the individual about their choices and will advise the individual about which of the waivers will likely best meet their needs.
5. An individual will not be enrolled if it is determined during the eligibility assessment process that the health, welfare, and safety of the individual cannot be maintained through the ABI waiver.
6. Inpatients of hospitals, NFs, or intermediate care facilities for people with intellectual disabilities are not eligible to receive waiver services (except as specifically permitted for support coordination discharge planning in the 90-day period prior to their discharge to the ABI waiver). The term intermediate care facilities for people with intellectual disabilities, which is used in this document, is equivalent to intermediate care facilities for persons with mental retardation (ICFs/MR) under federal law.

2-2 Applicant freedom of choice of NF or waiver

1. When an individual is determined eligible for ABI waiver services, the individual and the individual's legal representative if applicable will be offered the choice

of NF or home and community-based care.

2. A copy of the DSPD publication AN INTRODUCTORY GUIDE—Division of Services for People with Disabilities (Guide), which describes the array of services and supports available in Utah through both NFs and the Home and Community Based Services (HCBS) waiver programs, is given to each individual applying for waiver services.
    a) Choice of waiver services will only be offered if:
        i. The individual's needs assessment indicates the services the individual requires, including waiver services, are available in the community;
        ii. The PCSP has been agreed to by all parties; and
        iii. The health and safety of the individual can be adequately protected in relation to the delivery of waiver services and support.

3. Once the individual has received a copy of the guide, chosen home and community-based waiver services and the choice has been documented by the support coordinator in USTEPS, subsequent review of choice of program will only be required at the time a substantial change in the enrollee's condition results in a change in the PCSP. It is, however, the individual's option to choose NF care at any time during the period they are enrolled in a waiver program.

2-3 Waiver participant freedom of choice

1. Upon enrollment in the ABI waiver, the ABI waiver enrollee, and the individual's legal guardian if applicable, will be given the opportunity to choose the providers of ABI waiver services identified on the PCSP if more than one qualified provider is available to render the services. The individual's choice of providers will be documented in the individual's PCSP.
2. The ABI waiver support coordination agency will review the contents of the written PCSP with the participant prior to implementation. If the participant is not given the choice of HCBS as an alternative to NF care, is denied the ABI waiver service(s) of their choice, or is denied the waiver provider(s) of

their choice, the agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, Subpart E.

3. Subsequent revision of the participant's PCSP as a result of annual re-assessment or significant change in the participant's health, welfare, or safety requires proper notice to the participant as described in item B above.

2-4 Termination of home and community-based waiver services

1. When the need arises, participants are separated from the HCBS waiver program through a disenrollment process.

    a) The disenrollment process is a coordinated effort between DIH and DSPD that is expected to facilitate the following:

        i. Appropriate disenrollment and movement among waiver programs when applicable;

        ii. Effective utilization of waiver program potential;

        iii. Effective discharge and transition planning;

        iv. Provision of information, affording participants the opportunity to exercise all applicable waiver rights; and

        v. Program quality assurance/quality improvement measures.

2. All of the various circumstances for which it is permissible for DSPD to disenroll an individual from the waiver program can be grouped into three distinct disenrollment categories.

    a) <u>Voluntary disenrollments</u> are cases in which participants, or their legal representatives when applicable, choose to initiate disenrollment from the waiver. Disenrollments are also considered voluntary when the waiver participant enters a skilled nursing facility for a stay of less than

90 days and chooses not to transition back to the original waiver program. This includes cases in which the participant transitions to another waiver program from the skilled nursing facility.

Voluntary disenrollments require support coordinators to notify their DSPD program manager. DSPD, either through the program manager or other authorized designee, will in turn send written notification to DIH within 10 days from the date of disenrollment. No DIH prior review or approval of the decision to disenroll is required. Documentation will be maintained by DSPD and should include a written statement signed by the participant or their legal representative when applicable detailing their intent to disenroll from the ABI waiver program as well as discharge planning activities completed by the support coordinator with the waiver participant as part of the disenrollment process.

b) Pre-approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from the waiver for any of the following reasons including:

i. Death of the participant;

ii. Participant is determined ineligible for Medicaid services by the Department of Workforce Services as a result of no longer meeting the financial requirements for Medicaid eligibility; or

iii. Participant enters a skilled nursing facility for a stay of more than 90 days.

Pre-approved involuntary disenrollments require support coordinators to notify their DSPD program manager. DSPD, either through the program manager or other authorized designee, will in turn send written notification to DIH within 10 days from the date of disenrollment. No DIH prior review or approval of the decision to disenroll is required as the

reasons for pre-approved involuntary disenrollment have already been approved by the SMA. Documentation will be maintained by DSPD, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process when appropriate.

c) Special circumstance disenrollments are cases in which participants are disenrolled from the waiver for reasons that are non-routine in nature. These cases require prior review and approval by DIH and involve circumstances that are specific to the participant involved. Examples of this type of disenrollment include:

   i. Participant no longer meets the institutional NF level of care requirements for the waiver;

   ii. Participant's health and safety needs cannot be met by the waiver program's services and supports;

   iii. Participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a PCSP that meets minimal safety standards;

   iv. Participant has demonstrated non-compliance with a signed participant agreement with DSPD;

   v. Participant, or their legal representative when applicable, requests a transfer of the participant from the ABI waiver directly to another waiver program when a stay at a nursing facility has not been involved; and/or

   vi. Participant's whereabouts are unknown for more than 30 days and participant has not yet been determined ineligible for Medicaid services by the Department of Workforce Services.

The special circumstance disenrollment review process will consist of the

following activities:

a) The support coordinator shall compile information to articulate the disenrollment rationale.

b) Support coordinator will then submit disenrollment rationale information to their DSPD program manager for a review of the documentation of support coordination activities and of the disenrollment recommendation.

c) If DSPD management staff concurs with the recommendation, a request for disenrollment approval will be forwarded to DIH for a final decision.

d) DIH will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources, have been fully utilized to meet the participant's health and safety needs.

e) DIH may facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.

f) A DIH final disenrollment decision will be communicated in writing to both the support coordinator and the state-level program management staff.

If the special circumstance disenrollment request is approved by DIH, the support coordinator will provide the participant, or their legal representative when applicable, with the required written notice of action (NOA) and right to fair hearing information.

The support coordinator will initiate discharge planning activities sufficient to assure a smooth transition to an alternate Medicaid

program and/or to other services. Discharge planning activities shall be documented in the individual's case record.

2-5 Fair hearings

1. An individual and the individual's legal representative will receive a written NOA form 522, and hearing request form 490S, from the waiver support coordinator if the individual is:

   a) Denied a choice of institutional or waiver program,
   b) Found ineligible for the waiver program,
   c) Denied access to the provider of choice for a covered waiver service, or
   d) Experiences a denial, reduction, suspension, or termination in waiver services in accordance with R539-2-5.

2. The NOA delineates the individual's right to appeal the decision through an informal hearing process at DHS or an administrative hearing process at the Department of Health and Human Services (DHHS), or both. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions.
3. An aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. DIH may reinstate services for participants or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than ten (10) calendar days after the date of action.
4. Appeals related to establishing eligibility for state matching funds through DSPD/DHS in accordance with UCA 62A-5 will be addressed through the DHS hearing process. Decisions made through DHS may be appealed to DHHS strictly for procedural review. Appealed decisions demonstrating that DHHS followed the fair hearing process will be upheld by the DHHS as the final decision.
5. Documentation of notices and the opportunity to request a fair hearing is kept in the individual's case record/file and at DSPD - State Office.

6. Informal dispute resolution
   a) DSPD has an informal dispute resolution process. This process is designed to respond to a participant's concerns without unnecessary formality. The

dispute resolution process is not intended to limit a participant's access to formal hearing procedures; the participant may file a request for hearing any time in the first 30 days after receiving an NOA. Examples of the types of disputes include but are not limited to concerns with a provider of waiver services, concerns with provider personnel, etc.

b) Attempts to resolve disputes are completed as expeditiously as possible. No specific timelines have been identified as some issues may be resolved very rapidly while other more complex issues may take a greater period of time to resolve.

3 Provider participation

3-1 Provider enrollment

1. Home and community-based waiver services for participants with an ABI are covered benefits only when delivered by qualified providers that are enrolled with the SMA to provide the services as part of the ABI waiver. In addition to this Medicaid provider agreement, all providers of ABI waiver services must also have a current contract with DHS/DSPD.
2. The SMA will enter into a provider agreement with all willing providers who are selected by participants and meet licensure, certification, competency requirements and all other provider qualifications as defined in the ABI waiver SIP.
3. DHS in conjunction with the Bureau of Contract Management will issue solicitations to possible providers of waiver services through a request for proposal (RFP). All solicitations for each RFP are posted through the BidSync.com website. To submit an RFP, a provider must register with BidSync.com and can do so free of charge. RFPs always remain open, allowing for continuous recruitment. A review committee evaluates the proposals against the criteria contained in the RFP and selects those who meet the qualifications.

3-2 Provider reimbursement

1. Providers will be reimbursed according to the specified reimbursement rate(s) contained in the negotiated contract with DSPD.

2. Providers have the option to allow DHS/DSPD to bill Medicaid on its behalf for covered Medicaid services, or providers have the option to bill Medicaid directly through the Utah PRISM system. Providers may only claim Medicaid reimbursement for services that are authorized on the approved PCSP. Claims must be consistent with the amount, frequency, and duration authorized by and documented on the PCSP.

3-3 Standards of service

Providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, the terms and conditions of the ABI waiver SIP and the terms and conditions contained in the DSPD contract.

3-4 Data security and privacy

Providers are expected to take steps to ensure that all personal information related to the individual being served is protected. This includes both Personal Health Information (PHI) as well as Personally Identifiable Information (PII). Providers should use appropriate administrative, technical and physical safeguards to preserve the integrity, confidentiality, and availability of PHI/PII that they create, receive, maintain or transmit.

This includes using encrypted/secure email, fax, or other HIPAA compliant methods to transmit documents containing information about the individual being served. Providers shall ensure there is limited and controlled access to PHI/PII. In the performance of its services and operations, the provider shall make efforts to use, disclose and request only the minimum amount of PHI/PII considered reasonably necessary.

The provider shall also identify and protect against reasonably anticipated threats to the security or integrity of the information, protect against reasonably anticipated, impermissible uses or disclosures; and ensure compliance by their workforce.

3-5 Breach reporting/data loss

Providers must report to DSPD and DIH, either by email or telephone, any breach or loss of PHI/PII. This report should be completed not more than 24 hours after the provider knows or should have reasonably known about the breach. The provider must also submit a report in writing/by email to DSPD within 5 business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

3-6 Provider rights to a fair hearing

1. The DHHS offers hearing rights to providers who have experienced any adverse action taken by DHHS/DIH, or by the OA. Providers must submit a written request for a hearing to DHHS in order to access the hearing process. Please refer to the DHHS/DIH provider manual, General Information, Section 1, Chapter 6-15, Administrative review/fair hearing.
2. Adverse actions that providers may appeal include:
    a) Actions relating to enrollment as an ABI waiver provider,
    b) Contract reimbursement rates,
    c) Sanctions or other adverse actions related to provider performance, or
    d) Improper conduct by DSPD in performing delegated ABI waiver responsibilities.

3-7 Electronic visit verification

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, are effective for Utah Medicaid beginning July 1, 2019. EVV requirements apply to all personal care services and home health care services provided under a 1915 (c) Home and Community-Based Waiver.

Choice of reporting systems for EVV are by provider preference, but must meet all federal requirements, including the standards set in the Health Insurance Portability Accountability Act. The State will not implement a mandatory model for use. All provider choice EVV systems must be compliant with requirements of the Cures Act including:

1. type of service performed;

2. individual receiving the service;
3. date of the service;
4. location of service delivery;
5. individual providing the service;
6. time the service begins and ends; and
7. the date of creation of the electronic record.

Additional information including technical specifications for file creation/submission and EVV resources can be found at https://medicaid.utah.gov/evv

4 Support coordination

4-1 Support coordinator qualifications

Qualified support coordinators shall possess at least a bachelor's degree in nursing, behavioral science or a human services related field such as social work, sociology, special education, rehabilitation counseling, or psychology and demonstrate competency relating to the planning and delivery of health services to the ABI population through a successful completion of a training program approved by the SMA.

4-2 Support coordination and the PCSP

1. The PCSP is the mechanism through which all necessary ABI waiver services (as determined during the initial and ongoing comprehensive needs assessment process) are detailed in terms of the amount, frequency, and duration of the intervention to be provided to meet identified objectives.
2. The amount, frequency and duration of each service listed within the PCSP is intended to provide a budget estimate of the services required to meet the assessed needs of each participant over the course of a plan year. Utah Medicaid recognizes that a participant's needs may change periodically due to temporary or permanent conditions which may require changes to the annual PCSP budget.
3. The support coordinator is responsible to monitor service utilization for each participant under their care. When the support coordinator determines that a participant may require an increase in services, a request for additional services

(RAS) must be submitted to DSPD for approval.

4. The annual PCSP budget is the sum of all approved services within the PCSP including additional services authorized through an approved RAS that are added to the PSCP over the entire plan year. In this way, Utah Medicaid applies an annualized aggregate to the PCSP budget.
5. Services may not exceed the amount allotted through the annual PCSP budget. Billing in excess of the annual PCSP budget will be subject to a recovery of funds.

4-3 Support coordination encounters

While quarterly face to face visits is the standard, the support coordinator has the discretion to conduct face to face visits with the client more frequently than quarterly. In all cases, frequency will be dependent on the assessed needs of the client and will not exceed 90 days without a face to face visit.

Support coordinators will visit individuals receiving residential supports no less than once every 30 days or at a rate directed by the DSPD program manager. Such visits shall occur in the person's place of residence at least once every 60 days. However, no more than two of these visits during each plan year may occur at other naturally occurring settings within the participant's community provided that the support being offered to the participant during those visits shall be rendered by staff of the residential care provider.

This approach promotes support coordinators having specific information about their expected roles and responsibilities on an individualized waiver participant basis. Program performance reviews assess the accuracy and effectiveness of the link between the determination of need, the PCSP, the implementation of support coordination services and the ongoing evaluation of progress toward the stated objectives.

4-4 Assessment instrument

The CBIA serves as the standard comprehensive assessment instrument for the ABI waiver.

5 Self-directed employee model

1. Self-Administered Services (SAS) are made available to all waiver enrollees who elect to participate in this method. Under SAS, individuals and/or their chosen representatives hire individual employees to perform ABI waiver service(s). The individual and/or their chosen representative are then responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheets, etc., of the individual's employee(s). Individuals and/or their chosen representatives may avail themselves of the assistance offered them within the consumer preparation service should they request and/or be assessed as requiring additional support and assistance in carrying out these responsibilities.
2. Financial management services are offered in support of the SAS option. A financial management services provider (fiscal agent) facilitates the employment of individuals by the ABI waiver participant or designated representative including: (a) provider qualification verification, (b) employer-related activities including federal, state and local tax withholding/payments, fiscal accounting and expenditure reports and (c) Medicaid claims processing and reimbursement distribution.
3. The ABI waiver participant remains the employer of record, retaining control over the hiring, training, management and supervision of employees who provide direct care services.
4. Under the SAS method, the waiver participant submits their staff time sheet(s) to the fiscal agent. The fiscal agent pays the claim(s) and submits a bill to DHS/DSPD on Form 520. DHS/DSPD pays the fiscal agent then submits the billing claim(s) to DHHS for reimbursement. All payments are made through the fiscal agent under contract with DSPD. Payments are not issued to the waiver participant, but to and in the name of the employee hired by the person or their representative.

6 Waiver covered services rate setting methodology

1. DHS has entered into an administrative agreement with DHHS/DIH to set 1915c HCBS waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915c HCBS ABI waiver

program and other applicable Medicaid rules. There are four principal methods used in setting the DHS Maximum Allowable Rate (MAR) level. Each method is designed to determine a fair market rate. The four principle methods are:

a) existing market survey or cost survey of current providers
b) component cost analysis
c) comparative analysis
d) community price survey

2. The Support coordination covered waiver service provider rate is calculated using the cost survey of current providers' methodology in general but includes an added procedure in which each fiscal year the SMA establishes specific cost center parameters to be used in calculating the annual MAR.
3. Annual MAR schedules may be held constant or modified with a cost of living adjustment for any or all of the waiver covered services in lieu of completing one of the four principle methods depending on the budget allocation approved by the Utah State Legislature for the applicable fiscal year.
4. The SMA will maintain records of changes to the MAR authorized for each waiver covered service to document the rate setting methodology used to establish the MAR.

7 Service procedure codes

The procedure codes listed below are covered by Medicaid under the ABI waiver.

WAIVER SERVICE	CODE	UNIT OF SERVICE
Behavioral consultation service I	H0004	15 minute
Behavioral consultation service II	H0023	15 minute
Behavioral consultation service III	H2019	15 minute
Chore services	S5120	15 minute
Companion services	S5135	15 minute
Companion services - daily	S5136	Per day
Consumer preparation services	T1027	15 minute
Day supports (site/non-site)	T2021	15 minute
Day supports (site/non-site) - daily	T2020	Per day

Environmental adaptations (home)	S5165	Per episode
Environmental adaptations (vehicle)	T2039	Per episode
Extended living supports	H2021	15 minute
Financial management services	T2040	Per month
Homemaker services	S5130	15 minute
Living start-up costs	T2038	Per episode
Personal assistance	S5125	15 minute
Personal assistance - daily	S5126	Daily
Personal budget assistance	H0038	15 minute
Personal budget assistance - daily	H2014	Per day
Personal emergency response systems	S5160	Per episode
Personal emergency response systems (monthly)/Medication dispenser	S5161	Per month
Personal emergency response systems	S5162	Per episode
Professional medication monitoring I (LPN)	H0034	Per episode
Professional medication monitoring II (RN)	H2010	Per episode
Residential habilitation - facility based	T2031	Per day
Residential habilitation - facility based -	T2016	Per day
Residential habilitation - host home	S5140	Per day
Respite care, unskilled (routine and	S5150	15 minute
Respite care (routine, intensive, group) -	S5151	Per day
Respite care, out of home (intensive/group-	H0045	Per day
Respite care, weekly	T2036	Per week
Specialized medical equipment, monthly fee	T2028	Per month
Specialized medical equipment, purchase	T2029	Each
Supported employment	T2018	Per day
Supported employment - daily	T2019	15 minute
Supported living	T2017	15 minute
Transportation, non-medical, per mile	S0215	Per mile
Transportation, non-medical, per day	T2002	Per day
Transportation, non-medical, UTA	T2003	Per one way trip
Transportation, non-medical, multi-pass	T2004	Per month

Waiver support coordination	T2022	Per month

8 Incident reporting protocol

8-1 Purpose

The State Medicaid Agency (SMA) has the administrative authority over all 1915(c) Medicaid Home and Community-Based Services (HCBS) Waivers (waivers). Waiver programs must provide adequate and appropriate services that safeguard the health and welfare of all enrolled participants. Waiver programs must also assure financial accountability for funds expended for HCBS services. While these responsibilities are delegated to the Operating Agencies (OA), the SMA retains final authority and has the final responsibility to: 1) assure that appropriate actions have taken place when a critical incident or event occurs; and 2) in cases where appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard participants.

The critical incidents and events program is a collaborative effort between the OAs for each of the 1915(c) waivers and the SMA. The program has two levels. Level one describes the critical incidents/events that are required to be reported by the OA to the SMA for investigation, resolution and closure. Level two describes the critical incidents/events that are required to be reported to the OA for investigation, resolution and closure.

This Standard operating procedure stipulates:

1. Level one incidents and events required to be reported to the SMA;
2. Level two incidents and events that are required to be reported to the OA;
3. The agency is responsible for completing the review; and
4. Associated reporting requirements.

8-2 Reportable critical incidents/events

<u>Level One Incidents and Events – Reportable to the SMA</u>

The following list of the incidents/events (incidents) must be reported by the OA to the SMA. This is not an all- inclusive list. Other incidents that rise to a comparable level must be reported to the SMA.

1. **Unexpected hospitalization**
   Admission to the hospital for medical treatment related to one or more of the following reasons:
   a) Injuries that result in the loss of physical or mental function;
      i. i.e., loss of limb, paralysis, brain injury or memory loss
   b) Alleged/substantiated abuse or neglect;
   c) Attempted suicide;
   d) Medication errors;
   e) Self-Injurious behavior;
   f) Serious burns; and/or
   g) Substance abuse.
2. **Exploitation** (either alleged or substantiated)
   Unfairly taking advantage of a participant due to his/her age, health, and/or disability including:
   a) Serious and/or patterned/repeated event(s)- involving a single participant; or
   b) Involving multiple participants.
3. **Human rights violations**
   a) Serious infringements of participant human rights (jeopardizing the health and safety of the participant);
   b) Exceptions:
      i. Restrictive/intrusive intervention(s) clearly defined in individualized behavior support plans and/or care plan/person centered support plans pursuant to 42 CFR §441.301(c)(4)(5); and
      ii. Emergency behavioral interventions as defined by Utah Administrative Code, Title R539-4-6.
4. **Incidents involving the media or referred by elected officials**
   Incidents that have or are anticipated to receive public attention (i.e., events covered in the media or referred by the Governor, legislators, or other elected officials).
5. **Missing persons**

For reporting purposes, the following participants are considered to be missing:

a) Participants who have been missing for at least 24 hours; or
b) Regardless of the number of hours missing – any participant who is missing under unexplained, involuntary or suspicious circumstances and is believed to be in danger because of age, health, mental or physical disability, environment or weather or who could be in the company of a potentially dangerous person or some other factor that places the participant in peril.

6. **Unexpected deaths**

   All deaths are considered unexpected with the exception of:

   a) Participants receiving hospice care; and/or
   b) Deaths due to natural causes, general system failure or terminal/chronic health conditions.

   A death related to an adverse event that occurs while the participant is receiving treatment in an in-patient facility, which is regulated by Health Facilities Licensing and Certification, should be reported as an unexpected death, the QA/SMA team may opt not to require an investigation. (Reportable to Health Facilities Licensing)

7. **Waste, fraud or abuse of Medicaid funds**

   Alleged or confirmed waste, fraud or abuse of Medicaid funds:

   a) Perpetrated by the provider; or
   b) Perpetrated by the participant.

8. **Law enforcement involvement**

   Charges filed against the participant for activities resulting in the:

   a) Hospitalization of another (i.e., aggravated assault);
   b) Death of another; and/or
   c) Abuse and or exploitation of a vulnerable person, due to age, health, and/or disability.

9. **Private Health Information (PHI)/Personal Identifiable Information (PII) Security Breach**

   Any activity that could potentially put sensitive information at risk of unauthorized use, access, disclosure, or modification.

Procedure for Reporting to the State Medicaid Agency:

1. On the first business day after a critical incident has occurred*, a representative from the OA will notify a member of the SMA Quality Assurance Team via email, telephone or in person. If the OA has any question about whether a case meets the criteria for reporting to the SMA, the OA will contact the SMA for technical assistance.
   * In some cases, it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.
2. Within ten business days after notification, the OA will submit a completed Critical Incident Investigation form to the SMA.
3. Within five business days after receiving the Critical Incident Investigation form the SMA will review the investigation form submitted by the OA and will contact the OA if additional information or action is required.
4. When the SMA determines the investigation is complete, the SMA will document any findings or corrective action requirements on the SMA portion of the investigation form. The SMA will send the OA a copy of the finalized document, closing the case. In some cases, the SMA may continue to monitor findings or corrective actions.
5. Within two weeks after closing the case, the SMA will notify the participant or the participant's representative of the investigation results. A copy of the notification letter will be provided to the OA. The following types of incidents are excluded from the notification letter requirement: suicide attempt, missing person, death and investigations that conclude with disenrollment and/or are not concluded within six months of the original incident date.

Level Two Incidents and Events - Reportable to the OA

The following incidents must be reported by providers, participants and/or their representatives to the OA, but are not required to be reported to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the OA.

1. **Unexpected medical treatment** (requiring immediate medical treatment at an emergency room)

Medical treatment related to one or more of the following reasons:

a) Abuse/neglect/exploitation (either alleged or substantiated);
b) Medication errors; and/or
c) Substance abuse.

2. **Abuse/neglect/exploitation** (either alleged or substantiated)
    a) Exploitation of a participant's funds or property;
    b) Theft and/or diverting of a participant's medication(s); and/or
    c) Sexual assault/abuse/exploitation (regardless of medical treatment).
3. **Human rights violations**

    Such as:
    a) Unauthorized use of restrictive interventions- including but not limited to restraints (physical, mechanical, or chemical);
    b) Misapplied restrictive interventions, (included in the BSP);
    c) Unauthorized use of seclusion;
    d) Unwelcome infringement of personal privacy rights; and/or
    e) Violations of individual rights to dignity and respect.
    f) Exceptions:
        i. Restrictive/intrusive intervention(s) clearly defined in individualized behavior support plans and/or care plan/person centered support plans pursuant to 42 CFR §441.301(c)(4)(5); and
        ii. Emergency behavioral interventions as defined by Utah Administrative Code, Title R539-4-6.

Operating Agencies are responsible to ensure providers are compliant with 42 CFR §441.301(c)(4)(5)

4. **Attempted suicides**

An attempted suicide which did not result in the participant being admitted to a hospital. (Suicide attempts do not include suicidal thoughts or threats without actions)

5. **Compromised working or living environment**

An event in which the participant's working or living environment (e.g., roof collapse, fire, etc.) is compromised and the participant(s) require(s) evacuation.

6. **Law enforcement involvement**
    a) Participant(s)
        i. Criminal charges filed (not including those reportable to the SMA)
    b) Staff

i. Criminal charges filed (make report to APS/CPS when necessary).
ii. When staff is issued a moving violation while transporting participant(s).

For this category, the date of the incident will be recorded as the date on which the filing of charges occurred.

7. **Unexpected hospitalization**

Admission to the hospital for medical treatment related to one or more of the following reasons:

a) Injuries
b) Aspiration
c) Choking

These do not include medical diagnoses that pose an expected risk for aspiration or choking. Also excluded from this category are self-injurious behavior or injuries resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a participant that resulted in admission to a hospital for medical treatment (which is reportable to the SMA).

Procedure for Reporting to the Operating Agency

1. On the first business day after a critical incident has occurred*, a representative from the case management or support coordination agency (case manager) will notify the OA via email, telephone or in person.
2. Within ten business days after notification, the case manager will submit a completed Critical Incident Investigation form to the OA.
3. Within five business days after receiving the Critical Incident Investigation form the OA will review the investigation form submitted by the case manager and will contact the case manager if additional information or action is required.
4. When the OA determines the investigation is complete, the OA will document any findings or corrective action requirements on the OA portion of the investigation form. The OA will send the case manager a copy of the finalized document, closing the case. In some cases, the OA may continue to monitor findings or corrective actions.

5. Within two weeks after closing the case, the case manager will notify the participant or the participant's representative (in person, phone or in writing) of the investigation results and document notification in the participant's record. The following types of incidents are excluded from the notification requirement: suicide attempt, death, and investigations that conclude with disenrollment and/or are not concluded within six months of the original incident date.

* In some cases, it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

8-3 Required reports

OA quarterly report

The OA will submit a waiver specific quarterly report to the SMA, no later than one month after the end of the quarter (October 31, January 31, April 30, July 31) that includes:

1. name of the participant
2. date of the incident
3. date the incident was reported to the OA
4. category of the incident: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
5. brief summary of the incident and its resolution
6. date the case was closed
7. brief description of any corrective action required of the case manager or other provider

OA annual report

The OA will submit a waiver specific annual report to the SMA, no later than two months after the end of the fiscal year (August 31) that includes:

1. total number of incidents

2. number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
3. number of incidents that resulted in corrective action by the case manager or other provider
4. number of corrective actions that were implemented
5. number of incidents where the participant/representative was informed of the investigation results, and the number of incidents where the contact was made within 14 days of the investigation closure
6. summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
    a) If trends were noted, the report will include a description of the process improvement steps that will be implemented

State Medicaid Agency annual report

For incidents that are reportable to the SMA, the SMA will submit an annual report to the State Medicaid Director and OA Division Directors that includes:

1. For each waiver:
    a) number of incidents
    b) number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
    c) number of incidents that resulted in corrective action by the OA, case manager or other provider
    d) number of corrective actions that were implemented

2. Summary of all waivers:
    a) number of incidents
    b) number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
    c) number of incidents that resulted in corrective action by the case manager or other provider
    d) number of corrective actions that were implemented

e) summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
    i. If trends were noted, the report will include a description of the process improvement steps that will be implemented

Utah Medicaid Provider Manual

Utah Home and Community Based Services Waiver for Individuals Age 65 or Older

Division of Integrated Healthcare

Updated April 2022

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1 General information

This manual is designed to be used in conjunction with the Utah Medicaid provider manual, Section I: General Information. This can be found on the Utah Medicaid website, https://medicaid.utah.gov/utah-medicaid-official-publications.

1-1 General policy

Under section 1915(c) of the Social Security Act (SSA), a state may request approval through the federal Centers for Medicare and Medicaid Services (CMS) to "waive" certain statutory requirements in order to use Medicaid funds for an array of home and community based medical and non-medical assistance services provided to eligible recipients as an alternative to institutional care. The State of Utah has offered the Medicaid reimbursed Home and Community-Based Services (HCBS) Waiver for Individuals Age 65 or Older since July 1, 1992. On July 1, 2015, the Division of Integrated Healthcare (DIH) received approval from CMS to continue operating the HCBS Waiver for Individuals Age 65 or Older (Aging Waiver) through June 30, 2025. The approval includes waivers of:

1. The "comparability" requirements in subsection 1902(a)(10)(B) of the Social Security Act; and

2. The institutional deeming requirements in subsection 1902(a)(10)(C)(i)(III) of the Social Security Act.

Waiver of comparability

In contrast to Medicaid State Plan service requirements, under a waiver of comparability, the state is permitted to provide covered waiver services to a limited number of eligible individuals who meet the state's criteria for Medicaid reimbursement in a nursing facility (NF). "Waiver services" need not be comparable in amount, duration, or scope to services covered under the State Plan. However, each year the state must demonstrate that the waiver is a "cost-effective" or a "cost-neutral" alternative to facility-based services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver participants, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same participants received Medicaid-funded NF services.

Waiver of institutional deeming requirements

Under the waiver of institutional deeming requirements, the state uses more liberal eligibility income and resource calculations when determining recipients' Medicaid eligibility.

1-2 Definitions and acronyms

For purposes of the Aging Waiver, the following definitions and acronyms apply:

AAA

Area Agency on Aging

Aging Waiver

Home and Community-Based Services Waiver for Individuals Aged 65 or Older

OLTSS

Office of Long Term Services and Supports

CMA

Case Management Agency

CMS

Centers for Medicare and Medicaid Services

DAAS

Division of Aging and Adult Services

DAAS designee

Authorized representative to act for the Division of Aging and Adult Services (currently this refers specifically to Area Agencies on Aging (AAAs) although DAAS may designate a different organization if any AAA chooses not to be a designee)

DHHS

Department of Health and Human Services

DIH
Division of Integrated Healthcare

FMS
Financial Management Services

HCBS
Home and Community-Based Services

HCPCS codes
Healthcare Common Procedure Coding System Codes

ICF/ID
Intermediate Care Facility for Individuals with Intellectual Disabilities

LOC
Level of Care

MAR
Maximum Allowable Rate

MDS-HC
Minimum Data Set for Home Care; the Aging Waiver assessment instrument used to determine level of care (LOC)

NF
Nursing Facility

NOD
Notice of Decision

PAS
Personal Attendant Service

PCCP
Person-Centered Care Plan

SAS Model
Self-Administered Services Model; a method of providing services in which the participant administers their own care, acting as the direct employer

SIP
State Implementation Plan

SMA
State Medicaid Agency

SSA
Social Security Act

TE modifier
Modifier code used when billing claims to specify the service was provided by a licensed practical nurse

TN modifier
Modifier code used when billing claims to specify a rural rate enhancement

UDOH
Utah Department of Health

1-3 CMS approved State Implementation Plan

The State Implementation Plan (SIP) for the Aging Waiver approved by CMS serves as the state's authority to provide home and community-based services to the target group under its Medicaid plan. That document and all attachments constitute the terms and conditions of the program.

This manual does not contain the full scope of the Aging Waiver SIP. To understand the full scope and requirements of the Aging Waiver program, the SIP should be

referenced. In the event provisions of this manual are found to be in conflict with the SIP, the SIP will take precedent.

2 Provider participation

Aging Waiver services cover benefits only when delivered by a provider enrolled with the State Medicaid Agency (SMA) and with the DAAS designee to provide the services as part of the waiver.

2-1 Provider enrollment

Any willing provider that meets the qualifications defined in the Aging Waiver SIP may enroll at any time to provide an Aging Waiver service by enrolling through the Utah Medicaid PRISM provider portal. Providers may enroll by submitting a provider enrollment application through the PRISM provider portal. The PRISM provider portal link is located on the Utah Medicaid website at: https://medicaid.utah.gov. Refer to provider manual, Section I: General Information, for detailed provider enrollment information. Any setting in which services were not being provided under an approved State Plan, waiver or demonstration as of March 1, 2014, must be in compliance with regulations for the HCBS Settings Rule by the effective date of the program (the time the state submits a claim for federal HCBS reimbursement).

2-2 Provider reimbursement

Providers must bill with the appropriate NPI or Medicaid provider number associated with the waiver and area.

Providers will be reimbursed according to the specified reimbursement rate(s) contained in the provider fee schedule.

Providers may only claim Medicaid reimbursement for services that are ordered by DAAS or their designee. Claims must be consistent with the amount, frequency and duration ordered by DAAS or their designee. Personal Attendant Services (PAS) participant-employed providers may only be reimbursed for their services out of state or out of country for up to two weeks when the participant and PAS provider

travel together. Only two visits per year are allowed. Additional visits need to be approved by the Division of Aging and Adult Services (DAAS).

AAA's may be held financially responsible for issuing a care plan or service authorization form to a provider that does not match the services, start and end date, correct service name as defined in the SIP and unit of service as defined in the current codes and rates sheet, number of units, frequency of service, HCPCS code and/or provider name listed on an individual's approved care plan.

2-3 Standards of service

Providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement and the terms and conditions of the Aging Waiver SIP. In addition, providers participating in the Aging Waiver must adhere to the following requirement covering interactions with DAAS or their designee responsible for the day to day administration of the program:

1. Submit to each applicable DAAS designee a monthly written summary report of claims submitted for Medicaid reimbursement. The summary report shall be submitted within 10 calendar days after the end of each month and shall detail for each waiver participant the specific waiver services provided, the units of service billed for each service, the dates of service and the reimbursement amount billed.

2-4 Data security and privacy

Providers are expected to take steps to ensure that all personal information related to the individual being served is protected. This includes both Personal Health Information (PHI) as well as Personally Identifiable Information (PII). Providers should use appropriate administrative, technical, and physical safeguards to preserve the integrity, confidentiality, and availability of PHI/PII that they create, receive, maintain or transmit. This includes using encrypted/secure email, fax, or other HIPAA-compliant methods to transmit documents containing information about the participant being served. Providers shall ensure there is limited and controlled access to PHI/PII. In the performance of its services and operations, the provider shall make efforts to use, disclose and request only the minimum amount of

PHI/PII considered reasonably necessary. The provider shall also identify and protect against reasonably anticipated threats to the security or integrity of the information, protect against reasonably anticipated, impermissible uses or disclosures, and ensure compliance by their workforce.

2-5 Breach reporting/data loss

Providers must report to DAAS and DIH, either by email or telephone, any breach or loss of PHI/PII. This report should be completed not more than 24 hours after the provider knows or should have reasonably known about the breach. The provider must also submit a report in writing by email to DAAS within 5 business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

2-6 Provider rights to a fair hearing

The Department provides hearing rights to providers who have had any adverse action taken by the Utah Department of Health and Human Services, DIH, DAAS, or their designee, and who submit a written request for a hearing to the agency. This includes actions of a DAAS designee relating to enrollment of waiver providers, free choice of available providers by waiver participants, reimbursement rates, sanctions, or other adverse actions related to provider performance or improper conduct of the agency in performing delegated waiver responsibilities.

A Request for Hearing/Agency Action Form (hearing request) is available on the Utah Medicaid website at: https://medicaid.utah.gov/utah-medicaid-forms. This form may also be requested from the Office of Administrative Hearings by calling (801) 538-6576. Hearing requests must be filed with the Office of Administrative Hearings within 30 calendar days from the date of the adverse action.

3 Participant eligibility and service availability

Aging Waiver services cover benefits only when provided to an individual determined to meet the eligibility criteria defined in the CMS approved Aging Waiver SIP and only pursuant to a written comprehensive care plan.

3-1 Eligibility for Aging Waiver services

Aging Waiver services are covered benefits for a limited number of Medicaid eligible participants for whom there is a reasonable indication that they might need the services provided in a Medicaid-certified NF in the near future, unless they receive home and community-based services. The cost of which would be reimbursed under the Medicaid State Plan.

A. Eligibility activities

DAAS or their designee is responsible at a minimum, for conducting the following activities:

Aging Waiver application activities (performed at the time a demographic intake and screening is conducted with the participant):

1. Respond to inquiries by an interested participant regarding the waiver program.
2. Determine whether the waiver has available capacity within the limit delineated in appendix B-3 (table b-3-a) of the SIP.
3. Provide education related to the services covered by the waiver.
4. Conduct an initial assessment if available capacity exists to determine if the participant meets LOC requirements, has an imminent need for the services provided in a NF, and meets all other program eligibility requirements described in Items 2 through 6 of the Aging Waiver SIP.
5. Assist the participant to complete the Medicaid financial eligibility determination process.
6. Assist the participant to request a fair hearing if an adverse agency action is taken in relation to the waiver application.

Freedom of choice activities (performed at the time a participant is determined to be eligible for the Aging Waiver):

1. Identify the general service needs of the participant.
2. Inform the participant of the services the waiver program can provide and the services a Medicaid NF can provide to meet the identified general needs.
3. Offer the participant choice of the waiver program or the Medicaid NF program and document the choice selected.

4. Assist the participant to request a fair hearing if choice of the waiver program is denied.

Enrollment activities (performed at the time it is determined sufficient Aging Waiver capacity is available to permit an individual to be enrolled into the waiver):

1. Conduct a comprehensive assessment (MDS-HC) to determine if the participant meets LOC requirements.
2. Develop an initial comprehensive care plan based on the needs identified by the comprehensive assessment.
3. Assist the participant in selecting a waiver case management agency (CMA).
4. At the intervals specified in the Aging Waiver SIP, conduct ongoing comprehensive assessments to determine if the participant continues to meet LOC requirements, has an imminent need for the services that would be provided in a NF, meets all other program eligibility requirements in the Aging Waiver SIP, and develop updated comprehensive care plans annually or based on need.
5. Assist the individual to request a fair hearing if choice of the waiver CMA is denied.

B. Mental or physical condition determination

In determining whether the applicant has mental or physical conditions that can only be cared for in a NF, or the equivalent care provided through the Aging Waiver, the licensed professional responsible for assessing LOC shall document that the applicant meets the criteria as established in Utah Administrative Code, Title R414-502-3, Utah Medicaid program.

C. Eligibility restrictions

An individual will not be enrolled if it is determined during the eligibility assessment process that the health, welfare, and safety of the individual cannot be met through the Aging Waiver program.

Inpatients of hospitals, NFs, or Intermediate Care Facilities for People with Intellectual Disabilities (ICFs/ID) are not eligible to receive waiver services (except as

specifically permitted for case management discharge planning in the 90-day period before their discharge to the Aging Waiver).

3-2 Applicant freedom of choice of NF or Aging Waiver

Medicaid recipients who meet the eligibility requirements of the Aging Waiver may choose to receive services in a NF or the Aging Waiver if available capacity exists to address health, welfare, and safety needs.

If no available capacity exists in the Aging Waiver, the applicant will be advised in writing that he or she may access services through a NF or may wait for open capacity in the Aging Waiver.

If available capacity exists in the Aging Waiver, a comprehensive assessment will be completed by DAAS or their designee. The applicant will be advised of the needs identified and given the opportunity to choose to receive services to meet the identified needs through a NF or the Aging Waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the applicant's record.

Once the applicant has chosen to enroll and become a participant in the Aging Waiver and the choice has been documented, subsequent review of choice of program will only be required at the time of a substantial change in the participant's condition resulting in a change in the comprehensive care plan. It is, however, an Aging Waiver participant's option to choose facility-based care at any time and voluntarily disenroll from the Aging Waiver.

3-3 Aging Waiver participant freedom of choice

Upon enrollment in the Aging Waiver, the individual now becomes a participant on the waiver. The participant will be given choice among available waiver case management agencies (CMAs). The participant's choice will be documented in the case record.

Upon completion of a comprehensive needs assessment by DAAS or their designee, the participant will be active in the development of the comprehensive care plan and the person-centered care plan (PCCP) to address the participant's identified needs.

The participant will be given a choice of services to meet an identified need if more than one cost-effective option exists.

The participant will be given a choice of available qualified providers of Aging Waiver services identified in the comprehensive care plan.

DAAS or their designee will review the contents of the written comprehensive care plan with the participant prior to implementation. The written comprehensive care plan is signed by the participant and constitutes a formal notice of the agency's decision regarding authorized services to be provided to the participant.

Subsequent revisions to the participant's comprehensive care plan may occur as a result of the annual reassessment, or a result of a significant change in the participant's health, welfare, or safety and as otherwise warranted.

A significant change is defined as a major change in the participant's status that:

1. Is not self-limiting;
2. Impacts more than one area of the participant's health and safety status; and
3. Inter-disciplinary review is required and/or revision of the comprehensive care plan.

Note: A condition is defined as self-limiting when the condition will normally resolve itself without intervention by Aging Waiver services. Generally, if the condition has not resolved within approximately two weeks, a comprehensive reassessment should begin.

A reassessment is required if significant change is consistently noted in two or more areas of decline, or two or more areas of improvement.

A LOC screening will also be conducted at the conclusion of an inpatient stay in a medical facility.

During the review of the written care plan, the participant will be informed in writing of any decision to deny, suspend, reduce, or terminate a waiver service listed in the service plan and will be informed of the right to a fair hearing.

3-4 Termination of Aging Waiver service

When the need arises, participants are separated from the Home and Community-Based waiver program through a disenrollment process.

The disenrollment process is a coordinated effort between DIH and DAAS that is expected to facilitate the following:

1. Verification that the disenrollment is appropriate for the waiver participant;
2. Movement among waiver programs (when applicable);
3. Ensuring effective utilization of waiver program services;
4. Effective discharge and transition planning;
5. Distribution of information to participants describing all applicable waiver rights; and
6. Program quality assurance.

All of the various circumstances for which it is permissible for participants to be disenrolled from the waiver program can be grouped into three distinct disenrollment categories.

A. Voluntary disenrollments are cases in which the participants, or their legal representative (when applicable), choose to initiate disenrollment from the waiver. Disenrollments are also considered voluntary when the waiver participant enters a skilled nursing facility for a stay of less than 90 days and chooses not to transition back to the original waiver program. This includes cases in which the participant transitions to another waiver program from the skilled nursing facility.

Voluntary disenrollments require that case managers notify DAAS within 10 days from the date of the disenrollment. No DIH prior review or approval of the decision to disenroll is required.

Additional documentation will be maintained by the case management agency that includes a written statement signed by the participant, or their legal representative (when applicable) describing their intent to disenroll from the waiver program. This documentation should also outline discharge planning activities completed by the case manager with the waiver participant as part of the disenrollment process.

B. Pre-approved involuntary disenrollments are cases in which the participants are involuntarily disenrolled from the waiver for any of the following reasons including:

1. Death of the participant;
2. Participant has been determined to no longer meet the financial requirements for the Medicaid program eligibility by the Department of Workforce Services;
3. Participant enters a skilled nursing facility, and the expected length of stay will exceed 90 days or longer (as verified by a physician) If the participant exceeds the 90 day stay, it needs DAAS approval;
4. Participant has moved out of state;
5. Participant's whereabouts are unknown for 30 days or more and all avenues to locate the participant have been exhausted; or
6. Participant has been incarcerated.

Pre-approved involuntary disenrollments require that case managers notify the DAAS program manager within 10 days from the date of disenrollment. No DIH prior review or approval of the decision to disenroll is required, as the reasons for pre-approved involuntary disenrollment have already been approved.

Documentation will be maintained by the case management agency, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process when appropriate.

C. Special circumstance disenrollments are cases in which participants are involuntarily disenrolled for reasons that are non-routine in nature and involve circumstances that are specific to the participant. These cases require prior review by DAAS and a second level approval by the Office of Long Term Services and Supports (BLTSS) quality assurance unit. Examples of this type of disenrollment include:

1. Participant no longer meets the level of care requirements for the waiver;
2. Participant's health and safety needs cannot be met by the waiver program's services and supports;

3. Participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a plan of care that meets minimal safety standards;
4. Participant has demonstrated non-compliance with a signed health and safety agreement with DAAS or their designee; or
5. Participant poses imminent danger to themselves or others.

The special circumstance disenrollment review process will consist of the following activities:

1. The AAA shall compile information to articulate the disenrollment rationale;
2. This information will then be submitted to DAAS for review of the case management activities, as well as the disenrollment recommendation;
3. If DAAS staff concurs with the recommendation, a request for disenrollment approval will be forwarded to the BLTSS quality assurance unit for a final decision;
4. The BLTSS quality assurance unit will review and assure that all State Plan, waiver, non-waiver and other available services/resources have been fully utilized to meet the participant's needs;
5. DAAS and/or the BLTSS quality assurance unit may facilitate meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment; and
6. The BLTSS quality assurance unit will communicate a final disenrollment decision to DAAS.

If the special circumstance disenrollment request is approved, DAAS or their designee will provide the participant, or their legal representative (when applicable), with the required written Notice of Decision (NOD) and right to fair hearing information.

The case management agency will initiate discharge planning activities sufficient to assure a smooth transition to an alternate Medicaid program and/or to other services. Discharge planning activities shall be documented in the participant's case record.

3-5 Fair hearing

The DIH provides a participant, applying for or receiving Aging Waiver services, an opportunity for a hearing upon written request, if the participant is:

1. Not given the choice between facility-based (NF) care and Aging Waiver services.
2. Denied the waiver provider(s) of choice if more than one provider is available to render the service(s).
3. Denied, reduced, suspended, or terminated access to waiver services.
4. Experiences a reduction, suspension or termination of waiver services identified as necessary to prevent facility placement.

An applicant, participant, or their legal representative when applicable, will receive a written NOD from DAAS or their designee if the participant is denied a choice between facility-based (NF) care and Aging Waiver services, found ineligible for the waiver program or denied access to the provider of choice for a covered waiver service. The NOD delineates the participant's right to appeal the decision.

An aggrieved participant may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The DIH may reinstate services for the participant or suspend any adverse action for providers if the aggrieved participant requests a formal hearing not more than ten calendar days after the date of action.

The participant is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request to the Department of Health and Human Services, DIH, for a formal hearing and determination.

An informal dispute resolution process does not alter the requirements of the formal fair hearings process. The participant must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the DIH. An informal dispute resolution must occur prior to the deadline for filing the

request for continuation of service and/or the request for formal hearing or be conducted concurrent with the formal hearing process.

A Request for Hearing/Agency Action Form (hearing request) is available on the Utah Medicaid website at: https://medicaid.utah.gov/utah-medicaid-forms. This form may also be requested from the Office of Administrative Hearings by calling (801) 538-6576.

4 Case management

Case management serves the purpose of maintaining the individual in the Home and Community-Based Services Waiver in accordance with the program requirements and the participant's assessed service needs and coordinating the delivery of quality waiver services.

4-1 Case management encounters

To better focus primary attention on providing the specific level of case management intervention needed on an individualized basis, as determined during the initial and ongoing comprehensive needs assessment process, the individual comprehensive care plan will be the vehicle through which the level of assessed need for case management will be detailed in terms of the amount, duration, and frequency of intervention to be provided. This approach will also promote case managers having specific information about their expected roles and responsibilities to an individualized waiver participant. Program performance reviews will assess the accuracy and effectiveness of the link between the determination of need, the comprehensive care plan and the implementation of case management services.

4-2 Plan of Care unit calculation

The comprehensive care plan is intended to be an estimate of the service units required to meet the assessed needs of each participant over the course of the plan of care year. The DIH recognizes that a participant's needs may change periodically due to temporary or permanent conditions which may require amendments to the participant's care plan.

DAAS is responsible to monitor service utilization for each recipient for whom DAAS or their designee created a comprehensive care plan. When DAAS or their designee determines that the assessed service needs of a participant exceed the amount that has been approved on that participant's existing plan of care, DAAS or their designee should submit an amendment/change to increase the number of units to meet the need. Amendments/changes must be made prior to the expiration of the plan of care.

The plan of care year is the sum of all approved units including amendments/changes over the entire year. In this way, Utah Medicaid applies an annualized aggregate of all plan of care units.

Providers may not exceed the units authorized on the approved care plan. Billing in excess of the approved number of units will be subject to recovery of funds by Utah Medicaid.

4-3 MDS-HC assessment instrument

The InterRAI Minimum Data Set – Home Care (MDS-HC) serves as the standard comprehensive assessment instrument used in the Aging Waiver. This instrument determines the needs of the participant. Registered nurses use this instrument when creating the comprehensive care plan.

4-4 Conflict free case management

Case management services are expected to be provided without conflict of interest. Provider entities having the capacity to perform case management functions and other waiver or non-waiver services must assure that the functions of the entity are clearly separated and their respective responsibilities well defined and must abide by the conflict free case management guidelines.

1. If the AAA is enrolled to provide other waiver services in addition to case management services or if they are an enrolled Medicare or Medicaid provider for other non-waiver services, they must pay careful attention to conflict of interest rules during the care plan development process. AAAs are not

permitted to be listed on a participant's care plan as a paid provider of any other waiver or non-waiver service except in the following circumstances:

a) Previous to February 1, 2019, if a participant was assessed to need goods and/or services through any of the following AW services the AAA may purchase the goods and/or service(s) from a non-Medicaid retailer or other entity and then receive direct Medicaid reimbursement through the usual and customary claims reimbursement process to pay the non-Medicaid retailer or other entity. For the following instances, it is permitted for the AAA to be listed on the care plan as a pass-through payment entity in order to ensure access to care:
   i. Chore services
   ii. Community living services
   iii. Environmental accessibility adaptations
   iv. Specialized medical equipment/supplies/assistive technology
   v. Supplemental meals

b) Effective February 1, 2019, the State Medicaid Agency implemented the use of a financial transaction services contractor to pay for goods and services purchased from retail stores, general contractors or other entities not directly enrolled as Medicaid providers. Beginning February 1, 2019, AAA's will not be permitted to act as a pass-through payment agent for the above listed services.

5 Participant-directed employer authority

The participant-directed employee authority (SAS model) requires the waiver participant to use a waiver Financial Management Services (FMS) provider as an integral component of the waiver service to assist with managing the employer-related financial responsibilities associated with the employer-employee relationship. The waiver FMS is a person or organization that assists waiver participants and their representatives, when applicable, in performing a number of employer-related tasks. The tasks performed by the waiver FMS include

documenting service provider's qualifications, collecting service provider time records, preparing payroll for participant's service providers and withholding, filing and depositing federal, state and local employment taxes.

PAS employees complete time sheets for work performed. The participant, or their legal representative when applicable, confirms the accuracy of the time sheet, signs it and forwards it to the waiver FMS for processing. The waiver FMS files a claim for reimbursement through the Medicaid MMIS (old) system, until superseded by the Provider Reimbursement and Information System for Medicaid (PRISM), and upon receipt of payment, forwards payment directly to the service provider for the services rendered.

6 Waiver covered services rate setting methodology

The Department of Human Services (DHS) has entered into an administrative agreement with the Department of Health and Human Services, DIH, to set 1915(c) HCBS Waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with the requirements under the 1915(c) HCBS Waiver program and other applicable Medicaid rules. There are four principle methods used in setting the DHS Maximum Allowable Rate (MAR). Each method is designed to determine a fair market rate. The four principle methods are:

1. Existing market survey or cost survey of current providers
2. Component cost analysis
3. Comparative analysis
4. Community price survey

The case management covered waiver service provider rate is calculated using the cost survey of current provider's methodology in general but includes an added procedure in which each fiscal year the SMA establishes specific cost center parameters to be used in calculating the annual MAR.

Annual MAR schedules may be held constant or modified with a Cost of Living Adjustment (COLA) for any or the entire waiver covered services in lieu of completing one of the four principle methods depending on the budget allocation approved by the Utah State Legislature for the applicable fiscal year.

7 Prior authorization of waiver services

No prior authorization of waiver covered services by the SMA is required. Provider participation and service delivery will be governed by waiver quality management systems for assuring proper development and implementation of plans of care, assuring waiver services are provided by qualified providers and assuring financial accountability for funds paid to providers for the waiver program.

8 Billing

Refer to the provider manual, Section I: General Information, for detailed billing instructions.

8-1 Time limit to submit claims

Providers are requested to submit claims within 90 days of the delivery of services; however, Medicaid allows for a 12-month claim submission and correction period. All claims and adjustments for services must be received by Medicaid within 12 months from the date of the service. New claims received past the one year filing deadline will be denied. Any corrections to a claim must also be received and/or adjusted within the same 12-month timeframe. If a correction is received after the deadline, no additional funds will be reimbursed. The one year timely filing period is determined from the date of service or “from” date on the claim.

8-2 Financial management services reimbursement

Reimbursement for PAS includes reimbursement for all mandatory employer payroll taxes, and workman’s compensation insurance premiums. These costs should be paid in addition to the self-administered service rate established between the waiver participant and the employee. For example, if a waiver participant negotiates an hourly wage of $10 per hour with their self-administered services employee, mandatory employer burden costs (e.g., Social Security and Medicare taxes, Federal Unemployment taxes, and Worker’s Compensation Insurance premiums) are paid in addition to the $10 per hour wage. The employee’s income tax withholding should be deducted from the negotiated wage.

8-3 Use of the U3 modifier

All claims billed to the Medicaid program for Aging Waiver services will need to be billed with the U3 modifier. Claims billed without the U3 modifier will result in a denied claim, and no reimbursement will be received for the service(s).

8-4 Use of the TE modifier

The TE modifier is used when respite care services are provided by an LPN for an Aging Waiver participant.

8-5 Use of the TN modifier

The use of the TN rural enhancement modifier is authorized in the Aging Waiver for the purpose of assuring access to waiver covered services in rural areas of the state where waiver service providers are required to travel extended distances to deliver services. The rate enhancement adjusts the per unit of reimbursement to account for the additional travel-related expenses not included in the normal rate setting process. For purposes of the rural enhancement rate, rural counties are all counties in Utah with the exception of Weber, Davis, Salt Lake, and Utah Counties.

The following limitations are imposed on the use of the rural enhancement:

1. DAAS or their designee must authorize use of the rural enhancement rate at the time the services are ordered.
2. The location assigned as the provider's normal base of operation must be in a county designated as rural;
3. The location from which the service provider begins the specific trip must be in a county designated as rural;
4. The location where the service is provided to the waiver participant must be in a county designed as rural;
5. The direct distance traveled by the provider from the starting location of the trip to the waiver participant must be a minimum of 25 miles with no intervening stops to provide waiver or State Plan services to other Medicaid participants. When a single trip involves service encounters for purposes of qualifying for the rural enhancement (i.e., each leg must involve a direct travel distance of 25 miles or more); and

6. When a single participant encounter involves multiple services, one line item (service) for a participant encounter will qualify for the use of the TN rural

enhancement modifier. (For example, if the provider visits a waiver participant and provides two hours of homemaker services, thirty minutes of budget assistance, and one hour of companion services, the provider may apply the TN modifier to the line of two hours of homemaker services, both hours will receive the additional reimbursement. If the provider chooses to apply the TN Modifier to one hour of companion services, they will receive the additional reimbursement for only one hour). Claims submissions utilizing the TN modifier for multiple services for a single participant encounter will be subject to recoupment.

8-6 Calculating claims using the TN modifier

When using the TN rural enhancement modifier for a claim, providers should bill the total amount to be reimbursed (base amount with a 1.75 increase). The Medicaid MMIS (old) system computes the Maximum Allowable Base Rate in the MMIS (old) system reference file multiplied by 1.75 and compares that number to the actual billed amount. The MMIS (old) system, until superseded by the Provider Reimbursement and Information System for Medicaid (PRISM), then pays the actual billed amount up to the MAR X 1.75.

8-7 Uniform authorization of the rural enhancement rate

It is the responsibility of DAAS or their designee to authorize any provider to bill for services using the rural enhancement code modifier. The use of the rural enhancement rate should be applied uniformly across the state according to the following guidelines:

1. If the initial authorization was verbal, DAAS or their designee will follow up with a written service authorization for rural enhanced reimbursement and will provide a copy of the written authorization to the person responsible for monitoring Aging Waiver billings.

2. DAAS or their designee is responsible to monitor the Medicaid billing statements to assure providers are appropriately using the rural enhancement rate. In the event of inappropriate use of the rural enhancement rate, the DAAS designee will notify DAAS.

3. When possible, providers must coordinate service delivery to minimize the use of the TN modifier by combining multiple service encounters in a single trip.

8-8 Electronic visit verification

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, are effective for Utah Medicaid beginning July 1, 2019. EVV requirements apply to all personal care services and home health care services provided under a 1915 (c) Home and Community-Based Waiver. Choice of reporting systems for EVV are by provider preference, but must meet all federal requirements, including the standards set in the Health Insurance Portability Accountability Act. The state will not implement a mandatory model for use. All provider choice EVV systems must be compliant with requirements of the Cures Act including:

1. Type of service performed;
2. Individual receiving the service;
3. Date of the service;
4. Location of service delivery;
5. Individual providing the service;
6. Time the service begins and ends; and
7. The date of creation of the electronic record.

Additional information including technical specifications for file creation/submission and EVV resources can be found at https://medicaid.utah.gov/evv.

9 Service procedure codes

The HCPCS codes listed below are covered by Medicaid under the Aging Waiver.

Waiver service	HCPCS code	Unit of service
Adult day health, licensed	S5102	per day
Case management, base	T1016	15 minutes
Case management, rural enhancement	T1016 TN	15 minutes
Chore services, base	S5120	each
Chore services, rural enhancement	S5120 TN	each
Adult companion services	S5135	15 minutes

Adult companion services, rural enhancement	S5135 TN	15 minutes
Environmental accessibility adaptions	S5165	per service
Supplemental meals, base	S5170	per meal
Supplemental meals, rural enhancement	S5170 TN	per meal
Homemaker services	S5130	15 minutes
Homemaker services, rural enhancement	S5130 TN	15 minutes
Personal attendant service, agency, base	T1019	15 minutes
Personal attendant service, agency, rural enhancement	T1019 TN	15 minutes
Personal attendant service, participant employed	S5125	15 minutes
Personal budget assistance	H0038	15 minutes
Personal budget assistance, rural enhancement	H0038 TN	15 minutes
Personal emergency response system – purchase, rental, repair	S5162	each
Personal emergency response system – response center service	S5161	per month
Personal emergency response – installation, testing, removal	S5160	each
Personal emergency response – installation, testing, removal, rural enhancement	S5162 TN	each
Medication reminder system	S5185	per month
Respite care, unskilled, base	S5150	15 minutes
Respite care, unskilled, rural enhancement	S5150 TN	15 minutes
Respite care, home health aide, base	T1005 TE	per hour
Respite care, home health aide, rural enhancement	T1005 TE, TN	per hour
Respite care, nursing facility	H0045	per day
Specialized medical equipment/supplies/assistive technology	T2029	each
Enhanced state plan supportive maintenance home health aide services, base	T1021	per hour
Enhanced state plan supportive maintenance home health aide services, rural enhancement	T1021 TN	per hour

Transportation services (non-medical), base	T2003	one way trip
Transportation services (non-medical), base, rural enhancement	T2003 TN	one way trip
Transportation services (non-medical), van, base	T2005	one way trip
Transportation services (non-medical), van rural enhancement	T2005 TN	one way trip
Community living services	T2038	per service
Financial management services	T2040	per month

10 Mandatory Adult Protective Services reporting requirements

All suspected incidents of abuse, neglect or exploitation must be reported in accordance with Utah State Law 76-5-111, Utah Code annotated 62-A-3-305 and State Rule R510-302.

Any person who has reason to believe that any vulnerable adult has been the subject of abuse, neglect, or exploitation shall immediately notify Adult Protective Services intake or the nearest law enforcement agency. When the initial report is made to law enforcement, law enforcement shall immediately notify Adult Protective Services intake. Adult Protective Services and law enforcement shall coordinate, as appropriate, their efforts to provide protection to the vulnerable adult.

When the initial report or subsequent investigation by Adult Protective Services indicates that a criminal offense may have occurred against a vulnerable adult, it shall notify the nearest local law enforcement agency. The law enforcement agency shall initiate an investigation in cooperation with Adult Protective Services.

Anyone who in good faith makes a report or otherwise notifies a law enforcement agency, the Division, or Adult Protective Services of suspected abuse, neglect, or exploitation is immune from civil and criminal liability in connection with the report or other notification.

Any person who willfully fails to report suspected abuse, neglect, or exploitation of a vulnerable adult is guilty of a class B misdemeanor.

Under circumstances not amounting to a violation of Section 76-8-508, a person who threatens, or attempts to intimidate a vulnerable adult who is subject of a report, a witness, the person who made the report, or any other person cooperating with an investigation conducted pursuant to this chapter is guilty of a class B misdemeanor.

The physician-patient privilege does not constitute grounds for excluding evidence regarding a vulnerable adult's injuries, or the cause of those injuries, in any judicial or administrative proceeding resulting from a report made in good faith pursuant to this part.

An adult is not considered abused, neglected, or a vulnerable adult for the reason that the adult has chosen to rely solely upon religious, non-medical forms of healing in lieu of medical care.

11 Incident reporting protocol

The State Medicaid Agency (SMA) has the administrative authority over all 1915(c) Medicaid Home and Community-Based Services (HCBS) Waivers. Waiver programs must provide adequate and appropriate services that safeguard the health and welfare of all enrolled participants. Waiver programs must also assure financial accountability for funds expended for HCBS services. While these responsibilities are delegated to the Operating Agencies (OA), the SMA retains final authority and has the final responsibility to assure that appropriate actions have taken place when a critical incident or event occurs, and in cases when appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard participants.

The critical incidents and events program is a collaborative effort between the OAs for each of the 1915(c) waivers and the SMA. The program has two levels: level one

describes the critical incidents/events that are required to be reported by the OA to the SMA for investigation, resolution and closure.
Level two describes the critical incidents/events that are required to be reported to the OA for investigation, resolution and closure.

This standard operating procedure stipulates:

1. Level one incidents and events that are required to be reported to the SMA;
2. Level two incidents and events that are required to be reported to the OA;
3. The agency responsible for completing the review; and
4. Associated reporting requirements.

11-1 Level one incidents and events – reportable to the SMA

The following list of the incidents/events must be reported by the OA to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the SMA.

1. Unexpected hospitalization

Admission to the hospital for medical treatment related to one or more of the following reasons:

a) Injuries that result in the loss of physical or mental function. (i.e., loss of limb, paralysis, brain injury or memory loss);
b) Alleged/substantiated abuse or neglect;
c) Attempted suicide;
d) Medication errors;
e) Self-injurious behavior;
f) Serious burns; and/or
g) Substance abuse

2. Exploitation (either alleged or substantiated)

Unfairly taking advantage of a participant due to his/her age, health, and/or disability.

a) Serious and/or patterned/repeated event(s)- involving a single participant,
b) Involving multiple participants.

3. Human rights violations

a) Serious infringements of participant human rights (jeopardizing the health and safety of the participant);
b) Exceptions;
   i. Restrictive/intrusive intervention(s) must be clearly defined in individualized behavior support plans and/or care plan/person centered support plans pursuant to 42 CFR §441.301(c)(4)(5).
   ii. Emergency behavioral interventions as defined by Utah Administrative Code, Title R539-4-6 are not considered a human rights violation.

4. Incidents involving the media or referred by elected officials

Incidents that have or are anticipated to receive public attention (i.e., events covered in the media or referred by the Governor, legislators or other elected officials).

5. Missing persons

For reporting purposes, the following participants are considered to be missing:

a) Participants who have been missing for at least 24 hours; or
b) Regardless of the number of hours missing – any participant who is missing under unexplained, involuntary or suspicious circumstances and is believed to be in danger because of age, health, mental or physical disability, environment or weather or who could be in the company of a potentially dangerous person or some other factor that places the participant in peril.

6. Unexpected deaths

All deaths are considered unexpected with the exception of:

a) Participants receiving hospice care; and/or
b) Deaths due to natural causes, general system failure or terminal/chronic health conditions.

A death related to an adverse event that occurs while the participant is receiving treatment in an inpatient facility, which is regulated by Health Facilities Licensing and Certification, should be reported as an unexpected death, the QA/SMA team may opt not to require an investigation. (Reportable to Health Facilities Licensing)

7. Waste, fraud or abuse of Medicaid funds

Alleged or confirmed waste, fraud or abuse of Medicaid funds

a) Perpetrated by the provider, or

b) Perpetrated by the participant.

8. Law enforcement involvement

Charges filed against the participant for activities resulting in the:

a) Hospitalization of another (i.e., aggravated assault),
b) Death of another; and/or
c) Abuse and or exploitation of a vulnerable person, due to age, health, and/or disability.

9. Private Health Information (PHI)/Personal Identifiable Information (PII) security breach

Any activity that could potentially put sensitive information at risk of unauthorized use, access, disclosure, or modification.

Procedure for reporting to the State Medicaid Agency:

1. On the first business day after a critical incident has occurred[1], a representative from the OA will notify a member of the SMA Quality Assurance team via email, telephone or in person. If the OA has any question about whether a case meets the criteria for reporting to the SMA, the OA will contact the SMA for technical assistance.
2. Within ten business days after notification, the OA will submit a completed Critical Incident Investigation form to the SMA.
3. Within five business days after receiving the Critical Incident Investigation form the SMA will review the investigation form submitted by the OA and will contact the OA if additional information or action is required.
4. When the SMA determines the investigation is complete, the SMA will document any findings or corrective action requirements on the SMA portion of the investigation form. The SMA will send the OA a copy of the finalized document, closing the case. In some cases, the SMA may continue to monitor findings or corrective actions.

[1] In some cases, it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

5. Within two weeks after closing the case, the SMA will notify the participant or the participant's representative of the investigation results. A copy of the notification letter will be provided to the OA. The following types of incidents are excluded from the notification letter requirement: suicide attempt, missing person, death and investigations that conclude with disenrollment and/or are not concluded within six months of the original incident date.

B. Level two incidents and events – reportable to the OA

The following incidents must be reported by providers, participants and/or their representatives to the OA, but are not required to be reported to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the OA.

1. Unexpected medical treatment (requiring immediate medical treatment at an emergency room)

   Medical treatment related to one or more of the following reasons:

   a) Abuse/neglect/exploitation (either alleged or substantiated);
   b) Medication errors and/or;
   c) Substance abuse.

2. Abuse/neglect/exploitation (either alleged or substantiated)
   a) Exploitation of a participant's funds or property;
   b) Theft and/or diverting of a participant's medication(s); and/or
   c) Sexual assault/abuse/exploitation (regardless of medical treatment).

3. Human rights violations

   Such as:

   a) Unauthorized use of restrictive interventions- including but not limited to restraints (physical, mechanical or chemical) ;
   b) Misapplied restrictive interventions, (included in the BSP);
   c) Unauthorized use of seclusion; and/or
   d) Unwelcome infringement of personal privacy rights;
   e) Violations of individual rights to dignity and respect.
   f) Exceptions;

i. Restrictive/intrusive intervention(s) must be clearly defined in individualized behavior support plans and/or care plan/person centered support plans pursuant to 42 CFR §441.301(c)(4)(5).

ii. Emergency behavioral interventions as defined by Utah Administrative Code, Title R539-4-6 are not considered a human rights violation.

Operating Agencies are responsible to ensure providers are compliant with 42 CFR §441.301(c)(4)(5).

4. Attempted suicides

An attempted suicide which did not result in the participant being admitted to a hospital. (Suicide attempts do not include suicidal thoughts or threats without actions)

5. Compromised working or living environment

An event in which the participant's working or living environment (e.g., roof collapse, fire, etc.) is compromised and the participant(s) require(s) evacuation.

6. Law enforcement involvement
   a) Participant(s)
      i. Criminal charges filed (not including those reportable to the SMA)
   b) Staff
      ii. Criminal charges filed (make report to APS/CPS when necessary).
      iii. When staff is issued a moving violation while transporting participant(s).

For this category, the date of the incident will be recorded as the date on which the filing of charges occurred.

7. Unexpected hospitalization

   Admission to the hospital for medical treatment related to one or more of the following reasons:
   a) Injuries
   b) Aspiration
   c) Choking

These do not include medical diagnoses that pose an expected risk for aspiration or choking. Also excluded from this category are self-injurious behavior or injuries

resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a participant that resulted in admission to a hospital for medical treatment (which is reportable to the SMA).

Procedure for reporting to the operating agency:

1. On the first business day after a critical incident has occurred[2], a representative from the case management or support coordination agency (case manager) will notify the OA via email, telephone or in person.
2. Within ten business days after notification, the case manager will submit a completed Critical Incident Investigation form to the OA.
3. Within five business days after receiving the Critical Incident Investigation form the OA will review the investigation form submitted by the case manager and will contact the case manager if additional information or action is required.
4. When the OA determines the investigation is complete, the OA will document any findings or corrective action requirements on the OA portion of the investigation form. The OA will send the case manager a copy of the finalized document, closing the case. In some cases, the OA may continue to monitor findings or corrective actions.

Within two weeks after closing the case, the case manager will notify the participant or the participant's representative (in person, phone or in writing) of the investigation results and document notification in the participant's record. The following types of incidents are excluded from the notification requirement: suicide attempt, death, and investigations that conclude with disenrollment and/or are not concluded within six months of the original incident date.

Required reports

A. OA Quarterly Report

[2] In some cases, it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The OA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

The OA will submit a waiver specific quarterly report to the SMA, no later than one month after the end of the quarter (October 31, January 31, April 30, July 31) that includes:

1. name of the participant
2. date of the incident
3. date the incident was reported to the OA
4. category of the incident: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
5. brief summary of the incident and its resolution
6. date the case was closed
7. brief description of any corrective action required of the case manager or other provider

B. OA Annual Report

The OA will submit a waiver specific annual report to the SMA, no later than two months after the end of the fiscal year (August 31) that includes:

1. total number of incidents
2. number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
3. number of incidents that resulted in corrective action by the case manager or other provider
4. number of corrective actions that were implemented
5. number of incidents where the participant/representative was informed of the investigation results, and the number of incidents where the contact was made within 14 days of the investigation closure
6. summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
    a) If trends were noted, the report will include a description of the process improvement steps that will be implemented

C. State Medicaid Agency Annual Report

1. For each waiver:

a) number of incidents
b) number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
c) number of incidents that resulted in corrective action by the OA, case manager or other provider
d) number of corrective actions that were implemented

2. Summary of all waivers:
   a) number of incidents
   b) number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
   c) number of incidents that resulted in corrective action by the case manager or other provider
   d) number of corrective actions that were implemented
   e) summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
      i. If trends were noted, the report will include a description of the process improvement steps that will be implemented

Utah Medicaid Provider Manual

Utah Home and Community Based Services Waiver for Individuals with Intellectual Disabilities or other Related Conditions

Division of Integrated Healthcare

Updated July 2020

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1 General policy

1. Under Section 1915(c) of the Social Security Act, a state may request approval through the federal Centers for Medicare and Medicaid Services (CMS) to "waive" certain statutory requirements in order to use Medicaid funds for an array of home and community-based services (HCBS) provided to eligible recipients as an alternative to institutional care. The State of Utah has provided Medicaid-reimbursed home and community-based waiver services to individuals with intellectual disabilities and other related conditions since July 1, 1987. The Division of Integrated Healthcare (DIH) received approval from CMS through a waiver renewal process to continue operating the Community Supports Waiver for Individuals with Intellectual Disabilities or Other Related Conditions (Waiver) through June 30, 2015. The approval includes:

   a) The waiver of comparability requirements in subsection 1902(a)(10)(B) of the Social Security Act. In contrast to Medicaid State Plan service requirements, under a waiver of comparability, the state is permitted to provide covered waiver services to a limited number of eligible individuals who meet the level of care criteria for Medicaid reimbursement in an intermediate care facility for persons with intellectual disabilities (ICF/ID). The term ICF/ID, which is used in this document, is equivalent to intermediate care facility for persons with mental retardation (ICF/MR) under federal law.

      Waiver services need not be comparable in amount, duration or scope to services covered under the State Plan. However, each year the state must demonstrate that the waiver is a cost-effective or a "cost-neutral" alternative to institutional (ICF/ID) services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded ICF/ID services.

b) The waiver of institutional deeming requirements in section 1902(a)(10)(C)(I)(III) of the Social Security Act. Under the waiver of institutional deeming requirements, the state uses more liberal eligibility income and resource calculations when determining recipients' Medicaid eligibility.

2. The State Medicaid Agency (SMA) has ultimate administrative oversight and responsibility for the waiver program. The day to day operations have been delegated to the Department of Human Services (DHS), Division of Services for People with Disabilities (DSPD), through an interagency agreement with the SMA. This agreement and the State Implementation Plan (SIP) describe the responsibilities that have been delegated to DSPD as the Operating Agency (OA) for the waiver program.

1-1 Acronyms and definitions

For purposes of the waiver, the following acronyms and definitions apply:

CMS Centers for Medicare and Medicaid Services
CSW Community Supports Waiver
DHS Department of Human Services
DIH Division of Integrated Healthcare
DOH Department of Health
DSPD Division of Services for People with Disabilities
HCBS Home and Community-Based Services
ICF/ID Intermediate Care Facility for Persons with Intellectual Disabilities
*This is equivalent to intermediate care facility for persons with mental retardation (ICF/MR) under Federal law.
MAR Maximum Allowable Rate
NOA Notice of Action
OA Operating Agency
PCSP Person Centered Support Plan
PHI Personal and Protected Health Information
PII Personal Identifiable Information
QIDP Qualified Intellectual Disabilities Professional

*This is equivalent to Qualified Mental Retardation Professional (QMRP) under federal law.

RAS Request for Additional Services
RFP Request for Proposal
SIP State Implementation Plan
SMA State Medicaid Agency

1-2 CMS approved State Implementation Plan (SIP)

1. The CMS approved SIP for the Community Supports Waiver (CSW or Waiver) serves as the state's authority to provide HCBS to the target group under its Medicaid plan. The SIP and all attachments constitute the terms and conditions of the program.

2. This manual does not contain the full scope of the SIP. To understand the full scope and requirements of the Waiver, providers should refer to the SIP. In the event provisions of this manual are found to be in conflict with the SIP, the SIP will take precedent.

2 Service availability

Waiver services are covered benefits only when provided to an individual determined to meet the eligibility criteria defined in the current Community Supports Waiver SIP and only pursuant to a written Person Centered Support Plan (PCSP) that has been approved by DSPD.

2-1 Eligibility for community supports waiver services

1. Waiver services are limited to individuals with the following condition(s):
   a) Must have a diagnosis of mental retardation as per 42CFR483.102(b)(3) or a condition closely related to mental retardation as per 42CFR435.1010.
   b) Conditions closely related to mental retardation do not include individuals whose functional limitations are due solely to mental illness, substance abuse, personality disorder, hearing impairment, visual impairment, learning disabilities, behavior disorders, physical problems,

borderline intellectual functioning, communication or language disorders, aging process, terminal illnesses, or developmental disabilities that do not result in an intellectual impairment.

2. In addition, individuals served in this Waiver program must also demonstrate substantial functional limitations in three or more areas of major life activity and meet the ICF/ID level of care criteria as described in Utah Administrative Rule 414-502-8.
3. This waiver is limited to persons with disabilities who have established eligibility for state matching funds through DHS in accordance with UCA 62A-5. If the waiver applicant is determined to be ineligible for state matching funds through DHS, the participant will be given an opportunity to appeal the decision through the DHS hearing process as described in Section 2-5 of this provider manual. Decisions made through the DHS hearing process on the question of DSPD eligibility will be the final decision.
4. If a person is eligible for more than one of the waivers operated by DSPD, the Division will educate the individual about their choices and will advise the individual about which of the waivers will likely best meet their needs.
5. An individual will not be enrolled if it is determined during the eligibility assessment process that the health, welfare, and safety of the individual cannot be maintained through the Waiver.
6. Inpatients of hospitals, nursing facilities, or ICFs/ID are not eligible to receive Waiver services (except as specifically permitted for support coordination discharge planning in the 90-day period prior to their discharge to the waiver).

2-2 Applicant freedom of choice of ICF/ID or waiver

When an individual is determined eligible for waiver services, the individual and the individual's legal representative if applicable, will be informed of the alternatives available under the waiver and offered the choice of institutional care (ICF/ID) or home and community-based care.

A copy of the DSPD publication, An Introductory Guide—Division of Services for People with Disabilities (Guide), which describes the array of services and supports available in Utah through both ICFs/ID and the HCBS waiver programs, is given to

each individual applying for waiver services. In addition, during the intake process individuals will be given a 2-sided Informational Fact Sheet (Form IFS-10) which describes the eligibility criteria and services available through both the waiver program and through ICFs/ID, including contact information for DSPD intake and for each of the ICFs/ID throughout the state.

If no available capacity exists in the waiver, the applicant will be advised that he or she may access services through an ICF/ID or may wait for open capacity to develop in the Waiver.

If available capacity exists in the waiver, a pre-enrollment screening of health, welfare, and safety needs will be completed by a waiver representative. The applicant will be advised of the preliminary needs identified and given the opportunity to choose to receive services to meet the identified needs through an ICF/ID or the waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the individual record.

1. Choice of waiver services will only be offered if:

    a) The individual's needs assessment indicates the services the individual requires, including waiver services, are available in the community;
    b) The PSCP has been agreed to by all parties; and
    c) The health and safety of the individual can be adequately protected in relation to the delivery of waiver services and supports.

Once the individual has chosen home and community-based waiver services, the choice has been documented in USTEPS by the support coordinator and the individual has received a copy of the guide and the informational fact sheet, subsequent review of choice of program will only be required at the time a substantial change in the enrollee's condition results in a change in the PCSP. It is, however, the individual's option to choose institutional (ICF/ID) care at any time during the period they are in the waiver.

If the participant is not given the choice of HCBS as an alternative to institutional

care, the participant will be given an opportunity for a fair hearing as described in Chapter 2-5 of this provider manual.

2-3 Waiver participant freedom of choice

1. Upon enrollment in the waiver, the individual, and the individual's legal guardian if applicable, will be given choice among available waiver support coordination agencies. The applicant's choice will be documented in the case record.
2. Upon completion of the comprehensive assessment instrument by the DSPD evaluation specialist, the individual and the individual's legal representatives if applicable, in conjunction with the support coordination agency and any others that the individual wishes to invite, will participate in the development of the PCSP to address the individual's identified needs.
3. The waiver participant, and the individual's legal representative if applicable, will be given the opportunity to choose the providers of waiver services identified on the PCSP if more than one qualified provider is available to render the services. The individual's choice of providers will be documented in the PCSP.
4. The waiver support coordination agency will review the contents of the written PCSP with the participant prior to implementation. If the participant is denied the waiver service(s) or their choice or the waiver provider(s) of their choice, they will be given an opportunity in writing for a fair hearing as described in Chapter 2-5 of this provider manual.
5. Subsequent revision of the participant's PCSP as a result of annual re-assessment or significant change in the participant's health, welfare, or safety requires proper notice to the participant as described in item D above, plus notice that the participant has the right to select to receive services in a Medicaid ICF/ID in lieu of continued participation in the waiver.

2-4 Termination of home and community-based waiver services

1. When the need arises, participants are separated from the home and community-based waiver program through a disenrollment process.
   a) The disenrollment process is a coordinated effort between DIH and DSPD that is expected to facilitate the following:

i. Appropriate disenrollment and movement among waiver programs when applicable;
ii. Effective utilization of waiver program potential;
iii. Effective discharge and transition planning;
iv. Provision of information, affording participants the opportunity to exercise all applicable waiver rights; and
v. Program quality assurance/quality improvement measures.

2. All of the various circumstances for which it is permissible for DSPD to disenroll an individual from the waiver program can be grouped into three distinct disenrollment categories.

a) Voluntary disenrollments are cases in which participants, or their legal representatives when applicable, choose to initiate disenrollment from the waiver. Disenrollments are also considered voluntary when the waiver participant enters a skilled nursing facility for a stay of less than 90 days and chooses not to transition back to the original waiver program. This includes cases in which the participant transitions to another waiver program from the skilled nursing facility.

Voluntary disenrollments require support coordinators to notify their DSPD program manager. DSPD, either through the program manager or other authorized designee, will in turn send written notification to DIH within 10 days from the date of disenrollment. No DIH prior review or approval of the decision to disenroll is required.

Documentation will be maintained by DSPD and should include a written statement signed by the participant or their legal representative when applicable detailing their intent to disenroll from the waiver program as well as discharge planning activities completed by the support coordinator with the waiver participant as part of the disenrollment process.

b) Pre-Approved involuntary disenrollments are cases in which participants

are involuntarily disenrolled from the waiver for any of the following reasons including:

i. Death of the participant;
ii. Participant is determined ineligible for Medicaid services by the Department of Workforce Services as a result of no longer meeting the financial requirements for Medicaid eligibility; or
iii. Participant enters a skilled nursing facility for a stay of more than 90 days.

Pre-approved involuntary disenrollments require support coordinators to notify their DSPD program manager. DSPD, either through the program manager or other authorized designee, will in turn send written notification to DIH within 10 days from the date of disenrollment. No DIH prior review or approval of the decision to disenroll is required as the reasons for pre-approved involuntary disenrollment have already been approved by the SMA. Documentation will be maintained by DSPD, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process when appropriate.

c) Special circumstance disenrollments are cases in which participants are disenrolled from the waiver for reasons that are non-routine in nature. These cases require prior review and approval by DIH and involve circumstances that are specific to the participant involved. Examples of this type of disenrollment include:

i. Participant no longer meets the institutional level of care requirements for the waiver ICF/ID;
ii. Participant's health and safety needs cannot be met by the waiver program's services and supports;
iii. Participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a PCSP that meets minimal safety standards;
iv. Participant has demonstrated non-compliance with a signed participant agreement with DSPD;
v. Participant, or their legal representative when applicable, requests a

transfer of the participant from the CSW directly to another waiver program when a stay at a nursing facility has not been involved; and/or

vi. Participant's whereabouts are unknown for more than 30 days and participant has not yet been determined ineligible for Medicaid services by the Department of Workforce Services.

The special circumstance disenrollment review process will consist of the following activities:

1. The support coordinator shall compile information to articulate the disenrollment rationale.
2. Support coordinator will then submit disenrollment rationale information to their DSPD program manager for a review of the documentation of support coordination activities and of the disenrollment recommendation.
3. If DSPD management staff concurs with the recommendation, a request for disenrollment approval will be forwarded to DIH for a final decision.
4. DIH will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources, have been fully utilized to meet the participant's health and safety needs.
5. DIH may facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.
6. A DIH final disenrollment decision will be communicated in writing to both the support coordinator and the state-level program management staff.

If the special circumstance disenrollment request is approved by DIH, the support coordinator will provide the participant, or their legal representative when applicable, with the required written notice of action (NOA) and right to fair hearing information.

The support coordinator will initiate discharge planning activities sufficient to assure a smooth transition to an alternate Medicaid program and/or to other services. Discharge planning activities shall be documented in the individual's case record.

2-5 Fair hearings

1. An individual and the individual's legal representative will receive a written NOA form 522 and hearing request form 490S, from the waiver support coordinator if the individual is:
   a) Denied a choice of institutional or waiver program,
   b) Found ineligible for the waiver program,
   c) Denied access to the provider of choice for a covered waiver service, or
   d) Experiences a denial, reduction, suspension, or termination in waiver services in accordance with R539-2-5.

2. The NOA delineates the individual's right to appeal the decision through an informal hearing process at DHS or an administrative hearing process at the Department of Health (DOH), or both. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions.
3. An aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. DIH may reinstate services for participants or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than 10 calendar days after the date of action.
4. Appeals related to establishing eligibility for state matching funds through DSPD/DHS in accordance with UCA 62A-5 will be addressed through the DHS hearing process. Decisions made through DHS may be appealed to DOH strictly for procedural review. Appealed decisions demonstrating that DHS followed the fair hearing process will be upheld by DOH as the final decision.
5. Documentation of notices and the opportunity to request a fair hearing is kept in the individual's case record/file and at DSPD state office.
6. Informal Dispute Resolution
   a) DSPD has an informal dispute resolution process. This process is designed to respond to a participant's concerns without unnecessary formality. The dispute resolution process is not intended to limit a participant's access to formal hearing procedures; the participant may file a request for hearing any time in the first 30 days after receiving an NOA. Examples of the types of disputes include but are not limited to concerns with a

provider of waiver services, concerns with provider personnel, etc.

b) Attempts to resolve disputes are completed as expeditiously as possible. No specific timelines have been identified as some issues may be resolved very rapidly while other more complex issues may take a greater period of time to resolve.

3 Provider participation

3-1 Provider enrollment

1. Waiver services are covered benefits only when delivered by qualified providers that are enrolled with the SMA to provide the services as part of the waiver. In addition to this Medicaid provider agreement, all providers of waiver services must also have a current contract with DHS/DSPD.
2. The SMA will enter into a provider agreement with all willing providers who are selected by participants and meet licensure, certification, competency requirements and all other provider qualifications.
3. DHS in conjunction with the Office of Contract Management will issue solicitations to possible providers of waiver services through a Request for Proposal (RFP). All solicitations for each RFP are posted through the BidSync.com website. To submit an RFP, a provider must register with BidSync.com and can do so free of charge. RFPs always remain open, allowing for continuous recruitment. A review committee evaluates the proposals against the criteria contained in the RFP and selects those who meet the qualifications.

3-2 Provider reimbursement

1. Providers will be reimbursed according to the specified reimbursement rate(s) contained in the negotiated contract with DSPD.
2. Providers have the option to allow DHS/DSPD to bill Medicaid on its behalf for covered Medicaid services, or providers have the option to bill Medicaid directly through the Utah PRISM system. Providers may only claim Medicaid reimbursement for services that are authorized on the approved PCSP. Claims must be consistent with the amount, frequency and duration authorized by and documented on the PCSP.

3-3 Standards of service

Providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, the terms and conditions of the waiver SIP and the terms and conditions contained in the DSPD contract.

3-4 Data security and privacy

Providers are expected to take steps to ensure that all personal information related to the individual being served is protected. This includes both Personal Health Information (PHI) as well as Personally Identifiable Information (PII). Providers should use appropriate administrative, technical and physical safeguards to preserve the integrity, confidentiality, and availability of PHI/PII that they create, receive, maintain or transmit. This includes using encrypted/secure email, fax, or other HIPAA compliant methods to transmit documents containing information about the individual being served.

Providers shall ensure there is limited and controlled access to PHI/PII. In the performance of its services and operations, the provider shall make efforts to use, disclose and request only the minimum amount of PHI/PII considered reasonably necessary. The provider shall also identify and protect against reasonably anticipated threats to the security or integrity of the information, protect against reasonably anticipated, impermissible uses or disclosures; and ensure compliance by their workforce.

3-5 Breach reporting/data loss

Providers must report to DSPD and DIH, either by email or telephone, any breach or loss of PHI/PII. This report should be completed not more than 24 hours after the provider knows or should have reasonably known about the breach. The provider must also submit a report in writing/by email to DSPD within 5 business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

3-6 Provider rights to a fair hearing

1. The DOH offers hearing rights to providers who have experienced any adverse action taken by DOH/DIH, or by the OA. Providers must submit a written request for a hearing to DOH in order to access the hearing process. Please refer to the DOH/DIH provider manual, Section 1: General Information, Chapter 6-15, Administrative review/fair hearing.
2. Adverse actions that providers may appeal include:
   a) Actions relating to enrollment as a waiver provider,
   b) Contract reimbursement rates,
   c) Sanctions or other adverse actions related to provider performance, or
   d) Improper conduct by DSPD in performing delegated waiver responsibilities.

3-7 Electronic visit verification

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, are effective for Utah Medicaid beginning July 1, 2019. EVV requirements apply to all personal care services and home health care services provided under a 1915 (c) Home and Community-Based Waiver.

Choice of reporting systems for EVV are by provider preference, but must meet all federal requirements, including the standards set in the Health Insurance Portability Accountability Act. The state will not implement a mandatory model for use. All provider choice EVV systems must be compliant with requirements of the Cures Act including:

1. Type of service performed;
2. Individual receiving the service;
3. Date of the service;
4. Location of service delivery;
5. Individual providing the service;
6. Time the service begins and ends; and
7. The date of creation of the electronic record.

Additional information including technical specifications for file creation/submission and EVV resources can be found at https://medicaid.utah.gov/evv.

4 SMA prior authorization of waiver services

Prior authorization by the State Medicaid Agency for waiver-covered services is not required. Provider participation and service delivery will be governed by waiver quality management systems for assuring proper development and implementation of plans of care, assuring waiver services are provided by qualified providers, and assuring financial accountability for funds paid to providers for the waiver program.

5 Support coordination

5-1 Support coordinator qualifications

1. Qualified support coordinators shall possess at least a bachelor's degree in nursing, behavioral science or a human services related field such as social work, sociology, special education, rehabilitation counseling, or psychology and demonstrate competency relating to the planning and delivery of health services to individuals with intellectual disabilities and other related conditions through a successful completion of a training program approved by the State Medicaid Agency. (Please refer to qualifications for a Qualified Intellectual Disabilities Professional (QIDP) as specified in the job specifications contained within: Interpretive Guidelines for ICF for Persons with Mental Retardation (W159-W180); Code of Federal Regulations, Centers for Medicare and Medicaid Services, State Operations Manual-Appendix J, pages 77-87.)
2. An individual with a "bachelor's degree in a human services related field" means an individual who has received: at least a bachelor's degree from a college or university (master and doctorate degrees are also acceptable) and has received academic credit for a minimum of 20 credit hours of coursework concentration in a human services field, as defined above. Although a variety of degrees may satisfy the requirements, majors such as geology and chemical engineering are not acceptable.

5-2 Support coordination and the PCSP

1. The PCSP is the mechanism through which all necessary waiver services (as determined during the initial and ongoing comprehensive needs assessment process) are detailed in terms of the amount, frequency and duration of the intervention to be provided to meet identified objectives.
2. The amount, frequency and duration of each service listed within the PCSP is intended to provide a budget estimate of the services required to meet the assessed needs of each participant over the course of a plan year. Utah Medicaid recognizes that a participant's needs may change periodically due to temporary or permanent conditions which may require changes to the annual PCSP budget.
3. The support coordinator is responsible to monitor service utilization for each participant under their care. When the support coordinator determines that a participant may require an increase in services, a request for additional services (RAS) must be submitted to DSPD for approval.
4. The annual PCSP budget is the sum of all approved services within the PCSP including additional services authorized through an approved RAS that are added to the PSCP over the entire plan year. In this way, Utah Medicaid applies an annualized aggregate to the PCSP budget.
5. Services may not exceed the amount allotted through the annual PCSP budget. Billing in excess of the annual PCSP budget will be subject to a recovery of funds.

5-3 Support coordination encounters

1. While quarterly face to face visits is the standard, the support coordinator has the discretion to conduct face to face visits with the client more frequently than quarterly. In all cases frequency will be dependent on the assessed needs of the client and will not exceed 90 days without a face to face visit.
2. Support coordinators will visit individuals receiving residential supports no less than once every 30 days or at a rate directed by the DSPD program manager. Such visits shall occur in the person's place of residence at least once every 60 days. However, no more than two of these visits during each plan year may occur at other naturally occurring settings within the

participant's community provided that the support being offered to the participant during those visits shall be rendered by staff of the residential care provider.

This approach promotes support coordinators having specific information about their expected roles and responsibilities on an individualized waiver participant basis. Program performance reviews assess the accuracy and effectiveness of the link between the determination of need, the PCSP, the implementation of support coordination services and the ongoing evaluation of progress toward the stated objectives.

6 Self-administered services

1. Self-administered services (SAS) are made available to all waiver enrollees who elect to participate in this method. Under SAS, individuals and/or their chosen representatives hire individual employees to perform a waiver service/s. The individual and/or their chosen representative are then responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheets, etc., of the individual's employee/s. Individuals and/or their chosen representatives may avail themselves of the assistance offered them within the Family Training and Preparation Service should they request and/or be assessed as requiring additional support and assistance in carrying out these responsibilities.
2. Financial management services are offered in support of the SAS option. A financial management services provider (fiscal agent) facilitates the employment of individuals by the waiver participant or designated representative including: (a) provider qualification verification, (b) employer-related activities including federal, state and local tax withholding/payments, fiscal accounting and expenditure reports and (c) Medicaid claims processing and reimbursement distribution.
3. The waiver participant remains the employer of record, retaining control over the hiring, training, management and supervision of employees who provide direct care services.
4. Under the SAS method, the waiver participant submits their staff time

sheet(s) to the fiscal agent. The fiscal agent pays the claim(s) and submits a bill to DHS/DSPD on Form 520. DHS/DSPD pays the fiscal agent then submits the billing claim(s) to DOH for reimbursement. All payments are made through the fiscal agent under contract with DSPD. Payments are not issued to the waiver participant, but to and in the name of the employee hired by the person or their representative.

7 Waiver covered services rate setting methodology

1. DHS has entered into an administrative agreement with the DOH/DIH to set 1915c HCBS waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915(c) HCBS Waiver program and other applicable Medicaid rules. There are four principal methods used in setting the DHS Maximum Allowable Rate (MAR) level. Each method is designed to determine a fair market rate. The four principle methods are:
   a) Existing market survey or cost survey of current providers
   b) Component cost analysis
   c) Comparative analysis
   d) Community price survey

2. The support coordination covered waiver service provider rate is calculated using the cost survey of current providers' methodology in general but includes an added procedure in which each fiscal year the SMA establishes specific cost center parameters to be used in calculating the annual MAR.
3. Annual MAR schedules may be held constant or modified with a cost of living adjustment (COLA) for any or all of the waiver covered services in lieu of completing one of the four principle methods depending on the budget allocation approved by the Utah State Legislature for the applicable fiscal year.
4. The SMA will maintain records of changes to the MAR authorized for each waiver-covered service to document the rate setting methodology used to establish the MAR.

8 Service procedure codes

The procedure codes listed below are covered by Medicaid under the Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions.

Waiver service	Code	Unit of service
Behavioral consultation service I	H0004	15 minute
Behavioral consultation service II	H0023	15 minute
Behavioral consultation service III	H2019	15 minute
Chore services	S5120	15 minute
Companion services	S5135	15 minute
Companion services - daily	S5136	Per day
Day supports (site/non-site)	T2021	15 minute
Day supports (site/non-site) - daily	T2020	Per day
Environmental accessibility adaptation (home)	S5165	Each
Environmental accessibility adaptation (vehicle)	T2039	Each
Extended living supports	H2021	15 minute
Family training and preparation services	S5110	15 minute
Family and individual training and preparation services	T1027	15 minute
Financial management services	T2040	Per month
Homemaker services	S5130	15 minute
Living start-up costs	T2038	Each
Massage therapy	T2025	15 minute
Personal assistance	S5125	15 minute

Personal assistance - daily	S5126	Daily
Personal budget assistance	H0038	15 minute
Personal budget assistance - daily	H2014	Per day
Personal emergency response systems (install)	S5160	Per episode
Personal emergency response systems (monthly)/medication dispenser	S5161	Per month
Personal emergency response systems (purchase)	S5162	Per episode
Professional medication monitoring I (LPN)	H0034	Per episode
Professional medication monitoring II (RN)	H2010	Per episode
Residential habilitation - facility based	T2031	Per day
Residential habilitation - facility based -DCFS	H2016	Per day
Residential habilitation - host home	S5140	Per day
Residential habilitation - professional parent -DCFS	S5145	Per day
Respite care (routine and intensive)	S5150	15 minute
Respite care (routine, intensive, group) daily	S5151	Per day
Respite care, out of home (intensive/group-R&B included)	H0045	Per day
Respite care, weekly	T2036	Per week
Specialized medical equipment, monthly fee	T2028	Per month
Specialized medical equipment, purchase	T2029	Each
Supported employment, enclave	T2018	Per day

Supported employment, direct and administrative	T2019	15 minute
Supported employment	H2025	15 minute
Supported living	T2017	15 minute
Transportation, non-medical, per mile	S0215	Per mile
Transportation, non-medical, per day	T2002	Per day
Transportation, non-medical, UTA	T2003	Per episode
Transportation, non-medical, bus pass	T2004	Per month
Waiver support coordination	T2022	Per month

9 Incident reporting protocol

I. Purpose:

The State Medicaid Agency (SMA) has the administrative authority over all 1915(c) Medicaid Home and Community-Based Services (HCBS) Waivers (waivers). Waiver programs must provide adequate and appropriate services that safeguard the health and welfare of all enrolled participants. Waiver programs must also assure financial accountability for funds expended for HCBS services. While these responsibilities are delegated to the operating agencies (OA), the SMA retains final authority and has the final responsibility to 1) assure that appropriate actions have taken place when a critical incident or event occurs; and 2) in cases where appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard participants.

The Critical Incidents and Events Program is a collaborative effort between the OAs for each of the 1915(c) waivers and the SMA. The program has two levels. Level one describes the critical incidents/events that are required to be reported by the OA to the SMA for investigation, resolution and closure. Level two describes the critical incidents/events that are required to be reported to the OA

for investigation, resolution and closure.

This standard operating procedure stipulates:

1. Level one incidents and events required to be reported to the SMA;
2. Level two incidents and events that are required to be reported to the OA;
3. The agency responsible for completing the review; and
4. Associated reporting requirements.

II. Reportable Critical Incidents/Events

Level one incidents and events – reportable to the SMA

The following list of the incidents/events (incidents) must be reported by the OA to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the SMA.

1. **Unexpected hospitalization**

   Admission to the hospital for medical treatment related to one or more of the following reasons:

   a) Injuries that result in the loss of physical or mental function (i.e., loss of limb, paralysis, brain injury or memory loss);
   b) Alleged/substantiated abuse or neglect;
   c) Attempted suicide;
   d) Medication errors;
   e) Self-injurious behavior;
   f) Serious burns; and/or
   g) Substance abuse.

2. **Exploitation (either alleged or substantiated)**

   Unfairly taking advantage of a participant due to his/her age, health, and/or disability including:

   a) Serious and/or patterned/repeated event(s) involving a single participant; or
   b) Involving multiple participants.

3. **Human rights violations**

   a) Serious infringements of participant human rights (jeopardizing the health and safety of the participant);

b) Exceptions;
   i. Restrictive/intrusive intervention(s) clearly defined in individualized behavior support plans and/or care plan/person centered support plans pursuant to 42 CFR §441.301(c)(4)(5); and
   ii. Emergency behavioral interventions as defined by Utah Administrative Code, Title R539-4-6.

4. **Incidents involving the media or referred by elected officials**

Incidents that have or are anticipated to receive public attention (i.e., events covered in the media or referred by the Governor, legislators or other elected officials).

5. **Missing persons**

For reporting purposes, the following participants are considered to be missing:

a) Participants who have been missing for at least 24 hours; or
b) Regardless of the number of hours missing – any participant who is missing under unexplained, involuntary or suspicious circumstances and is believed to be in danger because of age, health, mental or physical disability, environment or weather or who could be in the company of a potentially dangerous person or some other factor that places the participant in peril.

6. **Unexpected deaths**

All deaths are considered unexpected with the exception of:

a) Participants receiving hospice care; and/or
b) Deaths due to natural causes, general system failure or terminal/chronic health conditions.

A death related to an adverse event that occurs while the participant is receiving treatment in an in-patient facility, which is regulated by Health Facilities Licensing and Certification, should be reported as an unexpected death, the QA/SMA team may opt not to require an investigation. (Reportable to Health Facilities Licensing)

7. **Waste, fraud or abuse of Medicaid funds**

Alleged or confirmed waste, fraud or abuse of Medicaid funds

a) Perpetrated by the provider; or
b) Perpetrated by the participant.

8. **Law enforcement involvement**

Charges filed against the participant for activities resulting in the:

a) Hospitalization of another (i.e., aggravated assault);
b) Death of another; and/or
c) Abuse and or exploitation of a vulnerable person, due to age, health, and/or disability.

9. **Private Health Information (PHI)/Personal Identifiable Information (PII) security breach**

   Any activity that could potentially put sensitive information at risk of unauthorized use, access, disclosure, or modification.

Procedure for reporting to the State Medicaid Agency:

1. On the first business day after a critical incident has occurred*, a representative from the OA will notify a member of the SMA Quality Assurance team via email, telephone or in person. If the OA has any question about whether a case meets the criteria for reporting to the SMA, the OA will contact the SMA for technical assistance.

   * In some cases it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.
2. Within ten business days after notification, the OA will submit a completed Critical Incident Investigation form to the SMA.
3. Within five business days after receiving the Critical Incident Investigation form the SMA will review the investigation form submitted by the OA and will contact the OA if additional information or action is required.
4. When the SMA determines the investigation is complete, the SMA will document any findings or corrective action requirements on the SMA portion of the investigation form. The SMA will send the OA a copy of the finalized document, closing the case. In some cases, the SMA may continue to monitor findings or corrective actions.

5. Within two weeks after closing the case, the SMA will notify the participant or the participant's representative of the investigation results. A copy of the notification letter will be provided to the OA. The following types of incidents are excluded from the notification letter requirement: suicide attempt, missing person, death and investigations that conclude with dis-enrollment and/or are not concluded within six months of the original incident date.

Level two incidents and events - reportable to the OA

The following incidents must be reported by providers, participants and/or their representatives to the OA, but are not required to be reported to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the OA.

1. **Unexpected medical treatment** (requiring immediate medical treatment at an emergency room)

Medical treatment related to one or more of the following reasons:

   a) Abuse/neglect/exploitation (either alleged or substantiated);
   b) Medication errors; and/or
   c) Substance abuse.

2. **Abuse/neglect/exploitation** (either alleged or substantiated)
   a) Exploitation of a participant's funds or property;
   b) Theft and/or diverting of a participant's medication(s); and/or
   c) Sexual assault/abuse/exploitation (regardless of medical treatment).

3. **Human rights violations**

Such as:

   a) Unauthorized use of restrictive interventions, including but not limited to restraints (physical, mechanical, or chemical);
   b) Misapplied restrictive interventions, (included in the BSP);
   c) Unauthorized use of seclusion;
   d) Unwelcome infringement of personal privacy rights; and/or
   e) Violations of individual rights to dignity and respect.
   f) Exceptions:

i. Restrictive/intrusive intervention(s) clearly defined in individualized behavior support plans and/or care plan/person centered support plans pursuant to 42 CFR §441.301(c)(4)(5); and
ii. Emergency behavioral interventions as defined by Utah Administrative Code, Title R539-4-6.

Operating Agencies are responsible to ensure providers are compliant with 42 CFR §441.301(c)(4)(5).

4. **Attempted suicides**

An attempted suicide which did not result in the participant being admitted to a hospital. (Suicide attempts do not include suicidal thoughts or threats without actions)

5. **Compromised working or living environment**

An event in which the participant's working or living environment (e.g., roof collapse, fire, etc.) is compromised and the participant(s) require(s) evacuation.

6. **Law enforcement involvement**
   a) Participant(s)
      i. Criminal charges filed (not including those reportable to the SMA)
   b) Staff
      i. Criminal charges filed (make report to APS/CPS when necessary).
      ii. When staff is issued a moving violation while transporting participant(s).

For this category, the date of the incident will be recorded as the date on which the filing of charges occurred.

7. **Unexpected hospitalization**

Admission to the hospital for medical treatment related to one or more of the following reasons:
   a) Injuries
   b) Aspiration
   c) Choking

These do not include medical diagnoses that pose an expected risk for aspiration or choking. Also excluded from this category are self-injurious behavior or injuries

resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a participant that resulted in admission to a hospital for medical treatment (which is reportable to the SMA).

Procedure for reporting to the operating agency

1. On the first business day after a critical incident has occurred*, a representative from the case management or support coordination agency (case manager) will notify the OA via email, telephone or in person.
2. Within ten business days after notification, the case manager will submit a completed Critical Incident Investigation form to the OA.
3. Within five business days after receiving the Critical Incident Investigation form the OA will review the investigation form submitted by the case manager and will contact the case manager if additional information or action is required.
4. When the OA determines the investigation is complete, the OA will document any findings or corrective action requirements on the OA portion of the investigation form. The OA will send the case manager a copy of the finalized document, closing the case. In some cases, the OA may continue to monitor findings or corrective actions.
5. Within two weeks after closing the case, the case manager will notify the participant or the participant's representative (in person, phone or in writing) of the investigation results and document notification in the participant's record. The following types of incidents are excluded from the notification requirement: suicide attempt, death, and investigations that conclude with dis-enrollment and/or are not concluded within six months of the original incident date.

   * In some cases it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

III. Required reports

<u>OA Quarterly Report</u>

The OA will submit a waiver specific quarterly report to the SMA, no later than one month after the end of the quarter (October 31, January 31, April 30, July 31) that includes:

1. Name of the participant
2. Date of the incident
3. Date the incident was reported to the OA
4. Category of the incident: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
5. Brief summary of the incident and its resolution
6. Date the case was closed
7. Brief description of any corrective action required of the case manager or other provider

OA Annual Report

The OA will submit a waiver specific annual report to the SMA, no later than two months after the end of the fiscal year (August 31) that includes:

1. Total number of incidents
2. Number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
3. Number of incidents that resulted in corrective action by the case manager or other provider
4. Number of corrective actions that were implemented
5. Number of incidents where the participant/representative was informed of the investigation results, and the number of incidents where the contact was made within 14 days of the investigation closure
6. Summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
   a) If trends were noted, the report will include a description of the process improvement steps that will be implemented

State Medicaid Agency Annual Report

For incidents that are reportable to the SMA, the SMA will submit an annual report to the State Medicaid Director and OA Division Directors that includes:

1. For each waiver:
   a) Number of incidents
   b) Number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
   c) Number of incidents that resulted in corrective action by the OA, case manager or other provider
   d) Number of corrective actions that were implemented

2. Summary of all waivers:
   a) Number of incidents
   b) Number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
   c) Number of incidents that resulted in corrective action by the case manager or other provider
   d) Number of corrective actions that were implemented
   e) Summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
      i. If trends were noted, the report will include a description of the process improvement steps that will be implemented

Utah Medicaid Provider Manual

Medically Complex Children's Waiver

Division of Integrated Healthcare

Updated July 2020

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1 General information

This manual is designed to be used in conjunction with other sections of the Utah Medicaid provider manual, such as Section I: General Information.

1-1 General policy

Section 1915(c) of the Social Security Act permits states to offer, under a waiver of statutory requirements, a Medicaid funded home and community-based services (HCBS) waiver to eligible individuals as an alternative to facility-based care. Utah's Medically Complex Children's Wavier (MCCW) was initially approved by the Centers for Medicare and Medicaid Services effective October 1, 2015. Eligibility for to the MCCW is limited to individuals who meet the targeting criteria found in Chapter 3-2 of this manual. Federal approval includes authorization to "waive" Medicaid comparability requirements. This allows the state to "target" Medicaid reimbursed home and community-based services to a limited number of medically complex children. Additionally, the state is authorized to waive certain income and resource rules when determining eligibility for the MCCW.

The State Implementation Plan for the MCCW, approved by CMS, gives the state the authority to provide home and community services to the target group under its Medicaid plan. The State Implementation Plan and all attachments constitute the terms and conditions of the program.

This manual does not contain the full scope of the State Implementation Plan. To understand the full scope and requirements of the MCCW program, refer to the MCCW State Implementation Plan.

Historically, it has been necessary to admit a medically complex child into nursing facility to obtain needed services and supports. The MCCW is designed to offer individuals and their families an option to facility based care. Under the MCCW program, individuals who would otherwise require a level of care provided in a nursing facility (NF) may instead be offered the choice to receive Medicaid reimbursed services at home and in their community. Individuals enrolled in the

MCCW are eligible to receive home and community based services in addition to traditional medical services covered by Medicaid.

All HCBS waiver services must comply with federal HCBS settings regulations (42 CFR § 441.301) on an ongoing basis.

1-2 Fee for service or managed care

This manual provides information regarding Medicaid policy and procedures for fee for service Medicaid beneficiaries. This manual is not intended to provide guidance to providers for Medicaid beneficiaries enrolled in a managed care plan (MCP). A Medicaid beneficiary enrolled in an MCP (health, behavioral health, or dental plan) must receive services through that plan with some exceptions called “carve-out services,” which may be billed directly to Medicaid. Clients of the MCCW are specifically carved-out from receiving services through a MCP health and dental plan but will be enrolled in behavioral health plans.

Refer to the provider manual, Section I: General Information, for information regarding MCPs and how to verify if a Medicaid beneficiary is enrolled in an MCP. Medicaid beneficiaries enrolled in MCPs are entitled to the same Medicaid benefits as fee for service beneficiaries. Please contact the MCP listed on the beneficiary’s medical card for further information.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid beneficiary enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a beneficiary enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a beneficiary’s enrollment in an MCP. However, it is the provider’s responsibility to verify eligibility and plan enrollment for a beneficiary before providing services. Eligibility and plan enrollment information for each beneficiary is available to providers from several sources. Therefore, if a Medicaid beneficiary is enrolled in a plan, a fee for service claim will not be paid unless the claim is for a carve-out service.

1-3 Definitions

Definitions of terms used in general Medicaid programs are available in Section I: General Information of the Utah Medicaid provider manual. Definitions specific to the content of this manual are provided below.

Applicant: Is used to refer to the child, or the child's parent or other family member who submits the program application on the child's behalf.
Office of Authorization and Community Based Services: The organizational unit within the Division of Integrated Healthcare that administers the MCCW program.
Client: Is used to refer to the child, or the child's parent, legal guardian or representative.
DIH: Division of Integrated Healthcare.
Financial Management Services (FMS): Services offered in support of the self-directed services option. Financial Management Services facilitate the employment of individuals by the waiver client or designated representative including: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, fiscal accounting and expenditure reports and (c) Medicaid claims processing and reimbursement distribution.
Home and Community Based Services (HCBS): Are Medicaid services provide through an approved 1915(c) waiver.
Medically Complex Children's Waiver (MCCW): The title of the approved 1915(c) waiver that serves eligible medically complex children.
Nursing Facility (NF): A nursing facility is the facility based service delivery alternative for MCCW clients.
Open enrollment: Is the period during which the Department accepts waiver applications.
Self-Directed Services (SDS): Clients directly employ individuals to perform waiver services. The client is responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheets, disciplining etc., of the employees.
State Implementation Plan (SIP): The State Implementation Plan for the MCCW, is approved by CMS. The SIP gives the State the authority to provide home and community services to the target group under its Medicaid plan. The SIP and all attachments constitute the terms and conditions of the program.

Waiver opening: Is the availability of an individual position on the MCCW program.

2 Provider participation requirements

2-1 Provider enrollment

Medicaid payment is made only to providers who are actively enrolled in the Utah Medicaid Program. Refer to provider manual, Section I: General Information, for provider enrollment information.

In addition to completing the general provider enrollment process described in Section I: General Information, waiver providers are required to complete an Attachment A document to assure that providers meet the waiver specific provider qualifications.

2-2 Provider rights to a fair hearing

The Department provides hearing rights to providers and participants who have had any adverse action taken by the Utah Department of Health and Human Services, DIH, and MCCW who return a Hearing Request Form to the agency. This includes the denial of an individual's choice of provider (when more than one is available), contract reimbursement rates, sanctions, or other adverse actions related to provider performance or improper conduct of the agency in performing delegate Waiver responsibilities.

A Request for Hearing/Agency Action Form (hearing request) is available on the Utah Medicaid website. This form may also be requested from the Office of Administrative Hearings by calling (801) 538-6576. Hearing requests must be filed with the Office of Administrative Hearings within 30 calendar days from the date of the adverse action.

3 Client eligibility requirements

3-1 General eligibility

MCCW services are only available to individuals who meet the program eligibility requirements and who are enrolled in the MCCW.

A Medicaid member is required to present the Medicaid identification card before each service, and every provider must verify each member's eligibility each time services are rendered. For more information regarding verifying eligibility, refer to Section I: General Information, Verifying Medicaid eligibility, or to the Eligibility Lookup Tool located at https://medicaid.utah.gov/eligibility.

3-2 Establishing program eligibility

To be eligible for the program, the child must meet the following requirements at the time of application or during periodic reassessments:

1. Be 0 through 18 years of age;
2. Meet nursing facility level of care criteria as defined in R414-502-3; RN case managers will review documentation to verify the applicant meets nursing facility level of care as demonstrated by:
   a) Evaluation of the applicant's ability to perform age-appropriate activities of daily living; and
3. Have a level of disability determined by the Social Security Administration or the State Medical Review Board; and
4. Have complex chronic medical conditions and medical fragility associated with disabilities, technology dependencies, ongoing involvement of multiple subspecialty services and providers and/or frequent or prolonged hospitalizations or skilled nursing facility stays.
   a) To determine if a child has the medical complexity and intensity of services required for program eligibility, the child must have had within the last 24 months from the date of program application/review, or since the birth of the child if the child is less than 24 months old:
      i ≥ 3 organ systems affected; and
      ii) ≥ 3 specialty physicians involved in the child's care or treatment in a comprehensive clinic with different specialty providers; and
      iii) Prolonged dependence (> 3 months) on medical devices or treatments intended to support adequate organ function.
      iv) Meeting the established minimum medical acuity score from the program application.

4 Program enrollment

Entrance into the program will be managed by accepting application during open enrollment periods to be determined by the Department.

4-1 Open enrollment procedures

1. The Department accepts the following means of application during open enrollment periods:
    a) Online application, with a time and date stamp confirming that the application was received within the open enrollment period;
    b) Facsimile, with a time and date stamp confirming that the application was received within the open enrollment period; and
    c) Mail, with the postmark on applications dated no sooner than the first day of the open enrollment period and no later than the last day of the open enrollment period.
2. Incomplete applications, including applications in which required attachments are not submitted, will not be accepted.
3. The number of individuals who may enroll in the waiver program during an open enrollment period is based on the availability of funds.
4. If the number of applications does not exceed the number of available openings when the open enrollment period ends, the Department will enroll all individuals who meet program eligibility requirements described in Chapter 3-2, Establishing program eligibility.
5. If the number of applications exceeds the number of available waiver openings, the Department will prioritize entrance into the program based on the complexity of the child's medical conditions and the critical needs of the child and the child's family as identified in the Application for Utah's Medically Complex Children's Waiver (the application).
    a) Applications will be ranked by Department clinical staff based on a score derived from 1) the application that was completed and submitted by the applicant and 2) the associated required attachments: physician certification form, and a history and physical or well child check summary completed by the child's physician within the last 24 months from the date of program application.

b) Prior to enrollment into the MCCW, if Department clinical staff detect a discrepancy between the applicant's responses to the application and the physician's responses provided on the physician certification form or the history and physical or well child check summary, Department staff will attempt to contact the applicant to resolve the discrepancy. To resolve the discrepancy for scoring purposes, the applicant will be required to submit written clarification from the physician. The written clarification must be submitted to the Department with a time and date stamp that confirms the discrepancy clarification document was received within 14 days from the date Department staff attempted to contact the applicant.

   i. Attempts to contact will include calling and emailing the applicant using the telephone number and email address provided in the application. The applicant is responsible to ensure that the Department has current and up-to-date contact information.
   ii. If the applicant does not provide written clarification from the physician within the 14 day period, the lesser of the two scores for the item that is the object of the discrepancy will be used.

c) If there are multiple applications with the same prioritized score, and the total number of same-scored applications is greater than the number of remaining waiver openings, the medical score will be used to select applications until all waiver openings are filled. If there are multiple applications with the same medical Score and the total number of same-scored applications is greater than the number of remaining waiver openings, the Department will assign each application a random number and will create a randomized list. The list will be sorted based on the random number assigned to the application from least to greatest number. The Department will begin selecting applicants at the top of the randomized list and will select applications until all waiver openings are filled.

6. Entrance into the waiver is dependent on an application with the Department of Workforce Services (DWS). Once selected for enrollment, applicants will

have 30 days from the date the application is selected for enrollment to apply for Medicaid with DWS or the waiver application will be denied. Applicants will be required to return the form "Statement of Understanding" indicating that they understand program criteria and completed application with DWS. Enrollment is determined by participant meeting financial requirements for the Medicaid program eligibility by the Department of Workforce Services.

7. If an applicant is being served in a nursing facility at the time of their application they must submit a certification from the physician indicating the client is expected to return to a community setting within 90 days. If after 90 days the client continues to be served in a facility, the department will re-evaluate the clinical condition of the applicant and may elect to hold the position for no greater than 180 days from the date the application was selected for enrollment.

4-2 Fair hearing

DIH provides a participant, applying for or receiving Medically Complex Children's Waiver services, an opportunity for a hearing upon written request, if the participant is:

1. Not given the choice between facility-based (NF) care and MCCW services.
2. Denied the waiver provider(s) of choice if more than one provider is available to render the service(s).
3. Denied, suspended, or terminated access to the waiver program.
4. Experiences a reduction, suspension, denial or termination of waiver services identified as necessary to prevent facility placement.

A participant, or their legal representative when applicable, will receive a written notice of decision from MCCW if the participant is denied a choice between facility-based (NF) care and MCCW waiver services, found ineligible for the waiver program or denied access to the provider of choice for a covered waiver service. The notice of decision delineates the participant's right to appeal the decision.

An aggrieved participant may request a hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The DIH may reinstate

services for the participant or suspend any adverse action for providers if the aggrieved participant requests a hearing not more than ten calendar days after the date of action.

The participant is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing form and directing the request to the Department of Health and Human Services, DIH, for a hearing and determination. An informal dispute resolution process does not alter the requirements of the hearings process. The participant must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the DIH. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for a hearing or be conducted concurrent with the hearing process.

A Request for Hearing/Agency Action Form (hearing request) is available on the Utah Medicaid website. This form may also be requested from the Office of Administrative Hearings by calling (801) 538-6576.

5 Covered services

The MCCW offers respite services when delivered pursuant to an approved person centered care plan. Respite care is an intermittent service provided to an eligible individual to relieve the primary care giver from the stress of providing continuous care, thereby avoiding premature or unnecessary placement in facility-based care. Respite care may be provided by a Medicaid enrolled home health agency or through the self-directed service (SDS) model. For program clients, typical utilization of respite care is estimated at approximately three hours per week. Nurse case managers will conduct an assessment and develop a person centered care plan with the client to determine the type and amount of respite needed and to assist in the coordination of waiver and other services.

Families will have 90 days to complete the person centered care plan once the nurse completes her assessment. In addition to waiver services, clients will have access to traditional Medicaid service coverage.

5-1 Types of respite services

1. **Skilled nursing respite care** coverage includes an initial RN assessment to establish a new client. Skilled nursing respite care may be provided in the home or other approved community settings.
    a) Qualified skilled nursing respite care providers include:
        i. Medicaid enrolled, licensed home health agencies that employ or contract with registered nurses, licensed practical nurses and home health aides; and are capable of providing respite care services to medically complex children in their homes and other approved community based settings.
        ii. Registered Nurses in the State of Utah under the SDS model which:
            1 Are licensed in accordance with Title 58, Chapter 31b, Part 3, Occupational and Professional Licensing, Utah Code Annotated 1953 as amended (records kept by FMS);
            2 Complete and pass a background and criminal investigation check annually. Annually is defined as 365 days (records kept by FMS);
            3 Are covered under an individual nursing malpractice insurance policy (records kept by FMS);
            4 Have a current basic CPR certification (records kept by FMS);
            5 Are enrolled with an FMS agency; and
            6 Demonstrate the ability to perform the necessary skilled nursing functions to safely care for the client (Client is responsible for completing this function).
2. **Routine respite care** may be provided in the home or other approved community settings.
    a) Qualified routine respite care providers include:
        i. Agency-based providers enrolled as Medicaid HCBS waiver providers.
        ii. Individuals hired by the client under the SDS model who meet the following requirements:

1. Complete and pass a background and criminal investigation check annually. Annually is defined as 365 days (records kept by FMS);
2. Are enrolled with an FMS agency; and
3. Demonstrate the ability to perform the necessary functions to safely care for the client (Client is responsible for completing this function).

5-2 Self-directed services (SDS)

Self-directed services (SDS) are made available to all waiver enrollees who elect to participate in this method. Under SDS, clients hire individual employees to perform waiver services. The client is responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of time sheets, disciplining, etc., of the individual employees.

Financial management services (FMS) are offered in support of the SDS option. FMS facilitate the employment of individuals by the waiver client: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, fiscal accounting and expenditure reports and (c) Medicaid claims processing and reimbursement distribution.

The waiver client is the employer of record, retaining control over the hiring, training, management and supervision of employees who provide direct care services. Under the SDS method, the waiver client submits their staff time sheet(s) to the FMS provider. The FMS provider pays the claims and submits a claim to the Department for reimbursement. All payments are made through the enrolled FMS provider. Payments are made directly to the employee and are not issued to the waiver client.

Financial management services reimbursement

Reimbursement for self-administered services includes reimbursement for all mandatory employer payroll taxes, and workman's compensation insurance premiums. These costs should be paid in addition to the self-administered service rate established between the waiver participant and the employee. For example, if a waiver participant negotiates an hourly wage of $10 per hour with their self-

administered services employee, mandatory employer burden costs (e.g., Social Security and Medicare taxes, Federal Unemployment Taxes, and Worker's Compensation Insurance premiums) are paid in addition to the $10 per hour wage. The employee's income tax withholding should be deducted from the negotiated wage.

6 Billing

Refer to the provider manual, Section I: General Information, for detailed billing instructions.

6-1 General billing information

Description	Procedure Code	Modifier	Provider Type
Skilled Nursing Respite	T1005	U2	58- Home Health Agency 68- Personal Care Waiver Services Agent
Routine Respite	S5150	U2	54- Personal Care Agency 58- Home Health Agency 68- Personal Care Waiver Services Agent 76- Day Treatment Facility 77-Day/ Residential Treatment Facility
Financial Management	T2040	U2	68- Personal Care Waiver Services Agent

6-2 Billing for siblings

If it is determined by the nurse case manager during the person centered care planning process that a single respite provider may safely care for siblings enrolled in the program, the provider must bill for the approved service using the "UN" HCPCS modifier. This will allow the provider to be paid at 75% of the approved rate for both

clients served. No more than two siblings may be served at one time by a single provider.

6-3 Electronic visit verification

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, are effective for Utah Medicaid beginning July 1, 2019. EVV requirements apply to all personal care services and home health care services provided under a 1915 (c) Home and Community Based Waiver.

Choice of reporting systems for EVV are by provider preference, but must meet all federal requirements, including the standards set in the Health Insurance Portability Accountability Act. The state will not implement a mandatory model for use. All provider choice EVV systems must be compliant with requirements of the Cures Act including:

1. type of service performed;
2. individual receiving the service;
3. date of the service;
4. location of service delivery;
5. individual providing the service;
6. time the service begins and ends; and
7. the date of creation of the electronic record.

Additional information including technical specifications for file creation/submission and EVV resources can be found at https://medicaid.utah.gov/evv

7 Disenrollment

When the need arises, participants are separated from the Home and Community Based waiver program through a disenrollment process.

The disenrollment process is a coordinated effort between the MCCW program team and the Office of Authorization and Community-Based Services quality assurance unit and is expected to facilitate the following:

1. Verification that the disenrollment is appropriate for the waiver participant;
2. Movement among waiver programs (when applicable);
3. Ensuring effective utilization of waiver program services;

4. Effective discharge and transition planning;
5. Distribution of information to participants describing all applicable waiver rights; and
6. Program quality assurance.

All of the various circumstances for which it is permissible for participants to be disenrolled from the waiver program can be grouped into three distinct disenrollment categories.

A. Voluntary disenrollments are cases in which the participants, or their legal representative (when applicable), choose to initiate disenrollment from the waiver. Disenrollments are also considered voluntary when the waiver participant enters a skilled nursing facility for a stay of less than 90 days and chooses not to transition back to the original waiver program. This includes cases in which the participant transitions to another waiver program from the skilled nursing facility.
No prior review or approval of the decision to disenroll is required from the OACBS quality assurance unit.

Additional documentation will be maintained by the MCCW Program that includes a written statement signed by the participant, or their legal representative (when applicable) describing their intent to disenroll from the waiver program. This documentation should also outline discharge planning activities completed by the case manager with the waiver participant as part of the disenrollment process.

B. Pre-Approved involuntary disenrollments are cases in which the participants are involuntarily disenrolled from the waiver for any of the following reasons including:

1. Death of the participant;
2. Participant has been determined to no longer meet the financial requirements for the Medicaid program eligibility by the Department of Workforce Services;
3. Participant enters a skilled nursing facility, and the expected length of stay will exceed 90 days (as verified by a physician)

No OACBS quality assurance unit prior review or approval of the decision to disenroll is required, as the reasons for pre-approved involuntary disenrollment have already been approved. Documentation will be maintained by MCCW, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process when appropriate.

C. Special circumstance disenrollments are cases in which participants are involuntarily disenrolled for reasons that are non-routine in nature and involve circumstances that are specific to the participant. These cases require prior review by MCCW and a second level approval by the OACBS quality assurance unit. Examples of this type of disenrollment include:

1. Participant no longer meets the level of care requirements for the waiver;
2. Participant's health and safety needs cannot be met by the waiver program's services and supports;
3. Participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a plan of care that meets minimal safety standards;

The special circumstance disenrollment review process will consist of the following activities:

1. The MCCW case manager shall compile information to articulate the disenrollment rationale;
2. If MCCW program manager concurs with the recommendation, a request for disenrollment approval will be forwarded to the OACBS quality assurance unit for a final decision;
3. The OACBS quality assurance unit will review and assure that all State Plan, waiver, non-waiver and other available services/resources have been fully utilized to meet the participant's needs;
4. MCCW and/or the OACBS quality assurance unit may facilitate meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment; and
5. The OACBS quality assurance unit will communicate a final disenrollment decision to MCCW.

If the special circumstance disenrollment request is approved, MCCW or their designee will provide the participant, or their legal representative (when applicable), with the required written notice of decision and right to fair hearing information.

The case management agency will initiate discharge planning activities sufficient to assure a smooth transition to an alternate Medicaid program and/or to other services. Discharge planning activities shall be documented in the participant's case record.

8 Incident reporting protocol

The State Medicaid Agency (SMA) has the administrative authority over all 1915(c) Medicaid Home and Community Based Services (HCBS) Waivers (waivers). Waiver programs must provide adequate and appropriate services that safeguard the health and welfare of all enrolled participants. Waiver programs must also assure financial accountability for funds expended for HCBS services. While these responsibilities are delegated to the operating agencies (OA), the SMA retains final authority and has the final responsibility to 1) assure that appropriate actions have taken place when a critical incident or event occurs; and 2) in cases where appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard participants.

The critical incidents and events program is a collaborative effort between the OAs for each of the 1915(c) waivers and the SMA. The program has two levels. Level one describes the critical incidents/events that are required to be reported by the OA to the SMA for investigation, resolution and closure. Level two describes the critical incidents/events that are required to be reported to the OA for investigation, resolution and closure.

This standard operating procedure stipulates:

1. Level one incidents and events required to be reported to the SMA;
2. Level two incidents and events that are required to be reported to the OA;
3. The agency responsible for completing the review; and
4. Associated reporting requirements.

Reportable critical incidents/events

Level one incidents and events – reportable to the SMA

The following list of the incidents/events (incidents) must be reported by the OA to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the SMA.

1. Unexpected hospitalization

Admission to the hospital for medical treatment related to one or more of the following reasons:

- a) Injuries that result in the loss of physical or mental function. (i.e., loss of limb, paralysis, brain injury or memory loss);
- b) Alleged/substantiated abuse or neglect;
- c) Attempted suicide;
- d) Medication errors;
- e) Self-injurious behavior;
- f) Serious burns; and/or
- g) Substance abuse

2. Exploitation (either alleged or substantiated)

Unfairly taking advantage of a participant due to his/her age, health, and/or disability.

- a) Serious and/or patterned/repeated event(s) involving a single participant,
- b) Involving multiple participants.

3. Human rights violations

- a) Serious infringements of participant human rights (jeopardizing the health and safety of the participant);
- b) Exceptions;
  - i. Restrictive/intrusive intervention(s) must be clearly defined in individualized behavior support plans and/or care plan/person centered support plans pursuant to 42 CFR §441.301(c)(4)(5).
  - ii. Emergency behavioral interventions as defined by Utah Administrative Code, Title R539-4-6 are not considered a human rights violation.

4. Incidents involving the media or referred by elected officials

Incidents that have or are anticipated to receive public attention (i.e., events covered in the media or referred by the Governor, legislators, or other elected officials).

5. **Missing persons**

For reporting purposes, the following participants are considered to be missing:

a) Participants who have been missing for at least 24 hours; or
b) Regardless of the number of hours missing – any participant who is missing under unexplained, involuntary or suspicious circumstances and is believed to be in danger because of age, health, mental or physical disability, environment or weather or who could be in the company of a potentially dangerous person or some other factor that places the participant in peril.

6. **Unexpected deaths**

All deaths are considered unexpected with the exception of:

a) Participants receiving hospice care; and/or
b) Deaths due to natural causes, general system failure or terminal/chronic health conditions.

A death related to an adverse event that occurs while the participant is receiving treatment in an inpatient facility, which is regulated by Health Facilities Licensing and Certification, should be reported as an unexpected death, the QA/SMA team may opt not to require an investigation. (Reportable to Health Facilities Licensing)

7. **Waste, fraud or abuse of Medicaid funds**

Alleged or confirmed waste, fraud or abuse of Medicaid funds

a) Perpetrated by the provider; or
b) Perpetrated by the participant.

8. **Law enforcement involvement**

Charges filed against the participant for activities resulting in the:

a) Hospitalization of another (i.e., aggravated assault);
b) Death of another; and/or
c) Abuse and or exploitation of a vulnerable person, due to age, health, and/or disability.

9. Private Health Information (PHI)/Personal Identifiable Information (PII) security breach

Any activity that could potentially put sensitive information at risk of unauthorized use, access, disclosure, or modification.

<u>Level two incidents and events - reportable to the OA</u>

The following incidents must be reported by providers, participants and/or their representatives to the OA, but are not required to be reported to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the OA.

1. **Unexpected medical treatment (requiring immediate medical treatment at an emergency room)**

Medical treatment related to one or more of the following reasons:

a) Abuse/neglect/exploitation (either alleged or substantiated);
b) Medication errors; and/or
c) Substance abuse.

2. **Abuse/neglect/exploitation (either alleged or substantiated)**

a) Exploitation of a participant's funds or property;
b) Theft and/or diverting of a participant's medication(s); and/or
c) Sexual assault/abuse/exploitation (regardless of medical treatment).

3. **Human rights violations**

Such as:

a) Unauthorized use of restrictive interventions – including but not limited to restraints (physical, mechanical, or chemical);
b) Misapplied restrictive interventions, (included in the BSP);
c) Unauthorized use of seclusion; and/or
d) Unwelcome infringement of personal privacy rights;
e) Violations of individual rights to dignity and respect;
f) Exceptions;
    i. Restrictive/intrusive intervention(s) must be clearly defined in individualized behavior support plans and/or care plan/person centered support plans pursuant to 42 CFR §441.301(c)(4)(5).

ii. Emergency behavioral interventions as defined by Utah Administrative Code, Title R539-4-6 are not considered a human rights violation.

Operating Agencies are responsible to ensure providers are compliant with 42 CFR §441.301(c)(4)(5).

4. **Attempted suicides**

   An attempted suicide which did not result in the participant being admitted to a hospital. (Suicide attempts do not include suicidal thoughts or threats without actions.)

5. **Compromised working or living environment**

   An event in which the participant's working or living environment (e.g., roof collapse, fire, etc.) is compromised and the participant(s) require(s) evacuation.

6. **Law enforcement involvement**

   a) Participant(s)
      i. Criminal charges filed (Not including those reportable to the SMA)

   b) Staff
      i. Criminal charges filed (Make report to APS/CPS when necessary).
      ii. When staff is issued a moving violation while transporting participant(s).

For this category, the date of the incident will be recorded as the date on which the filing of charges occurred.

7. **Unexpected hospitalization**

Admission to the hospital for medical treatment related to one or more of the following reasons:

   a) Injuries
   b) Aspiration
   c) Choking

These do not include medical diagnoses that pose an expected risk for aspiration or choking. Also excluded from this category are self-injurious behavior or injuries resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a participant that resulted in admission to a hospital for medical treatment (which is reportable to the SMA).

8-1 Procedure for reporting fraud, waste, or abuse to the state Medicaid agency

1. On the first business day after a critical incident has occurred[1], a representative from the OA will notify a member of the SMA quality assurance team via email, telephone, or in person. If the OA has any question about whether a case meets the criteria for reporting to the SMA, the OA will contact the SMA for technical assistance.
2. Within 10 business days after notification, the OA will submit a completed critical incident investigation form to the SMA.
3. Within 5 business days after receiving the critical incident investigation form the SMA will review the investigation form submitted by the OA and will contact the OA if additional information or action is required.
4. When the SMA determines the investigation is complete, the SMA will document any findings or corrective action requirements on the SMA portion of the investigation form. The SMA will send the OA a copy of the finalized document, closing the case. In some cases, the SMA may continue to monitor findings or corrective actions.
5. Within 2 weeks after closing the case, the SMA will notify the participant or the participant's representative of the investigation results. A copy of the notification letter will be provided to the OA. The following types of incidents are excluded from the notification letter requirement: suicide attempt, missing person, death and investigations that conclude with dis-enrollment and/or are not concluded within 6 months of the original incident date.

8-2 Required reports

<u>OA quarterly report</u>

The OA will submit a waiver specific quarterly report to the SMA, no later than one month after the end of the quarter (October 31, January 31, April 30, July 31) that includes:

1. name of the participant

[1] In some cases, it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

2. date of the incident
3. date the incident was reported to the OA
4. category of the incident: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
5. brief summary of the incident and its resolution
6. date the case was closed
7. brief description of any corrective action required of the case manager or other provider

<u>OA annual report</u>

The OA will submit a waiver specific annual report to the SMA, no later than two months after the end of the fiscal year (August 31) that includes:

1. total number of incidents
2. number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
3. number of incidents that resulted in corrective action by the case manager or other provider
4. number of corrective actions that were implemented
5. number of incidents where the participant/representative was informed of the investigation results, and the number of incidents where the contact was made within 14 days of the investigation closure
6. summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
   a) If trends were noted, the report will include a description of the process improvement steps that will be implemented

<u>State Medicaid agency annual report</u>

For incidents that are reportable to the SMA, the SMA will submit an annual report to the State Medicaid director and OA Division directors that includes:

1. For each waiver:
   a) number of incidents

b) number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
c) number of incidents that resulted in corrective action by the OA, case manager or other provider
d) number of corrective actions that were implemented

2. Summary of all waivers:
   a) number of incidents
   b) number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
   c) number of incidents that resulted in corrective action by the case manager or other provider
   d) number of corrective actions that were implemented
   e) summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
      i. If trends were noted, the report will include a description of the process improvement steps that will be implemented

UTAH HOME AND COMMUNITY BASED WAIVER SERVICES
NEW CHOICES WAIVER
PROVIDER MANUAL

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1 GENERAL POLICY

Under section 1915(c) of the Social Security Act, a State may request approval through the federal Centers for Medicare and Medicaid Services (CMS) to “waive” certain statutory requirements in order to use Medicaid funds for an array of home and community-based medical assistance services provided to eligible recipients as an alternative to institutional care. The State of Utah has requested Medicaid reimbursed home and community-based waiver services for individuals who are currently residing long term in nursing facilities, assisted living facilities, small health care (Type N) facilities or other licensed Utah medical institutions, except for institutions for mental disease (IMD) and wish to receive supportive services in a home or community-based setting, and who but for the provision of such services, would require nursing facility placement. On April 1, 2007, the Division of Medicaid and Health Financing received approval from CMS to begin operating the New Choices Waiver. The approval includes waivers of: the “comparability” requirements in subsection 1902(a)(10)(B) of the Social Security Act, and the institutional deeming requirements in section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Waiver of Comparability

In contrast to Medicaid State Plan services requirements, under a waiver of comparability, the State is permitted to provide covered waiver services to eligible individuals who meet the State’s criteria for Medicaid reimbursement in a nursing facility (NF), and “waiver services” need not be comparable in amount, duration, or scope to services covered under the State Plan. However, each year the State must demonstrate that the waiver is a “cost-neutral” alternative to institutional (NF) services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded NF services.

Waiver of Institutional Deeming Requirements

Under the waiver of institutional deeming requirements, the State uses more liberal eligibility income and resource calculations when determining recipients’ Medicaid eligibility.

1-1 Acronyms and Definitions

For purposes of the New Choices Waiver the following acronyms and definitions apply:

BLTSS	Bureau of Long Term Services and Supports
CMS	Centers for Medicare and Medicaid Services
DMHF	Division of Medicaid and Health Financing
FMS	Financial Management Services
HCBS	Home and Community Based Services
IMD	Institution for Mental Disease
Licensed Utah Medical Institution	Any licensed Utah medical institution (non IMD) other than a nursing facility, assisted living facility or small health care (Type N) facility, e.g., hospital, hospice facility, etc.

LOC	Level of Care
MDS-HC	Minimum Data Set for Home Care is the standard comprehensive assessment instrument used in the New Choices Waiver to determine if an individual meets nursing facility level of care criteria and to assess the needs of each individual.
NCW	New Choices Waiver – the Medicaid 1915(c) Waiver Program
NF	Nursing Facility
SAS	Self-Administered Services is a service delivery method in which the participant and/or their chosen designee hires individual employees to deliver a waiver service rather than choosing to receive that service through the traditional agency-based service delivery method. New Choices Waiver offers four service types through the SAS model. (See the Self-administered Services section for more information.)
SFY	State Fiscal Year (July 1 – June 30)
SIP	State Implementation Plan. This is the formal way to refer to the CMS approved waiver application.
SMA	State Medicaid Agency
Target Group	The group of people whom the waiver is designed to serve. This waiver serves long term residents of nursing facilities, assisted living facilities, small health care facilities (Type N) or other licensed Utah medical institutions (non-IMD) who wish to receive services in a home or community-based setting.

1-2 CMS Approved Waiver State Implementation Plan

1. The State Implementation Plan (SIP) for the New Choices Waiver (NCW), approved by CMS, gives the State the authority to provide home and community services to the target group under its Medicaid plan. That document and all attachments constitute the terms and conditions of the program.

2. This manual does not contain the full scope of the SIP. To understand the full scope and requirements of the NCW program, refer to the SIP.

3. If anything written in this manual is found to be in conflict with the SIP, the Plan will take precedence.

2 SERVICE AVAILABILITY

1. Home and community-based waiver services are covered benefits only when provided:

   A. an individual meets the eligibility criteria defined in the CMS approved SIP; and

   B. pursuant to a written and approved comprehensive care plan.

2-1 Eligibility for Waiver Program

1. Home and community-based New Choices Waiver services are covered benefits only for Utah Medicaid recipients who meet nursing facility level of care criteria as defined in R414-502, and who:

2. are 18 years of age or older at the time of application; and

3. one of the following six (6) scenarios describes their current situation:

    A. Are receiving nursing facility care and have been continuously receiving nursing facility care for a minimum of 90 days prior to admission; or

    B. Are receiving care in a small health care facility (Type N) and have been continuously receiving Type N facility care for a minimum of 365 days prior to application; or

    C. Are receiving licensed assisted living facility care and have been continuously receiving assisted living facility care for a minimum or 365 days prior to application; or

    D. Are receiving Medicare or Medicaid reimbursed care in another type of licensed Utah medical institution that is not an institution for mental disease (IMD) on an extended stay of at least 30 days, and will discharge to a Medicaid reimbursed nursing facility for an extended stay of at least 60 days absent enrollment into the waiver program; or

    E. Are receiving Medicaid reimbursed services through another of Utah's 1915(c) HCBS waivers and have been identified in need of immediate (or near immediate) nursing facility placement absent enrollment into the New Choices Waiver program; or

    F. Have previously been enrolled in the New Choices Waiver but were disenrolled from the waiver due to a long term nursing facility admission or due to receipt of a lump sum payment or other financial settlement that resulted in loss of Medicaid financial eligibility. This re-entry after disenrollment is permitted only when there has been no interruption in services equivalent to nursing facility care including equivalent waiver services (paid privately or by another funding source) during the disenrollment period. A new nursing facility level of care assessment is required prior to readmission.

Other Eligibility Considerations

1. For individuals leaving acute care hospitals, specialty hospitals (non IMD), and Medicare skilled nursing facilities, participation is limited to those receiving a medical, non-psychiatric level of care.

    A. Individuals with co-occurring mental illness may be considered as long as it is not the primary need for services and the Waiver can meet the individual's health and safety needs.

2. Individuals whose primary condition is attributable to a mental illness are not eligible for participation in the NCW.

3. Individuals who meet the intensive skilled level of care as defined in R414-502 are not eligible for participation in the NCW.

4. Individuals who meet the level of care criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) as defined in R414-502 are not eligible for participation in the NCW.

    A. Individuals with co-occurring intellectual disability and related conditions may be considered as long as it is not the primary need for services and the Waiver can meet the individual's health and safety needs.

5. Individuals with a complex set of health and/or safety needs who cannot be safely served in a home and community-based setting will not be eligible for participation in the NCW.

2-2 Nursing Facility Level of Care

1. In determining whether the applicant has mental or physical conditions that can only be cared for in a nursing facility or the equivalent care provided through the New Choices Waiver program, the individual responsible for assessing level of care shall, in accordance with R414-502, document that at least two of the following factors exist:

    A. Due to diagnosed medical conditions, the individual requires substantial physical assistance with activities of daily living above the level of verbal prompting, supervision, or setting up;

    B. The attending physician has determined that the individual's level of dysfunction in orientation to person, place, or time requires nursing facility care, or equivalent care provided through a Medicaid home and community-based waiver program; or

    C. The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting, or without the services and supports of a Medicaid home and community-based waiver program.

2. An individual will not be enrolled if it is determined during the eligibility assessment process that the person does not meet the nursing facility level of care criteria or that the health, welfare, and safety of the individual cannot be maintained through the New Choices Waiver program.

3. Individuals who are actively receiving inpatient care in hospitals, nursing facilities, or other licensed Utah medical institutions are not eligible to receive waiver services during the time of their inpatient admission, except as permitted for case management services in two specific circumstances:

    A. Up to 180 days immediately prior to waiver enrollment for discharge planning case management activities, or

B. When an enrolled waiver participant has been admitted to an inpatient setting for temporary care.

4. All waiver participants must be initially and continuously assessed to meet nursing facility level of care in order to maintain waiver eligibility.

3 NEW CHOICES WAIVER ADMISSION PROCESS

3-1 Application and Assessment

The NCW program office within the Department of Health, Division of Medicaid and Health Financing (DHMF) is the designated entity authorized to receive applications and to perform all screening and intake functions for the NCW program. An application can be requested by calling the NCW program office at (801) 538- 6155, option 6 or toll free at (800) 662-9651, option 6.

There are two different application processes for the NCW program. The process that applies to a particular application is determined by the type of facility the individual is residing in when they submit their application to the NCW program office.

1. For people residing in nursing facilities or other Utah licensed medical institutions (non-IMD):

   A. Applications will be accepted from those living in nursing facilities or other Utah licensed medical institutions (non-IMD) who meet the minimum eligibility requirements listed in Section 2-1. Applications will be accepted at any time throughout the year until the CMS approved waiver enrollment cap is reached.

   B. Upon receipt of an application, the NCW program office will perform an initial screening of the application materials to determine if the following minimum eligibility criteria appear to be met:
      i. The application is complete;
      ii. The applicant is at least 18 years of age;
      iii. The applicant has Utah Medicaid financial eligibility in place;
      iv. The applicant is residing in a qualifying facility type as described in Section 2-1;
      v. The applicant has satisfied the applicable length of stay requirement in the facility type in which they reside as described in Section 2-1;
      vi. The applicant has had nursing facility level of care approved through the nursing facility admission process or has supplied medical records sufficient to pass an initial nursing facility level of care screening; and
      vii. The PASRR determination letter (if applicable) indicates that the applicant is approved for long term nursing facility care.

   C. If during the screening process any of these minimum criteria are not met, the NCW program office will halt the application process and a denial letter will be generated and sent to the applicant and/or their representative. Hearing rights will be provided.
   D. If the minimum screening criteria are met, the NCW program office will forward a referral to the waiver case management agency that was selected by the applicant

or their representative on the Freedom of Choice Consent Form.

E. A registered nurse or licensed physician from the selected case management agency will formally confirm that the nursing facility level of care criteria is met by performing a thorough face to face assessment utilizing the MDS-HC. The deadline for completion of this assessment is within 14 calendar days of receiving the referral.

F. Upon completion of the MDS-HC assessment, the case management agency must complete and submit a Level of Care Determination Form to the NCW program office, indicating whether or not the nursing facility level of care criteria is met. This form is due within one business day following completion of the MDS-HC assessment.

G. A licensed social worker and a registered nurse from the case management agency will work with the applicant and any other representatives chosen by the applicant to understand the applicant's strengths, preferences, goals, desires, social needs, support systems, and risk factors.

H. New Choices Waiver applications will be denied if an applicant refuses to consent to quality assurance monitoring of assessments and service coordination.

2. For individuals residing in licensed assisted living facilities or small health care facilities (Type N), the following application process applies:

   A. Applications will be accepted from those living in licensed assisted living facilities and small health care facilities (Type N) who meet the eligibility requirements listed in Section 2-1.

   B. Applications will be accepted at any time throughout the year until the CMS approved waiver enrollment cap is reached.

   C. Upon receipt of an application, the NCW program office will perform an initial screening of the application materials to determine if the following minimum eligibility criteria appear to be met:
      i. The applicant is at least 18 years of age;
      ii. The applicant has Utah Medicaid financial eligibility in place OR has applied to the Department of Workforce Services (DWS) for consideration of Medicaid financial eligibility;
      iii. The applicant is residing in a qualifying facility type as described in Section 2-1;
      iv. The applicant has satisfied the applicable length of stay requirement in the facility type in which they reside as described in Section 2-1; and
      v. The applicant has supplied medical records sufficient to pass an initial nursing facility level of care screening. The applicant has supplied additional documentation requested by the NCW program needed to screen for eligibility within five business days.

   D. If during the screening process any of these minimum criteria are not met, the NCW

program office will halt the application process and a denial letter will be generated and sent to the applicant and/or their representative. Hearing rights will be provided.

E. Applications meeting the minimum criteria above will proceed to the next step in the application process by following the guidelines found in Section 3-4, Selection of Entrants to the Waiver.

F. Selected applications will be forwarded to the waiver case management agency that was chosen by the applicant or their representative on the Freedom of Choice Consent Form. Applications not selected will be returned and the applicant or representative will be provided with hearing rights.

G. A registered nurse or licensed physician from the selected case management agency will formally confirm that the nursing facility level of care criteria is met by performing a thorough face to face assessment utilizing the MDS-HC. The deadline for completion of this assessment is within 14 calendar days of receiving the referral.

H. Upon completion of the MDS-HC assessment, the case management agency must complete and submit a Level of Care Determination Form to the NCW program office, indicating whether or not the nursing facility level of care criteria is met. This form is due within one business day following completion of the MDS-HC assessment.

I. A licensed social worker and the registered nurse from the case management agency will work with the applicant and any other representatives chosen by the applicant to understand the applicant's strengths, preferences, goals, desires, social needs, support systems, and risk factors.

J. New Choices Waiver applications will be denied if an applicant refuses to consent to quality assurance monitoring of assessments and service coordination.

3-2 Case Management Agency Notices of Decision

1. Within one business day after completion of the MDS-HC, the selected case management agency will send a written notice of decision to the applicant/representative and to the NCW program office. The notice will clearly state the case management agency's decision to accept or decline to provide case management services to the applicant. This notice will include contact information for the NCW program office should the applicant or their representative wish to discuss their options.

2. If an applicant is declined by a case management agency, this does not always mean that the applicant will be denied access to the New Choices Waiver program altogether. In certain circumstances, an applicant/representative may request that their application be forwarded to an alternate case management agency for consideration, if there is another case management agency operating in their county of residence. These requests are managed by contacting the NCW program office. The NCW program office will advise applicants (or representatives) whether or not the circumstances permit selection of an alternate case management agency.

3. If an applicant is declined by a case management agency for any of the following reasons, the NCW program office will perform a review of the decision and any supporting documentation:

   A. The case management agency determined that the applicant did not meet nursing facility level of care during the face to face comprehensive assessment process;

   B. The case management agency determined that the applicant's primary condition is attributable to mental illness;

   C. The case management agency determined that the applicant is eligible for admission to an intermediate care facility for people with intellectual disabilities; or

   D. The face-to-face comprehensive assessment indicated that the applicant has complex health and/or safety needs that exceed the ability of the NCW program to safely serve the applicant.

4. If the case management agency declines an applicant for any of the four reasons listed above, the case management agency will forward the assessment information to the NCW program office for review. If the NCW program office agrees with the case management agency's determination, the NCW program office will generate and send a denial letter to the applicant/representative denying access to the waiver program altogether and the applicant will not be permitted to select an alternate case management agency. Hearing rights will be provided. If the NCW program office does not agree with the case management agency's determination, the application can be forwarded to another agency of the applicant's choice if another case management agency is available in the applicant's service area.

5. Case management services are required for all participants in the NCW program. An eligible applicant who has been declined by every available case management agency in their service area cannot be enrolled on the NCW until a case management agency willing to provide services is available. The NCW program office will assist the applicant by identifying all available case management agencies in their service area and by facilitating completion of new Freedom of Choice Consent Forms and referrals to alternate agencies until a willing case management agency is identified or until all possible choices have been exhausted. At the point there are no willing case management agencies, the NCW program office will generate and send a denial letter to the applicant/representative. Hearing rights will be provided.

3-3 Enrollment

1. Once a case management agency has determined that the applicant meets the nursing facility level of care criteria and makes the decision to work with an applicant, they will begin working toward official waiver enrollment. There are two distinct enrollment processes for the NCW program and the process that a particular application goes through is determined by the type of facility the applicant reside in at the time the NCW application was submitted.

   A. <u>For applicants residing in nursing facilities or licensed Utah medical institutions (non-</u>

IMD):

i. The case management agency will assist the applicant to locate a community-based residence that will meet the applicant's needs, preferences, goals and resources. This residence can be the applicant's own home or apartment, the home or apartment of a friend or family member, a licensed assisted living facility, a small health care facility (Type N), a community residential treatment facility or an independent living facility. All facility-based residential options are limited to facilities that are enrolled as providers for the NCW program.

ii. Payment for room and board is the responsibility of NCW clients; a rental agreement must be negotiated between the client (or their representative) and the residence that they have chosen. If the applicant needs assistance, the case management agency will help with negotiating a rental agreement for the chosen location. When the rental agreement is completed and signed by all parties, the case management agency must submit it to the NCW program office.

iii. The NCW program office cannot coordinate NCW enrollment with DWS until the Level of Care Determination Form, Notice of Decision Letter, signed 114AR release form and a signed rental agreement are received from the case management agency. All of these items must be sent to the NCW program office by 12:00 noon on the 20th day of the month (or on the last State business day prior to the 20th of the month) in order for official enrollment to take place by the first of the following month.

iv. When the all required documents are received, the NCW program office will generate and send the 927 form, the signed rental agreement and the signed 114AR release form to the Long Term Care team at DWS for a separate determination of Medicaid financial eligibility.

v. Once the approval or denial of Medicaid financial eligibility is determined, DWS will complete and sign section B of the 927 and return it to the NCW program office prior to the last day of the month.

vi. The NCW program office will notify the case management agency of the Medicaid financial eligibility determination and the applicant's authorization to enroll with the NCW upon receipt of an approved 927. The case management agency will notify the applicant and begin planning for the applicant's transition to the NCW program.

vii. All enrollments for hospital and nursing facility applicants take place on the first day of the month following the completion of the 927 form. If enrollment (and move out of the hospital/nursing facility) must be delayed due to a change in the applicant's health status or for any other reason, the case management agency must notify the NCW program office right away. For all delayed enrollments, the case management agency must continue to communicate regularly with the NCW program office and shall not enroll the applicant or move them out of the hospital/nursing facility until clearing it again with the NCW program office first.

viii. The final phase in the enrollment process is creation of the person-centered comprehensive care plan through the person-centered care planning (PCCP) process. The case management agency shall convene a PCCP meeting with the client and anybody else that the client wishes to be present. This meeting must take place prior to the implementation of the initial care plan. Initial care plans

must be written and have an effective date that is within 60 days after completion of the MDS-HC assessment. If the care plan cannot be created within 60 days, a new MDS-HC must be performed and services cannot be authorized until on or within 60 days after the new MDS-HC date. Care plan start dates can fall anytime within the 60-day window, but never earlier than the date the MDS-HC was performed or earlier than the date of NCW enrollment.

B. For applicants residing in licensed assisted living facilities and small health care (Type N) facilities:

i. Individuals applying from licensed assisted living or small health care (Type N) facilities are not required to have Medicaid financial eligibility in place at the time of application to the NCW program, but the NCW program office will verify that a Medicaid financial eligibility application has been submitted to DWS within 30 days of the level of care assessment performed by the case management agency. Individuals must establish financial eligibility for Medicaid within 180 days following the first level of care assessment performed by a case management agency. If either of the above requirements are not met within the specified time frames, the application will be denied and hearing rights provided.

ii. The case management agency must submit a completed Level of Care Determination Form within one day of completion of the MDS-HC assessment. The Level of Care Determination Form, a Notice of Decision Letter and a signed 114AR release form must be received by the NCW program office in order for the NCW program office to proceed to the next step of coordinating with DWS. For ALF and Type N applicants, a rental agreement is not needed at this stage, nor is there a defined deadline day of the month for the required forms to be submitted. However, case management agencies must strive to submit the required forms within one business day of completion of the MDS-HC assessment in order to avoid delaying the earliest possible enrollment date.

iii. Upon receipt of the required forms from the case management agency, the NCW program office will generate the 927 form and send it to DWS along with a copy of the Pre-enrollment Lease Disclosure Form from the application and the signed 114 AR release form. The NCW program office may act as a facilitator between the applicant and DWS while DWS determines the applicant's Medicaid financial eligibility in a separate application process.

iv. Once the approval or denial of Medicaid financial eligibility is determined, DWS will complete and sign section B of the 927 form and return it to the NCW program office.

v. The NCW program office will notify the case management agency of the financial eligibility determination upon receipt of the 927 form from DWS. If the 927 was approved, the case management agency will assist the applicant with locating a new residence (when applicable), negotiating a new rental agreement and coordinating the start date for waiver services. The case management agency will forward the rental agreement to the NCW program office as soon as it is completed and signed.

vi. The final phase in the enrollment process is creation of the person-centered care plan through the person-centered care planning (PCCP) process. The case

management agency shall arrange a PCCP meeting with the client and anybody else that the client wishes to be present and this meeting must take place prior to the implementation of the initial care plan. Initial care plans. Initial care plans must be written and have an effective date within 60 days after completion of the MDS-HC assessment. If the care plan cannot be created within 60 days, a new MDS-HC must be performed and services cannot be authorized until on or within 60 days after the new MDS-HC date. Care plan start dates can fall anytime within the 60-day window, but never earlier than the date the MDS-HC was performed or earlier than the date of NCW enrollment.

2. Summary of ultimate requirements that must be completed in full to receive waiver services:

   A. Approval of Medicaid financial eligibility in a separate application process with DWS.

   B. Confirmation that the applicant meets nursing facility level of care criteria based on a face toface MDS-HC assessment by the chosen waiver case management agency.

   C. Development and approval of a waiver comprehensive care plan. The comprehensive care plan must be created and have an effective date that falls within 60 days after the date the MDS-HC assessment was completed. The start date of services on the care plan can fall anytime within the 60-day window, but can be no earlier than the date of the MDS-HC assessment or later than 60 days after the MDS-HC date.

3. Reserved Waiver Capacity

The NCW program was designed to be a deinstitutionalization program with the original objective being to offer home and community-based options for people wishing to transition out of skilled nursing facilities and other Utah licensed medical institutions (non-IMD). In 2012, the waiver was expanded to include a second entry pathway for long term residents of licensed assisted living facilities and small health care (Type N) facilities. In order to ensure the majority of waiver slots are reserved for people wishing to transition out of nursing facilities or other Utah licensed medical institutions (non-IMD), each state fiscal year a minimum of 80% of available waiver slots will be reserved for applicants residing in nursing facilities or other Utah licensed medical institutions (non-IMD).

4. Selection of Entrants to the Waiver

At the beginning of each waiver year (July 1), the NCW program will calculate the total number of available waiver slots. A minimum of 80% of the total number of available waiver slots will be reserved for residents of nursing facilities and other Utah licensed medical institutions (non-IMD).

For applicants residing in nursing facilities or other Utah licensed medical institutions (non-IMD), no selection policies apply beyond the eligibility criteria described in Policy 2-1, Eligibility for Waiver Program. For this group, applications will be accepted throughout the year and are not limited to defined open application periods.

4 Applicant Freedom of Choice of Nursing Facility or New Choices Waiver

1. The NCW program is a voluntary home and community-based program that's intended to be one option among others in the range of long-term care services. Utah Medicaid recipients meeting the nursing facility level of care criteria and all other NCW criteria are afforded the choice of which long term care service delivery system they would like to access. Prior to enrollment in the NCW, applicants are advised of their right to choose to receive care provided in a NF or they may choose to receive services through the home and community-based NCW program.

2. As part of the application packet, the applicant and/or their chosen representative will be advised in writing of all available services and given the opportunity to state which long-term care service delivery option they choose to access. The applicant's choice will be documented in writing on the Freedom of Choice Consent Form, signed by the applicant or their representative, and maintained as part of the individual record. A member of the NCW program office will verify that this form has been completed and that the applicant has chosen to receive home and community-based services through the NCW program before processing the application to the next step in the process.

3. NCW participants are reminded at least annually during their annual comprehensive care plan review that they maintain the right to choose which long term care service delivery option they wish to access and that they have the right to voluntarily disenroll from the NCW and enter a nursing facility at any time.

4-1 Participant's Freedom of Choice of Providers

Each NCW participant will be presented with a Freedom of Choice of Providers form that clearly lists all available services and service providers in their county of residence. The participant will indicate in writing his or her choice of waiver service providers for the services they have been assessed to need and will sign the form to acknowledge that they were given a choice. The case management agency will be responsible for presenting this form and offering choice of providers each time a new service is added to the care plan, anytime the participant requests a different provider, and at each annual care plan review. The case management agency will maintain signed copies of this form in the individual case records.

Freedom of Choice and Conflict Free Case Management

Case management services are expected to be provided without conflict of interest. Provider entities having the capacity to perform case management functions and other waiver or non-waiver services must assure that the functions of the entity are clearly separated; their respective responsibilities well defined; and must abide by conflict free case management guidelines.

1. If a case management agency is enrolled with NCW to provide other waiver services in addition to case management services or if they are an enrolled Medicare or Medicaid provider for other non- waiver services, they must pay careful attention to conflict of interest rules during the care plan development process. Case management agencies are not permitted to be listed on a participant's care plan as a

paid provider of any other waiver or non-waiver service except in the following circumstances:

A. Until March 1, 2019, if a client has been assessed to need goods and/or services through any of the following NCW services the case management agency may purchase the goods and/or service(s) from a non-Medicaid retailer or other entity and then receive direct Medicaid reimbursement through the usual and customary claims reimbursement process to pay the non-Medicaid retailer or other entity. For these instances, it is permitted for the case management agency to be listed on the care plan as a pass-through payment entity in order to ensure access to care:

    i. Assistive Technology Devices (T2028)
    ii. Environmental Accessibility Adaptations (S5165 and T2039)
    iii. Community Living Services (T2038)
    iv. Transportation- non-medical – Public Transit Pass (T2004)
    v. Specialized Medical Equipment, Supplies and Supplements (T2029)

B. By March 1, 2019, Utah will implement the use of a financial transaction services contractor to pay for goods and services purchased from retail stores, general contractors or other entities not directly enrolled as Medicaid providers. Starting March 1, 2019, case management agencies will not be permitted to act as pass-through payment agents for the above listed services, except as provided in section 4-1-C.

C. If it has been determined that the case management agency is the only willing, qualified provider enrolled to offer other paid waiver or non-waiver services in a particular geographical region, an exception can be made to permit the client to select the case management agency as their provider for the other services. The case management agency must provide justification to the NCW program office during the care plan submission process and the NCW program office will perform an analysis to determine whether or not it is appropriate to override the conflict of interest rules.

4-2 Termination of Home and Community-Based Waiver Services

1. When the need arises, participants are separated from the NCW program through a disenrollment process.

    A. The disenrollment process is a coordinated effort between NCW staff and case management agencies that is expected to facilitate the following:

        i. Verification that the disenrollment is appropriate for the waiver participant;
        ii. Movement among waiver programs (when applicable);
        iii. Ensuring effective utilization of waiver program services;

iv. Effective discharge and transition planning;
v. Distribution of information to participants describing all applicable waiver rights; and
vi. Program quality assurance.

2. All of the various circumstances for which it is permissible for individuals to be disenrolled from the waiver program can be grouped into three distinct disenrollment categories.

   A. Voluntary disenrollments are cases in which participants, or their representative (when applicable), choose to initiate disenrollment from the waiver.
      i. Refusal to participate in quality assurance monitoring is considered voluntary disenrollment.
      ii. Disenrollments are also considered voluntary when the waiver participant enters a skilled nursing facility for a stay of less than 90 days and chooses not to transition back to the original waiver program. This includes cases in which the participant transitions to another waiver program from the skilled nursing facility.
      iii. Voluntary disenrollments require that case managers notify NCW within 10 days from the date of disenrollment using the DPF-1 form. The DPF-1 form must be signed by the participant or their designated representative, if applicable. NCW prior review or approval of the decision to disenroll is not required.
      iv. Additional documentation will be maintained by the case management agency that describes the participant's intent to disenroll from the waiver program. This documentation should also outline discharge planning activities completed by the case manager with the waiver participant as part of the disenrollment process.

   B. Pre-Approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from the waiver for any of the following reasons including:
      i. Death of the Participant;
      ii. Participant has been determined to no longer meet the financial requirements for Medicaid program eligibility by the Department of Workforce Services;
      iii. Participant enters a skilled nursing facility, and the expected length of stay will exceed 90 days (as verified in writing by a physician).
      iv. Participant enters a skilled nursing facility and the actual length of stay has reached 90 days or more. (A physician's statement is not required for this circumstance.)
      v. Pre-Approved involuntary disenrollments require that case managers notify NCW within 10 days from the date of disenrollment using a DPF-1 form. Prior review or approval of the decision to disenroll is not required. Documentation will be maintained by the case management agency, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process when appropriate.

   C. Special circumstance involuntary disenrollments are cases in which participants are involuntarily disenrolled for reasons that are non-routine in nature and involve circumstances that are specific to the participant. These

cases require prior review by NCW and a second level approval by the BLTSS Quality Assurance Unit. Examples of this type of disenrollment include:

i. Participant no longer meets the level of care requirements for the New Choices Waiver;
ii. Participant's health and safety needs cannot be met by the waiver program's services and supports;
iii. Participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a plan of care that meets minimal safety standards;
iv. Participant has demonstrated non-compliance with a signed health and safety agreement with NCW or the case management agency; or
v. Participant's whereabouts are unknown for more than 30 days, and a decision regarding ongoing financial eligibility from the Department of Workforce Services has not been rendered.

The special circumstance involuntary disenrollment review process will consist of the following activities:

1. The case management agency shall compile all applicable log notes, records and other information to support that supports the disenrollment request;

2. This information will then be submitted to the NCW program office along with a completed DPF-2 form detailing specific discharge plans to address each of the client's assessed needs;

3. If after reviewing the submitted documents the NCW program office agrees with the disenrollment recommendation and believes the discharge planning activities are sufficient to meet the client's assessed needs, a request for disenrollment approval will be forwarded to the BLTSS Quality Assurance Unit for a final decision;

4. The BLTSS Quality Assurance Unit will review and assure that the disenrollment request is appropriate, that adequate discharge planning is in place to meet the client's assessed needs and that all Medicaid State Plan, waiver services, non-waiver services and other available services/resources have been fully utilized in an effort to meet the participant's needs prior to disenrollment being requested;

5. The NCW program office and/or the BLTSS Quality Assurance Unit may facilitate meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment; and

6. The BLTSS Quality Assurance Unit will communicate a final disenrollment decision to the NCW program office.

If the special circumstance disenrollment request is approved, the NCW program office will provide the client, or their legal representative (when applicable), with the required written disenrollment Notice of Decision (NOD) and right to fair hearing information.

The case management agency will initiate discharge planning activities sufficient to assure a smooth transition to an alternate Medicaid program and/or to other services. Discharge planning activities shall be documented in the client's case record within the case management agency. If the client (or representative) files an appeal with the Medicaid Fair Hearings Office, the case management agency will continue to serve the client and maintain all NCW standards (including updating the comprehensive care plan when appropriate) throughout the hearing process and until a decision is reached.

If an individual who has been disenrolled from the NCW program through the special circumstance involuntary disenrollment process later reapplies to the NCW program, the NCW program office will review records from their current place of residence and any other relevant information to determine whether the circumstances causing the disenrollment have been resolved. If the NCW program office determines that the circumstances causing the individual's disenrollment continue to exist, the application will be denied and hearing rights will be provided.

4-3 Grievances and Appeals

At any time for any reason, NCW applicants, participants and/or their chosen representatives may file a grievance or complaint with their case management agency, the NCW program or with the Constituent Services Office within the DMHF. Contact information for each of these entities is provided in Section 14 (Contact Information).

1. If a waiver applicant, a waiver client or their chosen representative(s) disagree with a decision that has been made regarding their NCW application or regarding their services, providers or any other aspect of their care, they may elect to engage in an informal dispute resolution process by contacting the Complaints and Grievances Coordinator with the NCW program office at (800)662-9651, option 6.

2. DMHF provides an opportunity for a Fair Hearing upon written request, if an individual is:

   A. Not given the choice of institutional (NF) care or HCBS waiver services;

   B. Denied the NCW provider(s) of choice if more than one provider is available to provide the service(s);

   C. Denied access to the NCW program or to services identified as necessary to prevent institutionalization or given services that are insufficient in amount, duration or frequency to meet the identified need; or

   D. Experiences a reduction, suspension, or termination of NCW services that the client or their representative believes they are eligible to receive.

3. The NCW program office will notify the applicant and/or their chosen representative with a NOD if the applicant is denied access to the waiver program. The NOD will provide

instructions for how to request a Medicaid Fair Hearing.

4. The case management agency will notify the participant and/or their chosen representative with a NOD if an enrolled participant experiences any of the other situations described above. The NOD will provide instructions for how to request a Medicaid Fair Hearing.

5. A participant who believes they have been wrongly denied choice of services or access to services or providers may request a Fair Hearing within 30 calendar days from the date listed on the NOD. The participant may elect to continue their waiver services if the participant or provider requests a hearing within 10 calendar days after the date of action.

6. The participant is encouraged to use the informal dispute resolution process to bring about a fair resolution more quickly, but the informal dispute resolution process is not required and a client or their representative may bypass or interrupt the informal dispute resolution process by completing a request for hearing and sending it to the Division of Medicaid and Health Financing.

7. The choice to engage in the informal dispute resolution process does not change the timely filing requirements of the Fair Hearings process. If a client wishes to go before the Hearings Office, a request for hearing must be submitted within the mandatory timeframes established by the Division of Medicaid and Health Financing.

5 PROVIDER PARTICIPATION

5-1 Provider Enrollment

1. Home and community-based waiver services for NCW participants are covered benefits only when delivered by a provider enrolled with the State Medicaid Agency to provide the services as part of the NCW program and that are authorized by each participant's chosen case management agency in an approved comprehensive care plan.

2. Any setting in which services were not being provided under an approved state plan, waiver or demonstration as of March 1, 2014 must be in compliance with regulations for the HCBS Settings Rule by the effective date of the program (the time the state submits a claim for Federal HCBS reimbursement).

3. Any willing provider that meets the qualifications defined in the New Choices Waiver Implementation Plan, Appendix C-2, may enroll at any time to provide a NCW service by submitting a provider enrollment application through the PRISM Provider Portal. Information about how to access the Provider Portal can be found on the Utah Medicaid website: https://medicaid.utah.gov/.

4. Providers are only authorized to provide the waiver services specified and approved in the provider's Attachment A within the PRISM Provider Portal. The service area for each NCW service the provider enrolls to offer is limited to the counties specified for that specific service

in the same Attachment A. Services cannot be provided to NCW clients until the services (including amount, frequency, duration and price) are authorized by a NCW case management agency representative in an approved comprehensive care plan. Providers shall not initiate services for a NCW client until the provider has an approved written service authorization from the client's chosen waiver case management agency.

5-2 Provider Reimbursement

1. A unique provider number is issued for each waiver service provider. When submitting claims for reimbursement, the provider must use the proper provider number associated with the waiver that the participant is enrolled in. Claims containing a provider number that is not associated with the proper waiver will be denied.

2. Providers will be reimbursed according to the specified reimbursement rate(s).

3. Direct service providers may only claim Medicaid reimbursement for services that are ordered by the responsible NCW case management agency and for which the provider has a current, signed service authorization form for the individual participant for whom the service is authorized. Service authorizations are valid for a maximum of one year, and must be reissued yearly or when there is a change in the service type, amount, frequency, price (when applicable), or end date of an existing service or a new service is started. The case management agency will supply the service provider with a service authorization form clearly identifying the NCW participant, the service requested, the HCPCS billing code, authorized per unit price for applicable HCPCS codes, the amount and frequency of the service ordered and the start and end date of the service. Claims must be consistent with the authorized participant and the HCPCS code(s), authorized per unit price (when applicable), amount, frequency and dates ordered by the waiver case management agency. Claims paid for services provided that exceed the authorized per unit price, unit amount, frequency or dates authorized, or for HCPCS codes (services) for which there is no approved service authorization form will be subject to a recovery of funds. Case management agencies may be held financially responsible for issuing a service authorization form to a provider that does not match the HCPCS code, authorized per unit price (when applicable), service scope, start and end date, number of service units, frequency of service, and/or provider name listed on an individual's approved care plan with an end date of July 1, 2019 or later.
   A. Price authorizations are applicable for the following HCPCS codes:
      - T2028-Assitive Technology Devices
      - T2029-Specialist Medical Equipment
      - T2038-Community Living Services
      - T2039-Environmental Accessibility Adaptions (vehicle)
      - S5120-Chore Services
      - S5165-Environemental Accessibility Adaptions (home)

4. With the exception of permitted case management services, providers may not provide services to participants who have been admitted to any inpatient setting including but not limited to a hospital, skilled nursing facility, specialty behavioral health hospital, or

rehabilitation facility.

5. All providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, the terms and conditions of Attachments A and B for each service type and the terms and conditions of the New Choices Waiver State Implementation Plan.

6. Accurate records of each service encounter must be kept by each provider (including case management agencies) and made available upon request by the NCW program office or any other unit within the DMHF. Records should include at a minimum:

   A. The participant's first and last name;

   B. The date of service for each service encounter;

   C. The start and end times for each service encounter;

   D. The service provided (by service title);

   E. Notes describing the service encounter in detail;

   F. The name(s) of the individual direct service provider(s) who performed the service; and

   G. Signature(s) of the individual direct service provider(s).

7. The following are examples of circumstances that are not reimbursable by Medicaid. This is not an all-inclusive list:

   A. If a NCW participant misses a scheduled appointment, Medicaid cannot be billed for the missed appointment even if the participant did not abide by the provider's cancellation policy. The provider can bill the individual directly for a missed appointment only if it is part of the provider's policy to bill all clients for missed appointments, not just Medicaid recipients. If the provider has such a policy, they are responsible to notify the participant of this policy prior to providing services to the individual.

   B. Services provided to a NCW participant who was not authorized to receive the service cannot be billed to Medicaid.

   C. Unused units that have been authorized for one NCW participant cannot be transferred to another NCW participant. If a provider believes that a participant requires more units of service than are authorized on the service authorization form, the provider must contact the assigned case management agency to request an assessment of need.

   D. Claims submitted for services that were not rendered to the participant are not

reimbursable, even if there are unused units remaining.

E. Any claims paid for services in excess of the amount, duration, price (when applicable) or frequency listed on the approved care plan or for services that are not listed on the approved care plan for the specific participant will be recovered.

8. Providers are accountable for all terms of agreements as defined in the Utah Department of Health, Division of Medicaid and Health Financing Provider Agreement, which was signed upon enrollment with the New Choices Waiver.

5-3 Standards of Service

Data Security & Privacy

Providers are expected to take steps to ensure that all personal information related to the individual being served is protected. This includes both Personal Health Information (PHI) as well as Personally Identifiable Information (PII). Providers should use appropriate administrative, technical and physical safeguards to preserve the integrity, confidentiality, and availability of PHI/PII that they create, receive, maintain or transmit. This includes using encrypted/secure email, fax, or other secure methods to transmit documents containing information about the individual being served. Providers shall ensure there is limited and controlled access to PHI/PII. In the performance of its services and operations, the provider shall make efforts to use, disclose and request only the minimum amount of PHI/PII considered reasonably necessary. The provider shall also identify and protect against reasonably anticipated threats to the security or integrity of the information, protect against reasonably anticipated, impermissible uses or disclosures; and ensure compliance by their workforce.

Breach Reporting/Data Loss

Providers must report to the NCW program, either by email or telephone, any breach or loss of PHI/PII. This report should be completed not more than 24 hours after the provider knows, or should have reasonably known about the breach. The provider must also submit a report in writing/by email to NCW within 5 business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

5-4 Provider Rights to a Fair Hearing

The Department provides hearing rights to providers who have had any adverse action taken by the Bureau of Long Term Services and Supports, , who submit a written request for a hearing to the agency. Please refer to Utah Department of Health, Division of Medicaid and Health Financing Provider Manual, General Information, Section 1, Chapter 6 – 15, Administrative Review/Fair Hearing. This includes actions relating to enrollment as a waiver provider, contract reimbursement rates, sanctions or other adverse actions related to provider performance, or improper conduct of the agency in performing delegated waiver responsibilities.

5-5 Provider Non-Compliance

Contract Termination

The State Medicaid Agency may terminate the provider's NCW contract in accordance with R414-22, Administrative Sanction Procedures and Regulations, after giving the provider 30 days advance written notice for either of the following reasons:

1. The State Medicaid Agency detects a pattern of non-compliance with general Utah Medicaid provider standards.

2. The State Medicaid Agency detects a pattern of non-compliance with NCW policies, procedures and/or provisions.

3. The State Medicaid Agency detects significant misconduct or substantial evidence of misconduct that violates requirements of the Medicaid waiver program.

The provider will be given hearing rights for any adverse actions taken by the State Medicaid Agency.

Examples of conduct that constitute patterns of non-compliance include but are not limited to:

1. Abuse, neglect or exploitation of NCW clients;

2. Isolating individuals from the broader community and non-compliance with the HCBS Settings Final Rule;

3. Inaccurate level of care assessment documentation;

4. Billing Medicaid in excess of the amount, duration and frequency of services that have been authorized;

5. Billing Medicaid for services not provided;

6. Inadequate or non-existent record keeping;

7. Repeatedly tardy care plan submission;

8. Billing Medicaid for case management services provided by individuals that do not meet the minimum qualifications of RN or SSW licensure (or equivalent or higher licensure);

9. Not maintaining minimum provider qualifications such as required business license or certification;

10. Acts of direct marketing to prospective or currently enrolled NCW clients or their representatives;

11. Acts of coercion or manipulation of client freedom of choice rights;

12. Acts of offering or receiving incentives or kick-backs to or from other providers or entities in an effort to manipulate client freedom of choice rights;

13. Lack of adequate provider representation at annual mandatory provider trainings and/or completion of required provider trainings; or

14. Billing NCW clients or their representatives for services covered by Medicaid.

If the State Medicaid Agency discovers conduct that constitutes a pattern of non-compliance, or discovers that a single violation of general Medicaid or NCW policy has occurred, but elects not to terminate the provider's New Choices Waiver contract, the State Medicaid Agency may instead:

1. Require the provider to repay any overpayments;

2. Complete additional training;

3. Submit a Corrective Action Plan;

4. Submit to additional monitoring activities in order to avoid contract termination;

5. Withhold payment in accordance with R414-1-31, Withholding of Payments; or

6. Suspend referrals of new clients until the provider has met established compliance targets or has established an approved Corrective Action Plan.

Corrective Action Plan

The State Medicaid Agency may request the provider submit a Corrective Action Plan to address individual instances or patterns of non-compliance with general Medicaid or NCW policy. A Corrective Action Plan may take any of several forms. It may include training, revised provider agency policies/procedures, additional staff, different staffing patterns, etc. Technological solutions may be implemented to alert for timeliness of home visits, levels of care and service plans, etc. Each Corrective Action Plan must measure the impact to determine whether it was effective. If not, other interventions should be explored. The State Medicaid Agency may require additional monitoring activities to assure the effectiveness of interventions.

Assuring Freedom of Choice

NCW affords clients the fundamental right to select their preferred provider for waiver services assessed to be needed and to select the preferred provider for Medicaid State Plan services. This

selection is to be made without coercion or undue influence. Providers may not influence prospective or current clients' Freedom of Choice in any way and are prohibited from direct marketing activities. Examples of direct marketing include, but are not limited to, unsolicited direct marketing activities to prospective NCW clients during inpatient stays; unsolicited direct marketing to health care settings where prospective NCW clients may reside; and unsolicited direct marketing to health care providers/entities. Providers may not enter into formal or informal contracts/agreements with other entities or quid pro quo arrangements that have the effect of influencing or manipulating Freedom of Choice. Outside of excellent NCW service provision which would naturally garner recognition, marketing strategies shall be limited to indirect marketing (materials such as brochures and business cards that individuals can access at their preference.)

Providers may not approach prospective or currently enrolled NCW clients or their representatives unless the client or representative explicitly requests information from the provider for the purposes of exploring available provider options. When approached by prospective or currently enrolled NCW clients or their representatives who need general information about the NCW program or assistance with the application process, the provider may refer the inquirer to the NCW program office helpline for information or the provider may assist but shall make it expressly clear that the individual has the right to select any available waiver provider or change their provider at any time. Providers may not require a prospective client or their representative to select a particular provider, including themselves, in exchange for assistance with understanding the NCW program services or assistance with the application process. Any assistance provided by case management agencies to prospective clients or their representatives prior to receipt of a referral from the NCW Program Office is not reimbursable under the NCW program.

Providers may not offer financial incentives or other enticements or otherwise persuade a prospective or currently enrolled NCW client to choose or transfer to the provider or to an individual case worker for case management services. If a case manager leaves employment with one NCW case management provider and becomes employed with another NCW case management provider, that case manager shall not advise clients on their existing NCW caseload to switch to the new case management agency in order to keep that case manager. Provider may not require NCW clients to select a certain waiver or non-waiver provider for other services listed on the person-centered care plan.

The State Medicaid Agency shall engage in surveillance and monitoring activities to assure that individual Freedom of Choice is afforded. Instances of violation of Freedom of Choice may be addressed with a series of restrictions concluding with contact termination. The State Medicaid Agency may withhold authorization to serve additional NCW clients for 90 days after the first violation; for 180 days after the second violation; and shall terminate the provider's New Choices Waiver contract following the third violation. The provider will be given hearing rights for any adverse actions taken by the State Medicaid Agency.

6 AUTHORIZATION OF WAIVER SERVICES

All waiver services must be approved by the NCW program office in order to be eligible for payment. The selected case management agency will submit the individual comprehensive care plan to the NCW program office for review and the approval by an authorized representative will

constitute prior approval. The case management agency will provide the selected NCW service provider(s) with a New Choices Waiver Adult Residential Services Provider Authorization Form or a New Choices Waiver Service Authorization Form, as applicable.

The service authorization form clearly identifies participant's name, Medicaid number, service start and end date, approved waiver service(s), approved number of service units, approved frequency of service, HCPCS code and authorized per unit price for applicable HCPCS codes. Units and per unit price listed on the service authorization form may not exceed units and/or authorized per unit prices approved by the NCW program office. Any services provided in excess of approved annualized aggregate amounts are not billable to Medicaid. Any paid claims in excess of approved amounts, authorized per unit price or for services not listed on the approved care plan will be recovered. Case management agencies may be held financially responsible for issuing a service authorization form to a provider that does not match the HCPCS code, authorized per unit price for applicable HCPCS codes, service scope, start and end date, number of service units, frequency of service, and/or provider name listed on an individual's approved care plan with an end date of July 1, 2019 or later. Applicable HCPCS codes are listed in Section 5-2.

7 MDS-HC ASSESSMENT INSTRUMENT / LEVEL OF CARE

The Inter RAI MINIMUM DATA SET - HOME CARE (MDS-HC) is the standard comprehensive assessment instrument used by NCW. It includes all the data fields necessary to measure the participant's level of care as defined in the State's Medicaid nursing facility admission criteria. Registered nurses (RN) or physicians licensed in Utah are responsible for collecting the needed information and for making the level of care determinations. Each RN or physician assessor must receive MDS-HC training provided by designated State level staff prior to administering the MDS-HC for the first time.

Following completion of the MDS-HC assessment of a NCW client, case management agencies must complete the Level of Care Determination Form and submit it to the NCW program office. The information listed on the Level of Care Determination Form is expected to accurately reflect all of the findings of the comprehensive MDS-HC assessment.

7-1 Participant – Centered Care Planning

As a component of the NCW application process, each applicant or designated representative will be provided with a list of rights and responsibilities, including protections related to abuse, neglect and exploitation.

Furthermore, during the assessment and person-centered care planning process, the NCW case management agency will review participant rights and responsibilities with each participant and/or their representative and will provide avenues through which to notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation. Each participant and/or representative will be provided with a copy of their rights and responsibilities and with contact information to notify appropriate authorities or entities.

The care plan is driven by the NCW participant. It is developed based upon the assessed needs, strengths, goals, preferences and desired outcomes of the participant. The participant, representative, primary paid care givers, the participant's case management agency and any other individuals of the participant's choosing including family, friends and/or other caregivers are involved throughout the assessment and planning process and work together as a Person-Centered Care Planning (PCCP) team. The case management agency completes the formal assessment process along with the PCCP team and the results are shared with all parties included in this process. The participant or legal representative will be advised of any needs identified during the assessment process and given the opportunity to accept or decline services that would address those needs.

Risk Assessment and Mitigation

The plan will identify the assessed risks while considering the participant's right to assume some degree of personal risk, and will include resources and/or measures available to reduce risks or identify alternate ways to achieve personal goals.

During the care planning process, it is the responsibility of the case manager to monitor for non-compliant HCBS settings as well as to document any human rights restrictions which apply to the participant. This documentation must include information on the restriction, why it is being used, what lesser intrusive methods were tried previously (and why they were insufficient to maintain the health and safety of the individual) and a plan to phase-out the use of the intervention/restriction (if possible).

Care Plan Development Timeframe Requirements

1. The case management agency will work with the participant to develop a comprehensive care plan to address the participant's identified needs, goals, preferences and desired outcomes within60 days of completing an initial MDS-HC and LOC prior to enrollment, and within 31days of completing an annual or significant change MDS-HC and Level of Care while enrolled.

2. The start date for wavier services becomes the effective date of the care plan. This date is permitted to fall anytime within the 60 or 31 day range listed above, even if the effective date is retroactive. Under no circumstances can the start date be prior to the date of the MDS-HC assessment date or after the 60 or 31 day range expires.

3. The initial comprehensive care plan cannot be created until all other eligibility criteria for enrollment has been met (including Medicaid financial eligibility). If any of the eligibility criteria remains unmet after the first 60 day MDS-HC assessment window, a new MDS-HC assessment must be performed and waiver services cannot begin until on or within sixty (60) days of the new assessment date. This cycle repeats as each 60-day range passes until full NCW enrollment criteria are met.

Other Care Planning Requirements

1. The case management agency and participant will review the contents of the care plant as

part of the PCCP team and the case management agency will submit it to NCW program office for review and approval prior to implementation. The approval of the care plan by the NCW program office will constitute formal authorization to the case management agency of the services to be provided to the participant.

2. The comprehensive care plan will include a statement notifying the participant of their right to appeal to the State Medicaid Agency if they are denied their choice of service providers of if they are denied services that they believe they are eligible to receive. The client or legal representative must acknowledge receipt of their right to a fair hearing by signing the comprehensive care plan. The case management agency will be responsible for maintaining a written copy or electronic facsimiles of these plans of care for a minimum period of three years as required by 45 CFR 74.53.

3. The case management agency will review the list of authorized service providers with the participant and complete a Freedom of Choice form acknowledging the participant's selected service providers. The case management agency will maintain this form as part of the participant's records and update it in conjunction with the revision of the comprehensive care plan.
4. The case management agency will provide a service authorization form to the participant selected service providers in accordance with the approved comprehensive care plan. The service authorization form clearly identifies the participant's name, Medicaid number, service start and end date, approved waiver service, approved number of service units, approved frequency of service and HCPCS code, and authorized per unit price for applicable HCPCS codes. Units and authorized per unit price listed on the service authorization form may not exceed units and/or per unit price approved by the NCW program office on the care plan. Service authorization forms will be updated in conjunction with changes made to the comprehensive care plan. Case management agencies must also notify providers if a service authorization previously issued has been changed or terminated. Case management agencies may be held financially responsible for issuing a service authorization form to a provider that does not match the HCPCS code, authorized per unit price, service scope, start and end date, number of service units, frequency of service, and/or provider name listed on an individual's approved care plan with an end date of July 1, 2019 or later. Applicable HCPCS codes are listed in Section 5-2.

5. The NCW program office is responsible for conducting quality assurance monitoring. Quality assurance is conducted through various activities and aims to assess the quality of services provided to waiver participants and evaluate adherence to policy.

   Through observational audits the NCW program office will assess the provision of case management, assessments, and person-centered care planning. In addition to the purpose of quality assurance stated above, observational audits will also allow the NCW program office to increase internal understanding of interactions between waiver participants and case management agencies.

   Participation in the observational audit, by the NCW participant and case management agency, is a requirement of waiver enrollment. Refusal to participate by the r participant is considered voluntarily disenrollment. Information gathered through the observational audit may

be used to determine a waiver participant's initial and ongoing eligibility; an application may be denied based on information collected through the observation. A provider may be subject to corrective action based on information gathered through quality assurance monitoring.

Care Plan Reviews

The comprehensive care plan is updated at least annually with changes made throughout the year as needed based on the participant's changing needs, requests or based on a significant change in the client's status.

A significant change is defined as a major change in the participant's status that:

1. is not self-limiting;

2. impacts on more than one area of the participant's health status; and

3. requires interdisciplinary review and/or revision of the plan of care.

NOTE: A condition is defined as self-limiting when the condition will normally resolve itself without intervention by case management agency personnel. Generally, if the condition has not resolved within approximately two weeks, staff should begin a comprehensive MDS-HC reassessment.

A full care plan review and update is conducted:

1. When a significant change is consistently noted in two or more areas of decline or two or more areas of improvement;

2. Whenever indicated by the results of a health status screening;

3. In conjunction with completion of a full comprehensive assessment;

4. At a minimum of annually (no later than by the end of the calendar month of the last care plan and no later than within 31 days of the annual MDS-HC); and

5. Anytime during the plan year the NCW participant or the participant's representatives may also request updates or changes to the existing plan outside of annual reviews of the comprehensive care plan. These requests would be addressed directly with the case manager.

Significant Change Care Plans

All significant change care plans requesting the addition of a new service(s) to an existing approved care plan must be submitted to the NCW program office either before or within 30 days of the start date of the new service.

Significant change care plans submitted to correct errors to existing services or for other reasons will still be considered for approval, if they are submitted within 60 days of the care plan's expiration date. Examples include:

1. Any needed corrections in pricing including, the amount, per unit price, or frequency of services requested

2. Errors in the provider's name

3. Errors in the HCPCS Code or service title

4. Inadvertent omission of a service

Requests to amend an expired care plan can be submitted within the 90 days following the care plan expiration date. Requests for an amendment to care plans that are more than 90 days after the care plan's expiration date will be denied.

All revisions must be reviewed and approved by the NCW program office prior to implementation. The participant must be advised that they have the right to elect to receive services in a skilled nursing facility in lieu of continued participation in the waiver program.

Comprehensive Care Plan Unit Calculation

The comprehensive care plan is intended to be an estimate of the service units required to meet the assessed needs of each client over the course of the care plan year. NCW recognizes that a client's needs may change periodically due to temporary or permanent conditions which may require amendments to the client's care plan.

On an ongoing basis, the designated case management agency is responsible to monitor service utilization for each client for whom the case management agency created a comprehensive care plan. When the case management agency determines that the assessed service needs of a client exceed the amount that has been approved on that client's existing care plan, the case management agency should submit an amendment to increase the number of units to meet the need. Amendments should be submitted prior to the expiration of the care plan. Requests for an amendment to an expired care plan must be submitted within the 90 days following the care plan expiration date, or the request will be denied.

The care plan year is the sum of all approved units including amendments over the entire year. In this way, NCW applies an annualized aggregate of all care plan units.

Providers may not exceed the annualized aggregate of all approved care plan units or authorized per unit price for each applicable HCPCS code. Billing in excess of the approved number of units or per unit price will be subject to recovery of funds by Medicaid.

7-2 Inpatient Hospitalization / Nursing Home Admission

1. NCW case managers may continue to provide case management services to participants who

have entered a nursing home or hospital for up to 90 days after the participant has been admitted, if there is a reasonable expectation that the participant will be able to return to the community within the 90 day timeframe. A participant must be disenrolled from the waiver when it is determined by a physician that the expected length of stay in a hospital or nursing facility will exceed 90 days or if the actual length of stay has reached 90 days. (See Section 4-2 for disenrollment procedures.)

A. HCPCS Code T2024 should be used to bill for any units of case management provided on dates of service in which a participant is an inpatient of a nursing facility or hospital.

2. Participants who have been disenrolled due to exceeding a 90 day stay in a hospital or nursing facility may request to re-enroll upon stabilization of their medical condition.

A. If a former participant has remained in the nursing facility or hospital and has received continuous care, he or she may contact their case management agency directly and request a new evaluation without having to complete a new application. The case management agency must complete a full MDS-HC, Level of Care Determination Form, rental agreement, PCCP addendum and comprehensive care plan and submit them to NCW program office for approval prior to re-enrollment. Case management agencies must submit paperwork using the guidelines and deadlines listed in Section 6, Authorization of Waiver Services. Case management agencies should not initiate NCW services until an approved 927 is received and indicates a NCW re-enrollment date for the client.

B. If a disenrolled client experiences an interruption in nursing facility or equivalent care during the time of disenrollment from the NCW program, the individual will be required to submit a new application and reestablish that they meet all waiver eligibility criteria as specified in Section 2 and Section 3 of this manual in order to re-enroll in the NCW program.

3. Adult Residential Services providers may not bill for dates of service when the waiver client is away from the facility for full 24-hour days. NCW does not cover “room holds” for time periods when a NCW client is away, including during vacations, admissions to a hospital or nursing facility or any other absence of one or more 24-hour day. A 24-hour day begins and ends at midnight.

7-3 Case Management Monitoring

1. Case management monitoring activities are based on the assessed need of the individual participant.

2. At a minimum, the case management agency must make at least one monthly contact directly with the participant either by telephone or in person.

A. If a participant’s mental capacity or ability to communicate is diminished to the point

of being unable to have meaningful telephone contact, a monthly face to face contact with the participant will become necessary in order to ensure that the participant's needs are being met. Additional collateral contacts with involved care providers and/or family members may also become necessary for effective monitoring.

3. If a participant is able to have meaningful telephone contact, the case management agency may deem it appropriate based on assessed need to have monthly contact with the participant by telephone. At a minimum, one face to face visit per quarter is required.

4. The case management agency will monitor to assure the provision and quality of services identified in the participant's care plan. This includes ensuring that services are being provided in the amount, frequency and duration ordered in the care plan.

5. The case management agency will monitor on an ongoing basis the participant's health and safety status and initiate appropriate reviews of service needs and care plans as necessary. Case notes should reflect any health or safety issues and activities toward resolution of those issues.

6. The case management agency should be notified any time a participant is away from an adult residential facility overnight.

During routine on-site visits to monitor quality of care, case managers observe participants in their daily environment and conduct an interview to determine overall level of satisfaction with care and to determine whether any restraints, seclusions or other rights restrictions have occurred. Case management agencies are required to notify the NCW program office anytime a participant has been physically or chemically restrained or secluded in a facility, and the NCW program office is required to notify Health Facility Licensing.

8 SELF-ADMINISTERED SERVICES

8-1 Definition and Employer Authority

1. Self-administered services (SAS) are a few of the array of services available through the NCW that may be authorized to address the assessed needs of the participant. SAS is service delivery that is provided through a non-agency-based provider to a participant who lives in his or her own home or the home of a family member. Participants receiving Adult Residential Services are not eligible for SAS. Under the self-administered method, the participant and/or their chosen designee hire individual employees to deliver a NCW service. The participant/participant designee is then responsible to perform the functions of supervising, hiring, assuring that employee qualifications are met, scheduling, assuring accuracy of timesheets, etc. of the individual employee.

2. The self-administered employer authority requires the waiver participant to use a Waiver Financial Management Services (FMS) Agent as an integral component of the NCW services to assist with managing the employer-related financial responsibilities associated

with the employer-employee relationship. The Waiver FMS Agent is a person or organization that assists waiver participants and their representatives, when appropriate, in performing a number of employer-related tasks, without being considered the common law employers of the service providers. Tasks performed by the Waiver FMS Agent include documenting service provider's qualifications, collecting service provider time records, preparing payroll for participants' service providers, and withholding, filing, and depositing federal, state, and local employment taxes.

3. Participant employed service providers complete a time sheet for work performed. The participant confirms the accuracy of the time sheet, signs it, and forwards it to the Waiver FMS Agent for processing. The Waiver FMS Agent files a claim for reimbursement through the Medicaid MMIS system and upon receipt of payment, completes the employer-related responsibilities, deducts the established administrative fee, and forwards payment directly to the service provider for the services documented on the time sheet.

8-2 Self- Administered Services Available to Qualified Participants

1. Self –administered services apply only to those participants with identified needs that the case manager has determined to qualify for one or more of the services listed below. These services are the only services available under the self-administered services method:
   A. Attendant Care Services

   B. Chore Services

   C. Homemaker Services

   D. Respite care – Incremental

The services listed above are also available through agency-based providers.

8-3 Self- Administered Services Case Management Responsibilities

1. Follow all requirements in Attachment B – Special Provisions, Case Management Service Provider Responsibilities for the New Choices Waiver Program.

2. Determine that the participant or participant designee has the ability to understand the risks, rights and responsibilities of receiving services through and is able to participate in SAS.

3. Inform the participant that he or she may choose a designee to assist in the administration of the participant's services and the responsibilities as an employer. This designation is documented in the Participant Letter of Agreement.

4. Inform the participant of the ability to combine SAS with Agency-Based Services.

8-4 Self-Administered Services Case Manager Packet

1. The SAS case manager packet is a three-part packet which includes the instructions, forms and requirements necessary to initiate self-administered services. The case management agency keeps the case management packet and gives the participant and employee packets to the participant/participant designee to be completed and returned to the case management agency.

A. Case Manager Packet
- Case Manager Checklist
- Case Management Responsibilities
- Unit Allocation for Attendant Care
- Service Authorization Form

B. Participant Packet
- Employer Checklist
- Participant Letter of Agreement - requires participant/participant designee signature
- Back Up Service Plan – requires participant/participant designee and case manager signatures
- Utah Criminal History Record Review for Prospective Employees
- Employment Agreement Form –requires employee and participant/participant designee signatures
- New Choices Waiver Provider Code of Conduct – requires employee and participant/participant designee signatures
- Incident Reporting Protocol and Incident Reporting Form

In addition to this packet, the case management agency provides the participant with a packet for the selected Waiver FMS and a New Choices Waiver Participant Notebook to be used to keep records of the current care plan, employee information, signed agreements, financial management services forms, time sheets, back-up plan, training plans, Provider Code of Conduct and Incident Reporting Protocol.

C. Employee Packet
- Employee Checklist
- Utah Criminal History Record Review for Prospective Employee
- Employment Agreement Form
- State of Utah New Choices Waiver Code of Conduct (including signature page)
- Incident Reporting Protocol and Incident Reporting Form
- Social Security Card (copy)
- Driver License or other photo identification (copy)
- Form W-4
- Form I -9
- Direct Deposit Authorization Form (optional)

2. The case management agency retains completed copies of the following documents for their files:

    A. Participant Letter of Agreement

    B. Back up Service Plan

    C. Utah Criminal History Record Review for Prospective Employees

    D. Employment Agreement Form

    E. New Choices Waiver Provider Code of Conduct, including signed signature page

    F. Documents required by the FMS Agency

3. The case management agency reviews the following documents with the participant/participant designee:

    A. The requirements, rights and responsibilities of receiving self-administered services as outlined in the Participant Letter of Agreement.

    B. The role and process of the FMS Agency and assist in the choice of available FMS agencies.

    C. In addition to the Participant Letter of Agreement, review all State Medicaid Agency documents and forms included in the Participant Packet.

8-5 Self- Administered Services Care Planning

1. The case manager works with the participant/participant designee to determine the units of service appropriate to meet the identified service needs and discusses the care plan and service limits.

    A. Assess the participant's need for Consumer Preparation Services.

    B. If the participant is eligible for Attendant Care, use the Unit Allocation Form and instructions to assess the level of assistance required. Ensure participant has utilized Medicaid State Plan services to the extent available.

    C. If the participant is eligible for Chore Services, ensure that no other household member or other entity is capable of performing, responsible to provide, or financially able to pay for the service. In the case of rental property, examine the lease to make sure no one else is responsible to provide Chore Services.

    D. If the participant is eligible for Homemaker Services, ensure that the person normally responsible for homemaking is temporarily absent or unable to manage the home.

E. Once developed, the case manager will submit the care plan to the NCW program office for approval.

2. When all documents, requirements, and care planning are complete, fax or mail the Authorization Form for SAS and all required employer and employee forms to the selected FMS Agency:

   Morning Star Financial Services
   Fax: 888-657 0874
   9400 Golden Valley Road
   Golden Valley, MN 55427

   Acumen Fax: 888-249-7023
   PO Box 539
   Orem, UT 84059-0539

The FMS Agent will notify the case management agency when the employer and employee forms are complete and services can begin.

8-6 Self-Administered Services Ongoing Monitoring:

1. The case management agency is responsible for monitoring the safety and well-being of the participant and the quality and effectiveness of the self-administered service(s) being delivered.

2. The case management agency will monitor the relationship between the participant and the employee(s) and have ongoing contact with the participant/participant designee and employee(s) through the following methods:

   A. An initial face to face visit with the participant/participant designee and employee within two (2) weeks of start-up of the service. Additional face to face visits with the participant and employee may be required as determined by the case manager.

   B. Monthly contacts, either by telephone or face to face, as described in Section 7-4.

   C. An annual reassessment of the care plan to determine changes in condition, reevaluate and adjust the care plan, and offer additional training to the participant and/or employee(s).

   D. Event based contacts either by telephone or face to face visits, as warranted.

   E. During each contact assess the participant to assure his or her needs are being met. Document the results of each contact in the case file.

3. The case management agency is responsible for notifying the financial management agent when any of the following occurs:

   A. The participant is no longer eligible for services;

   B. A new service is authorized or an existing service is no longer authorized;

   C. There is a change in the number of units authorized or the frequency of service;

   D. The participant is deceased;

   E. There is a change in Case Managers;

   F. The participant is in the hospital or nursing home; and/or

   G. The participant has moved.

8-7 Discontinuation of Self-Administered Services

1. Reasons for potential discontinuation of self-administered services include:

   A. The participant is in the hospital, nursing or rehabilitation facility.

   B. Voluntary withdrawal.

   C. The participant or representative fails to provide the required documentation or refuses to follow the service descriptions agreed upon in the care plan.

   D. There is a determination that funds are being misused or evidence that the service is not being performed.

   E. There is evidence of abuse, neglect or exploitation of the participant by the employee or designee.

   F. The participant fails to maintain Medicaid waiver eligibility.

   G. The participant/participant designee fails to cooperate with the agreed upon care plan; and/or the participant or designee fails to cooperate with authorization changes or rules.

   H. If the case manager determines that the participant is no longer able to manage the services authorized in the care plan and no participant designee is available, self-administered services will no longer be authorized. The case manager will work with the participant to revise the care plan to order services from the array available through agency-based providers. This process will include all aspects of service plan development, including participation by the participant and individuals of his or her

choosing and offering choice of providers.

2. Prior to discontinuing services provided by the SAS method, the case manager will discuss with the participant the discontinuation of services and will notify the NCW program office. The participant/participant designee will be given written notice and will be given the opportunity to appeal the decision following established appeal procedures.

Denial of self-administered services will not affect continued participation in NCW.

9 Incident Reporting Protocol

PURPOSE

Waiver programs must provide adequate and appropriate services that safeguard the health and welfare of all enrolled participants. Waiver programs must also assure financial accountability for funds expended for waiver services. Systematic incident reporting provides a mechanism to assure ongoing monitoring of serious incidents, the provider's response to incidents and the interventions implemented to prevent reoccurrence. This protocol outlines the responsibilities of NCW providers regarding adverse incidents. Failure to comply with the NCW Incident Reporting Policy and/or the NCW program office's request for information during reporting/investigation activities may be addressed with a corrective action plan; withholding of payments in accordance with R414-1-31, Withholding of Payments; and/or holds on authorization to serve additional NCW participants in accordance with R414-22-4, Grounds for Sanctioning Providers.

RESPONSIBILITIES OF WAIVER SERVICES PROVIDERS

1. All negative events experienced by NCW participants must be reported by NCW service providers to the participant's case management agency within 24 hours of discovery by sending an incident report to the case management agency's designated incident reporting fax or email. This contact information and the NCW Incident Report Form can be found at the NCW website: https://medicaid.utah.gov/ltc/nc-providers/

2. In cases where the negative event and/or the timing of reporting falls on a weekend or holiday, reporting the negative event by the next business day is permissible.

3. Reportable negative events include, but are not limited to:

    - Death, regardless of the circumstances
    - Changes in medical or functional status
    - Falls with or without injury
    - ER treatment for any reason
    - Hospital admission for any reason
    - Mental health decline

- Suicide attempt
- The start of or discontinuation of hospice or home health services
- A move to a skilled nursing facility
- Any negative event that occurs at the client's place of residence or that occurs while the client is in the community
- Incidents expected to receive media, legislative or public scrutiny
- Compromised living environment requiring evacuation
- Person missing at least 24 hours or, regardless of the amount of time missing, under suspicious or unexplained circumstances
- Injury including burns, choking, brain trauma, fractures, aspiration and self-injurious behavior
- Abuse (physical or sexual)
- Neglect (caregiver neglect or self-neglect)
- Exploitation (including theft of medication)
- Waste, fraud or abuse of Medicaid funds (to include actions perpetrated by either participant and/or providers)
- Human rights violation
- Medication/treatment error, including inappropriate medication use while the medication is in control of the provider, participant or other individual
- Law enforcement involvement
- Substance abuse
- PHI/PII security breach
- Other type of incident causing concern for health and safety

4. Reportable negative events are broadly defined so case management agencies can address any identified needs, facilitate a resolution of any causal factors and follow-up to assure the effectiveness of any new safeguards implemented as a result of the event.

5. NCW services providers are required to promptly respond to case management agency requests for information, reports, summary of safeguards implemented and any process improvements implemented by the service provider.

RESPONSIBILITIES OF WAIVER CASE MANAGEMENT AGENCIES

1. The NCW case management agency is responsible for receiving, reviewing, and responding to all incident reports. Incident reports should be reviewed and sufficient information gathered to determine if the incident meets the criteria of a possible Critical Incident.

2. Upon being notified of any of the following types of incidents defined in this section as a possible Critical Incident, the case management agency shall notify the NCW program office within 24 hours by telephone, fax, or email. If notification is provided to the NCW program office by telephone, a written report must follow within 24 hours or on the next State business day. Possible Critical Incidents include:

- Unexpected or accidental death
- Suicide attempt (suicide attempts do not include suicidal thoughts or threats without actions)
- Incident expected to receive media, legislative or public scrutiny
- Compromised work or living environment requiring evacuation
- Person missing at least 24 hours, or regardless of the amount of time missing, under suspicious or unexplained circumstances
- Injury (includes burns, choking, brain trauma, fractures, aspiration and self-injurious behavior
- Abuse (physical or sexual)
- Neglect (caregiver neglect or self-neglect)
- Exploitation (including theft of medication)
- Waste, fraud, or abuse of Medicaid funds (to include actions perpetrated by either participant and/or providers)
- Human rights violation
- Medication/treatment errors resulting in marked adverse side effects (includes inappropriate medication use while the medication is in control of the provider, participant or other individual)
- Law enforcement involvement resulting in charges being filed (to include events where charges are filed against participant and/or staff)
- Other type of incident causing concern for health and safety
- Substance abuse requiring medical treatment
- PHI/PII security breach

3. In cases where the incident and/or the timing of reporting falls on a weekend or holiday, reporting the incident by the next business day is permissible.

4. If a NCW participant, participant's family member, or another individual reports an incident to the case manager that occurred while a participant was not receiving services from a NCW provider, the case manager is responsible for completing the incident report and submitting it to the NCW program office.

5. The case management agency must verify that reports of any actual or suspected incidents of abuse, neglect, or exploitation of a waiver participant have been reported to Adult Protective Services or local law enforcement. (UCA 62-A-3-301)

6. The case management agency is responsible for maintaining a record of all incident reports in the participants' case files. The case management agency will address any identified needs, facilitate a resolution of any causal factors and will follow-up to assure the effectiveness of any new safeguards implemented as a result of the incident.

7. If the NCW program office determines that the incident requires further investigation, the case management agency will complete a Critical Incident Investigation form and return it within 10 business days.

8. When the NCW program office determines the investigation is complete, it will document any findings or corrective action requirements. The NCW program office will send the case

manager a copy of the finalized document, closing the case. In some cases, the NCW program office may continue to monitor findings or corrective actions.

9. Within two (2) weeks of receiving notification that the investigate is closed the case management agency will notify the client or the client's representative (in person, phone or in writing) of the investigation results and document notification in the client's record. The following types of incidents are excluded from the notification requirement: suicide, death and investigations that conclude with disenrollment.

NOTIFICATION TO THE NCW PROGRAM OFFICE

Notification shall be submitted to:
FAX: 801-323-1586
Email: ncwincidents@utah.gov
From the Salt Lake City area: 801-538-6155, option 6
Outside of Salt Lake City & from neighboring states: 800-662-9651, option 6

10 Service Provider Interaction with Case Management Agency

Service providers participating in NCW must adhere to the following requirements covering interactions with the participant selected case management agency and the NCW program office, when applicable.

10-1 Incident reporting as described in Section 9-1

10-2 Service Authorization

1. Providers must adhere to all requirements described in section 6 of this manual, Prior Authorization of Waiver Services. Providers may only provide waiver services as ordered by the waiver participant's case management agency and approved by the NCW program office. Any concerns regarding ordered services should initially be addressed with the case management agency.

   A. Providers may only provide waiver services as ordered by the waiver participant's case management agency and approved by NCW. Any concerns regarding ordered services should initially be addressed with the case management agency.

   B. The case management agency must provide the service provider with a service authorization form. The form includes the participant's identifying information, the billable HCPCS procedure code, authorized price for applicable HCPCS codes, authorized number of units, frequency of service and beginning and ending dates of the service, as well as the case manager's contact information. Applicable HCPCS codes are listed in Section 5-2.

      - Any billing in excess of prior approved units of service and/or price will not be

payable and will be recouped.
- Do not provide any services to a NCW participant without first receiving the service authorization form from the case management agency.

10-3 Participant Out of Facility

1. Adult residential services providers must notify the case management agency whenever a participant is out of the facility overnight. This includes:
    - Hospitalizations
    - Vacations
    - Nursing home stays

2. All services must be coordinated through the case management agency in order to ensure maximum benefit, care plan adherence and continued waiver eligibility.

3. Adult residential services providers should not accept a NCWr participant who has been hospitalized or has been in the nursing facility on an extended stay basis back into their facility without first contacting their case manager to determine if they are still eligible for NCW services. NCW is not responsible for payment if the participant is not currently eligible.

11 CLAIMS AND REIMBURSEMENT

11-1 Time Limit to Submit Claims

All claims and adjustments for services must be received by Medicaid within 12 months from the date of service. New claims received past the one-year filing deadline will be denied. Any corrections to a claim must also be received and/or adjusted within the same 12-month timeframe. If a correction is received after the deadline, no additional funds will be reimbursed. The one-year timely filing period is determined from the date of service or “from” date on the claim. Payment will be made for Medicare/Medicaid Crossover claims only if claims are submitted within six months from the date of Medicare payment stated on the Medicare Explanation of Medical Benefits (EOMB). Code of Federal Regulations 42 (CFR), Section 447.45(d) (1). Utah Administrative Code, Rule R414-25x.

11-2 Calculating Claims Using TN Modifier

When using the TN rural enhancement modifier for a claim, providers should bill the total eligible amount to be reimbursed (base amount and 1.75 increase). The Medicaid MMIS system computes the Maximum Allowable Base Rate in the MMIS system reference file multiplied by 1.75 and compares that number to the actual billed amount. The MMIS system then pays the actual billed amount up to the Maximum Allowable Rate X 1.75.

11-3 Use of “TN” Rural Enhancement Modifier

The use of the TN rural enhancement modifier is authorized in the NCW for the

purpose of assuring access to waiver covered services in rural areas of the State where waiver service providers are required to travel extended distances to deliver services. The rate enhancement adjusts the per unit rate of reimbursement to account for the additional travel-related expenses not included in the normal rate setting process. For purposes of the rural enhancement rate, rural counties are all counties in Utah except Weber County, Davis County, Salt Lake County, and Utah County.

1. The following limitations are imposed on the use of the rural enhancement:

   A. The case management agency must authorize use of the rural enhancement rate at the time the services are ordered;

   B. The location assigned as the provider's normal base of operation must be in a county designated as rural;

   C. The location from which the service provider begins the specific trip must be in a county designated as rural;

   D. The location where the service is provided to the waiver participant must be in a county designated as rural; and

   E. The direct distance traveled by the provider from the starting location of the trip to the waiver participant must be a minimum of 25 miles with no intervening stops to provide waiver or State plan services to other Medicaid participants. When a single trip involves service encounters for multiple Medicaid participants, each leg of the trip will be treated as an independent trip for purposes of qualifying for the rural enhancement (i.e. each leg must involve a direct travel distance of 25 miles or more).

2. Uniform Authorization of the Rural Enhancement Rate

   A. It is the responsibility of the case management agency to authorize any provider to bill for services using the rural enhancement code modifier. The case management agency will complete the Service Authorization Form and send it to the service provider to be maintained in their files as proof of service authorization. The case management agency will maintain a copy of the written authorization form that includes authorization for enhanced billing in their files as well as submit a copy to the NCW program office.

   B. The NCW program office is responsible to monitor the Medicaid billing statements to assure providers are appropriately using the rural enhancement rate. In the event of inappropriate use of the rural enhancement rate, the provider and the case management agency will be notified by the NCW program office. Recoupment will be made for any inappropriate use of the rural enhancement rate.

3. When possible, providers must coordinate service delivery to minimize the use of the TN modifier by combining multiple service encounters in a single trip. Waiver case managers must consider the opportunity to coordinate service delivery among waiver participants served by a common provider when scheduling services as part of plan of care implementation.

11-4 Electronic Visit Verification

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, are effective for Utah Medicaid beginning July 1, 2019. EVV requirements apply to all personal care services and home health care services provided under a 1915 (c) Home and Community Based Waiver.

Choice of reporting systems for EVV are by provider preference, but must meet all federal requirements, including the standards set in the Health Insurance Portability Accountability Act. The State will not implement a mandatory model for use. All provider choice EVV systems must be compliant with requirements of the Cures Act including:

- type of service performed
- individual receiving the service
- date of the service
- location of service delivery
- individual providing the service
- time the service begins and ends
- the date of creation of the electronic record

Additional information including technical specifications for file creation/submission and EVV resources can be found at https://medicaid.utah.gov/evv

NEW CHOICES WAIVER SERVICES, LIMITS and PROVIDER SPECIFICATIONS

Adult Day Care

Service Definition

Services generally furnished four (4) or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the care plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant.

Limits on the Amount, Frequency or Duration of This Service

Transportation between the participant's place of residence and the adult day care site is not provided as a component of adult day care services and the cost of this transportation is not included in the rate paid to adult day care providers.

Those receiving adult residential services in an assisted living facility, Type N facility or licensed community residential care facility are not eligible for Adult Day Health unless the case management agency assesses a client-specific need that cannot be otherwise met by the facility of residence. Documentation of the identified need must be included in the comprehensive care plan.

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Provider Specifications for Service

NCW Service Name: Adult Day Care
HCPCS Billing Code: S5102
Billing Modifier: U8
Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Adult Day Care services; and
- Adult Day Care providers must be licensed in accordance with R501-13-1-13; or
- Assisted Living Facility providers must be licensed in accordance with R432-270-29b.

Adult Residential Services

Service Definition

Supportive services provided in an approved community-based adult residential facility. Supportive services are expected to meet scheduled and unpredictable participant needs and to

provide supervision, safety and security in conjunction with residing in a homelike, non-institutional setting.

Adult Residential Services in licensed assisted living facilities and small health care facilities (HCPCS T2031) includes homemaking services, chore services, 24-hour on-site response capability, attendant care services, meal preparation, medication assistance/oversight, social/recreational programming, and nursing/skilled therapy services that are incidental rather than integral to the provision of Adult Residential Services.

Adult Residential Services in licensed assisted living facilities, memory care (HCPCS T2016) includes homemaking services, chore services, 24-hour on-site response capability, attendant care services, meal preparation, medication assistance/oversight, social/recreational programming, memory care services, and nursing/skilled therapy services that are incidental rather than integral to the provision of Adult Residential Services.

Adult Residential Services in licensed community residential facilities (HCPCS T2033) includes meal preparation, behavioral health services, 24-hour on-site response capability, homemaking services, chore services, and social/recreational programming.

Adult Residential Services in certified community residential facilities (independent living facilities, HCPCS H0043) includes homemaking services, meal preparation, 24-hour on-site response capability and daily status checks (or more frequently as deemed appropriate in the comprehensive needs assessment).

All Adult Residential Services, no matter the setting includes, 24-hour on-site response capability or other alternative emergency response arrangements determined appropriate to meet scheduled or unpredictable participant needs and to provide supervision, safety and security in conjunction with residing in a homelike, non-institutional setting.

Limits on the Amount, Frequency or Duration of This Service:

Separate payment is not made for homemaker services furnished to a participant receiving Adult Residential Services, since these services are integral to and inherent in the provision of adult residential services.

Separate payment is not made for chore services unless an exceptional need is identified in the comprehensive needs assessment that is not specified in the formal lease agreement between the facility and the participant/family as being the responsibility of the facility. Example of an exceptional need: heavy cleaning resulting from hoarding behavior. Documentation of exceptional needs must be submitted with the care plan for approval. Exceptions will not be approved if the chore service is for the costs of general facility maintenance, upkeep or improvement.

Separate payment is not made for attendant care services furnished when the participant is actively receiving care inside the facility or during activities provided by the facility off campus. Attendant care may be provided when a need is identified for participation in off-campus activities not associated with the facility. Examples: personal shopping or accompanying the participant to doctor appointments.

Exceptions to the attendant care limitation are made for individuals residing in licensed community

residential facilities and independent living facilities because neither type of facility is licensed to perform hands-on assistance with activities of daily living.

Payment is not made for 24-hour skilled care or supervision. Federal financial participation is not available for room and board, for items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for adult residential services is described in Appendix I.

Provider Specifications for Service

NCW Service Name: Adult Residential Services – Utah Licensed Assisted Living Facilities (Type 1 and Type 2) and Utah Licensed Small Health Care (Type N) Facilities

HCPCS Billing Code: T2031

Billing Modifier: U8

Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Adult Residential Services; and
- Assisted living facilities must be licensed in accordance with Utah Administrative Rule R432-270; or
- Small health care (Type N) facilities must be licensed in accordance with Utah Administrative rule R432-300.

Provider Specifications for Service

NCW Service Name: Adult Residential Services – Licensed Assisted Living, Memory Care

HCPCS Billing Code: T2016

Billing Modifier: U8

Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Adult Residential Services; and
- Must be licensed in accordance with Utah Administrative Rule R432-270 and meet the Licensing requirements applicable to secure units (R432-270-16).

Provider Specifications for Service

NCW Service Name: Adult Residential Services – Certified Independent Living Facility

HCPCS Billing Code: H0043

Billing Modifier: U8

Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Adult Residential Services; and
- Must satisfactorily pass an on-site certification inspection performed by an official from the New Choices Waiver Program Office prior to enrollment and annually thereafter.

Provider Specifications for Service

NCW Service Name:	Adult Residential Services – Licensed Community Residential Care Facility
HCPCS Billing Code:	T2033
Billing Modifier:	U8

Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Adult Residential Services; and
- Must be a Licensed Residential Treatment Program in accordance with R432-270.

Assistive Technology Devices

Service Definition

This service under the waiver differs in nature, scope, supervision arrangements, or provider from services in the State plan. Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology devices include:

1. The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

2. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

3. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

4. Coordination and use of necessary interventions, or services with assistive technology devices, such as interventions or services associated with other services in the care plan;

5. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

6. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Devices that can be purchased

Hearing and Communication

- Amplified phones
- Digital enhanced cordless telecommunications (DECT) phones Remote controlled phones with infrared technology
- Large print and talking caller ID Phone headsets
- Headset amplifiers and tone control Large button phones
- TDD and TTY
- Video phones
- Communication software Basic communicators
- Picture communicators
- Audio and voice recorders
- Speech generating devices
- Voice amplifiers and synthesizers
- Blinking light "doorbell"
- Intercom system
- Hearing Amplifiers

Vision impairment adaptations

- Screen readers
- Text to speech software
- Digital book players
- Talking products
- Magnifiers
- True color floor lamp
- Eye drop squeezer

Switches

- Sip and Puff Switches Sensitive switches
- Foot switches
- Switch interfaces
- Mounting devices
- Chin switch Safety alarms

Other

- Adaptive utensils Oversized utensil handles
- Adaptive cookware Modified pot handles
- Adaptive dishes Reaching aids
- Automatic clock with day and date display
- Jar opener
- Door knob adapters
- Car caddie
- Adaptive dressing aids
- Button hooks
- Adaptive grooming aids
- Sock and shoe aids
- Long handle grooming aids
- Easy grasp key holders and turners

- Rolling lotion applicators
- Weight sensitive alarms
- Non-slip mats
- Bedside beverage holders
- Burn resistant smoker's apron
- Recliner lever extenders
- Portable access ramps

Limits on the Amount, Frequency or Duration of This Service:

Service Limit: The maximum allowable cost per assistive technology device is $2,000.00. At the point a NCW participant reaches the service limit, the care coordination team will conduct an evaluation to determine how the individual's health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.

Provider Specifications for Service

NCW Service Name:	Assistive Technology Devices
HCPCS Billing Code:	T2028
Billing Modifier:	U8

Provider Qualifications:

- Must have a current business license; and
- Must be a Medicaid provider enrolled to provide NCW Assistive Technology Devices.

Attendant Care Services

Service Definition

Attendant care services are those that reinforce an individual's strengths, while substituting or compensating for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant services incorporate and respond to the participant's preferences and priorities.

Limits on the Amount, Frequency or Duration of This Service:

This service cannot be provided to participants receiving Adult Residential Services or any other waiver service in which the tasks performed are duplicative of the attendant care services.

Provider Specifications for Service

NCW Service Name:	Attendant Care Services
HCPCS Billing Code:	S5125
Billing Modifier:	U8

Provider Qualifications:

- Must have a current business license; and
- Must be a Medicaid provider enrolled to provide NCW Attendant Care Services.

Caregiver Training

Service Definition

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion or co-worker who provides uncompensated care, training, guidance, companionship, or support to a person served on the waiver. Individuals who are employed to support the participant may not receive this service. Training includes instruction about treatment regimens and other services included in the care plan, use of equipment specified in the care plan, and includes updates as necessary to safely maintain the participant at home. All training the individuals who provide unpaid support to the participant must be included in the participant's care plan. The service covers the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the care plan.

Limits on the Amount, Frequency or Duration of This Service

No limits

Provider Specifications for Service

NCW Service Name:	Caregiver Training
HCPCS Billing Code:	S5115
Billing Modifier:	U8

Provider Qualifications:

- Must have a current business license as a formal Caregiver Training provider as applicable; or
- Caregiver Training providers in categories requiring license under State law must comply with licensing requirements contained within R156 or R432; and
- Must be a Medicaid provider enrolled to provide NCW Caregiver Training; and
- Must have demonstrated ability to perform the tasks ordered by the case management agency.

Case Management

Service Definition

Services that assist participants in gaining access to needed waiver services and other Medicaid State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source. Case Management consists of the following activities:

1. Complete the initial comprehensive assessment and periodic reassessments to determine the services and supports required by the participant to prevent unnecessary institutionalization;

2. Perform reevaluations of participants' level of care;

3. Complete the initial comprehensive care plan and periodic updates to maximize the participant's strengths while supporting and addressing the identified preferences, goals and needs;

4. Research the availability of non-Medicaid resources needed by an individual to address needs identified through the comprehensive assessment process and assist the individual in gaining access to these resources;

5. Assist the individual to gain access to available Medicaid State Plan services necessary to address identified needs;

6. Assist the individual to select from available choices, an array of waiver services to address the identified needs and assist the individual to select from the available choice of providers to deliver each of the waiver services including assisting with locating an appropriate home and community-based setting and assisting with negotiation of a rental agreement when needed;

7. Assist the individual to request a fair hearing if choice of waiver services or providers is denied, if services are reduced, terminated or suspended, or if the participant is disenrolled;

8. Monitor to assure the provision and quality of services identified in the individual's care plan;

9. Support the individual/legal representative/family to independently obtain access to services when other funding sources are available;

10. Monitor on an ongoing basis the individual's health and safety status and investigate critical incidents when they occur. At least one (1) telephone or face-to-face contact directly with the waiver participant is required each month and a minimum of one (1) face to face contact with the participant is required every 90 days. When meaningful telephone contact cannot be achieved due to a participant's diminished mental capacity or inability to communicate by phone, in-person contact must be made with the participant monthly;

11. Coordinate across Medicaid programs to achieve a holistic approach to care;

12. Provide case management and transition planning services up to 180 days immediately prior to the date an individual transitions to the waiver program;

13. Provide safe and orderly discharge planning services to an individual disenrolling from the waiver;

14. Perform internal quality assurance activities, addressing all performance measures; and

15. Monitor participant medication regimens.

Limits on the Amount, Frequency or Duration of This Service

In order to facilitate transition, case management services may be furnished up to 180 days prior to transition and providers may bill for this service once the participant enters into the waiver program.

Fifteen (15) units per month or less is the expected typical case management utilization pattern. Plans that include utilization of 16 units or greater will require submission of additional documentation to justify the need for additional services. Plans that include utilization of 26 units or greater will require a second level review by the NCW program office supervisor prior to approval.

Provider entities having the capacity to perform case management functions and other waiver or non- waiver services must assure that the functions of the entity are clearly separated and their respective responsibilities well defined. If the case management agency is listed on a comprehensive care plan as the provider for other waiver or non-waiver services, the case management agency must document that there are no other willing qualified providers available to provide the other waiver or non-waiver service(s). The State Medicaid Agency, NCW program office will review these situations on a case by case basis to determine whether or not to override the conflict of interest.

Case management agencies may not assign individual case managers to serve a NCW participant when any one or more of the following scenarios exist:

1. the case manager is related to the NCW participant by blood or by marriage;
2. the case manager is related to any of the NCW participant's paid caregivers by blood or by marriage;
3. the case manager is financially responsible for the NCW participant;
4. the case manager is empowered to make financial or health-related decisions on behalf of the individual; or
5. the case manager would benefit financially from the provision of direct care services included in the care plan.

Direct services not included in the service description above are not reimbursable under case management. Examples of non-reimbursable services are, but not limited to: transporting clients, directly assisting with packing and/or moving, personal budget assistance, shopping, and any other direct service that is not in line with the approved case management service description.

By July 1, 2017, Utah will fully implement the use of a Financial Management Service Agent FMS entity to pay for goods and services purchased from retail stores, general contractors or other entities not directly enrolled as Medicaid providers. The State will reimburse the Financial Management Service agency as an administrative activity.

Provider Specifications for Service

NCW Service Name:	Case Management Services
HCPCS Billing Code:	T2024 (Pre-enrollment and during post-enrollment inpatient admissions) T1016 (Post-enrollment)
Billing Modifier:	U8

Provider Qualifications:

- All providers must initially and continuously employ at least two qualified case managers, one with registered nurse (RN) licensure and one with social service worker (SSW) licensure or other licensure that is at least equivalent to or higher than RN and SSW licensure. Providers shall hire additional qualified case managers as their agency's client caseload increases in order to meet workload demands and to maintain quality standards. The State may consider exceptions to the minimum RN and SSW standards in remote geographical areas of the state where access to care issues would exist if not for the exception. These situations will be considered on a case by case basis;
- Must be accredited as a case management agency by the Bureau of Long Term Services and Supports;
- Must be a Medicaid provider enrolled to provide NCW Case Management Services; and
- Non-governmental agencies must have a current business license; or
- Must be recognized as a Division of Services for People with Disabilities Entity; or
- Must be recognized as an Area Agency on Aging entity within the State of Utah; or
- Must be recognized as a Center for Independent Living through the State Office of Rehabilitation.

Chore Services

Service Definition

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as carpet cleaning, pest eradication, cleaning windows and walls, tacking down loose rugs and tiles, lawn mowing, moving heavy items of furniture or snow removal which is necessary in order to provide safe access or egress.

Limits on the Amount, Frequency or Duration of This Service

These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other caregiver, landlord, community/volunteer agency, or third-party payer is capable or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service. Additionally, this service in not available concurrent with any other waiver service in which the tasks performed are duplicative of chore services.

Provider Specifications for Service

NCW Service Name:	Chore Services
HCPCS Billing Code:	S5120
Billing Modifier:	U8

Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Chore Services; and
- Must have a demonstrated ability to perform the tasks ordered by the case management agency.

Community Living

Services Service Definition

Provision of essential household items and services needed to establish and maintain basic living arrangements in a community setting that enable the individual to establish and maintain health and safety. Essential household items include basic furnishings; replacement of worn or soiled household items or furnishings; cleaning devices and supplies; and kitchen and bathroom equipment. This service also includes moving expenses; security deposits that are required to obtain a lease on an apartment or home; rental application fees; one-time non-refundable fees to establish utility services and other services essential to the operation of the residence, and services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy. This service can be accessed for the following events:

1. upon initial NCW enrollment when transitioning to a home or community-based setting, or

2. when an established NCW participant moves to another setting that is determined to better meet the participant's needs, or

3. when an established NCW participant's assessed health and safety warrant the replacement of old depleted household items or furnishings when moving to a new setting or in order to retain the current community living arrangement. Replacement items include a new mattress, mattress protector, linens, table, chair, kitchen furnishings, bathroom furnishings, duplicate keys, locks, a vacuum and storage containers..

Limits on the Amount, Frequency or Duration of This Service

1. Reimbursement for the cost of rent or food is not a covered expense under this service. Reimbursable items are limited to only those household items that are essential. Storage fees are not covered.

2. This service cannot be accessed unless a waiver participant is transitioning (moving) from one setting to another.

3. Reimbursement for the cost of refundable fees or deposits is not a covered expense under this service.

4. Moving expenses are not covered if the new setting is not determined to better meet the participant's assessed needs.

5. The maximum allowable cost for this service is $1,000.00. At the point a waiver participant reaches the allowable cost limit, NCW will conduct an evaluation to determine authorization of any additional service.

Provider Specifications for Service

NCW Service Name: Community Living
HCPCS Billing Code: T2038
Billing Modifier: U8
Provider Qualifications:

- Must have a current business license; and
- Must be a Medicaid provider enrolled to provide NCW Community Living Services.

Consumer Preparation

Service Definition

Services that assist the participant (or the participant's family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring employees, managing employees and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the care plan. This service does not duplicate other waiver services, including case management.

Limits on the Amount, Frequency or Duration of This Service

This service is limited to participants who direct some or all of their waiver services.

Provider Specifications for Service

NCW Service Name: Consumer Preparation Services
HCPCS Billing Code: S5108
Billing Modifier: U8
Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Consumer Preparation Services;
- Individual employee(s) serving NCW clients must be professionals with a bachelor's or a master's degree in social or behavioral health sciences; and
- Individual employee(s) serving NCW clients must demonstrate competence in related topical area(s) of:
    1. Self-determination;

2. Natural supports; and
3. Instruction and/or consultation with individuals and families on:
    a. Assisting self-sufficiency and
    b. Safety.

Environmental Accessibility Adaptations

Service Definition:

Equipment and/or physical adaptations to the individual's residence or vehicle which are necessary to assure the health, welfare and safety of the individual or which enable the individual to function with greater independence in the home and in the community. The equipment/adaptations are identified in the individual's care plan and the model and type of equipment are specified by a qualified individual.

The adaptations may include purchase, installation, and repairs. Other adaptation and repairs may be approved on a case by case basis as technology changes or as an individual's physical or environmental needs change. All services shall be provided in accordance with applicable State or local building codes and may include the following:

Home
Authorized equipment/adaptations such as:

- Ramps
- Grab bars
- Widening of doorways/hallways
- Modifications of bathroom/kitchen facilities
- Modification of electric and plumbing systems which are necessary to accommodate the medical equipment, care and supplies that are necessary for the welfare of the individual.

Vehicle
Authorized vehicle adaptations such as:

- Lifts
- Door modifications
- Steering/braking/accelerating/shifting modifications
- Seating modifications
- Safety/security modifications

Limits on the Amount, Frequency or Duration of This Service

The following are specifically excluded:

1. Adaptations or improvements to the home or vehicle that are of general utility, and

are not of direct medical or remedial benefit to the individual;

2. Adaptations that add to the total square footage of the home;

3. Purchase or lease of a vehicle; and

4. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

The maximum allowable cost per environmental accessibility adaptation is $2,000.00. At the point a NCW participant reaches the service limit, the care coordination team will conduct an evaluation to determine how the individual's health and safety can continue to be assured through authorization for additional service beyond the limit or alternative arrangements that meet the individual's needs while remaining in a community setting.

Provider Specifications for Service

NCW Service Name:	Environmental Accessibility Adaptations – Home Modifications
HCPCS Billing Code:	S5165
Billing Modifier:	U8

Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide Environmental Accessibility Adaptations;
- Must demonstrate an ability to perform the tasks ordered by the case management agency; and
- Home modifications installers or repairpersons must have a contractor's license.

Provider Specifications for Service

NCW Service Name:	Environmental Accessibility Adaptations – Vehicle Modifications Services
HCPCS Billing Code:	T2039
Billing Modifier:	U8

Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Environmental Accessibility Adaptations – Vehicle Modifications Services; and
- Must have demonstrated ability to perform the tasks ordered by the case management agency.

Financial Management

Service Definition

Financial Management Services is offered in support of the self-administered services delivery

option. Services rendered under this definition include those to facilitate the employment of individual service providers (employees) by the waiver participant (employer) or designated representative including:

1. Provider qualification verification;
2. Employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports;
3. Medicaid claims processing and reimbursement distribution, and
4. Providing monthly accounting and expense reports to the consumer.

Limits on the Amount, Frequency or Duration of This Service

Service is provided to those utilizing Self-Administered Services.

Provider Specifications for Service

NCW Service Name: Financial Management Services
HCPCS Billing Code: T2040
Billing Modifier: U8
Provider Qualifications:

- Must be a Certified Public Accountant in accordance with UCA 58-26A and R156-26A;
- Must be a Medicaid provider enrolled to provide NCW Financial Management Services;
- Must have a current business license;
- Must utilize accounting systems that operate effectively on a large scale as well as track individual budgets;
- Must utilize a claims processing system acceptable to the Utah State Medicaid Agency;
- Must establish time lines for payments that meet individual needs within DOL standards;
- Must generate service management, and statistical information and reports as required by the Medicaid program;
- Must develop systems that are flexible in meeting the changing circumstances of the Medicaid program;
- Must provide needed training and technical assistance to clients, their representatives, and others;
- Must document required Medicaid provider qualifications and enrollment requirements and maintain results in provider/employee file;
- Must act on behalf of the person receiving supports and services for the purpose of payroll reporting;
- Must develop and implement an effective payroll system that addresses all related tax obligations;
- Must make related payments as authorized by the case management agency;
- Must generate payroll checks in a timely and accurate manner and in compliance with all federal and state regulations pertaining to “domestic service” workers;

- Must conduct background checks as required and maintain results in employee file;
- Must process all employment records;
- Must obtain authorization to represent the individual/person receiving supports;
- Must prepare and distribute an application package of information that is clear and easy for the individuals hiring their own staff to understand and follow;
- Must establish and maintain a record for each employee and process employee employment application package and documentation;
- Must utilize and accounting information system to invoice and receive Medicaid reimbursement funds;
- Must utilize and accounting and information system to track and report the distribution of Medicaid reimbursement funds;
- Must generate a detailed Medicaid reimbursement funds distribution report to the individual Medicaid recipient or representative semi-annually;
- Must withhold, file and deposit FICA, FUTA and SUTA taxes in accordance with federal IRS and DOL, and state rules;
- Must generate and distribute IRS W-2s, Wage and Tax Statements and related documentation annually to all support workers who meet the statutory threshold earnings amounts during the tax year by January 31st;
- Must file and deposit federal and state income taxes in accordance with federal IRS and state rules and regulations;
- Must assure that employees are paid established unit rates in accordance with the federal and state Department of Labor Fair Labor Standards Act (FLSA);
- Must process all judgments, garnishments, tax levies or any related holds on an employee's funds as may be required by local, state or federal laws;
- Must distribute, collect and process all employee time sheets as summarized on payroll summary sheets completed by the person or his/her representative;
- Must prepare employee payroll checks, at least monthly, sending them directly to the employees;
- Must keep abreast of all laws and regulations relevant to the responsibilities it has undertaken with regard to the required federal and state filings and the activities related to being a Fiscal/Employer Agent;
- Must establish a customer service mechanism in order to respond to calls from individuals or their representative employers and workers regarding issues such as withholding and net payments, lost or late checks, reports and other documentation;
- Must have customer service representatives who are able to communicate effectively in English and Spanish by voice and TTY with people who have a variety of disabilities;
- Must have a Disaster Recovery Plan for restoring software and master files and hardware backup if management information systems are disabled so that payroll and invoice payment systems remain intact; and
- Must regularly file and perform accounting auditing to ensure system accuracy and compliance with general accounting practice.

The monthly payment to the FMS Agency can only be made when active financial management services were provided during that month. Payment is not available during inactive periods (such

as when there is an interruption in waiver services resulting from an admission to a nursing facility).

Habilitation

Service Definition

Habilitation Services are active teaching/training therapeutic activities to supply a person with the means to develop or maintain maximum independence in activities of daily living and instrumental activities of daily living, socialization and adaptive skills necessary to reside successfully in home and community- based settings.

Specific services include teaching/retraining the following:

1. daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, money management and maintenance of the living environment);
2. social skills training in appropriate use of community services; and
3. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion).

Limits on the Amount, Frequency or Duration of This Service

While it is recognized that observation of skills learned is a critical component of habilitation services, the expectation is that active teaching/training/therapeutic intervention will comprise the majority of each unit of service.

The following are specifically excluded from payment for habilitation services:

1. vocational services;
2. prevocational services;
3. supported employment services;
4. room and board;
5. companion services; and
6. services that are intended to compensate for loss of function such as would be provided by attendant care services.

Provider Specifications for Service

NCW Service Name:	Habilitation Services
HCPCS Billing Code:	T2017

Billing Modifier: U8
Provider Qualifications:

- Must be a Medicaid provider enrolled to provide NCW Habilitation Services;
- Must have a demonstrated ability to perform the tasks ordered on behalf of the waiver client;
- Must have a current business license; and
- For home health agencies, must be a licensed in accordance with R432-700.

Home Delivered Meals

Service Definition:

Home Delivered Supplemental Meal provides a nutritionally sound and satisfying meal to individuals residing in non-facility settings who are unable to prepare their own meals and who do not have a responsible party or volunteer caregiver available to prepare their meals for them.

A meal constitutes a supplemental meal when provided in an amount that meets the nutritional needs of the individual. Each supplemental meal provided shall provide a minimum of 33 1/3 percent of the daily Recommended Dietary Allowances (RDA) and Dietary Reference Intake (DRI) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, Institute of Medicine and Mathematica Policy Research, Incorporated.

Limits on the Amount, Frequency or Duration of This Service

1. Meals provided as part of this service shall not constitute a "full nutritional regimen" (3 meals per day).
2. Individuals receiving Adult Residential Services are not eligible for this service.

Provider Specifications for Service

NCW Service Name: Home Delivered Meals
HCPCS Billing Code: S5170
Billing Modifier: U8
Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Home Delivered Meals; and
- Must comply with UAC R70-530, Food Protection.

Homemaker Services

Service Definition

Services consisting of the performance of general household tasks (e.g., meal preparation, grocery shopping, laundry and routine household care including but not limited to cleaning bathrooms, doing dishes, dusting, vacuuming, sweeping, mopping) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

Limits on the Amount, Frequency or Duration of This Service

This service cannot be provided to participants receiving Adult Residential Services or any other waiver service in which the tasks performed are duplicative of the homemaker services.

Provider Specifications for Service

NCW Service Name: Homemaker Services
HCPCS Billing Code: S5130
Billing Modifier: U8
Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Homemaker Services; and
- Must have a demonstrated ability to perform the tasks ordered by the case management agency.

Medication Administration Assistance Services

Service Definition

Medication Reminder System (Not Face-To-Face)

Medication Reminder System provides a medication reminder by a third party entity or individual that is not the clinician responsible for prescribing and/or clinically managing the individual, not the entity responsible for the administration of medication, and not the entity responsible for the provision of nursing or personal care or attendant care services. Services involve non face-to-face medication reminder techniques (phone calls, telecommunication devices, medication dispenser devices with electronic alarms which alert the individual and a central response center staffed with qualified individuals).

Medication Set-Up and Administration

Services of an individual authorized by State law to set-up medications in containers that facilitate safe and effective self-administration when individual dose bubbling packaging by a pharmacy is not available and assistance with self-administration is not covered as an element of another waiver service. Nurses may also assist individuals in the administration of medications as part of a medication maintenance regimen.

Limits on the Amount, Frequency or Duration of This Service

This service is not available to individuals eligible to receive the service through the Medicaid

State Plan or other funding source.

Provider Specifications for Service

NCW Service Name:	Medication Administration – Medication Reminder System (Not Face-To-Face)
HCPCS Billing Code:	S5185
Billing Modifier:	U8

Provider Qualifications:

- Must be a Medicaid provider enrolled to provide NCW Medication Administration Services.

Provider Specifications for Service

NCW Service Name:	Medication Administration – Medication Set-Up and Administration Services
HCPCS Billing Code:	H0034
Billing Modifier:	U8

Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Medication Administration – Medication Set-Up and Administration Services; and
- Must meet and abide by all licensing, supervision and delegation standards for medication set-up and administration found within the Nurse Practice Act, UAC R156-31b.

Non-Medical Transportation

Service Definition

Service offered in order to enable waiver participants to gain access to non-medical waiver and other community services, activities and resources, as specified by the care plan. Transportation services under the waiver are offered in accordance with the participant's care plan.

Limits on the Amount, Frequency or Duration of This Service

This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, and does not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Non-Medical transportation is not available for the provision of transportation to medical appointments. Medical appointments are defined as appointments which are covered by the Medicaid state plan, PMHP and/or VA for which medical transportation is available.

Provider Specifications for Service

NCW Service Name:	Transportation – Non-Medicaid – Per One Way Trip

HCPCS Billing Code: T2003
Billing Modifier: U8
Provider Qualifications:

- Non-Medical Transportation AND Valid Driver's License
- Registered and insured vehicle: UCA 53-3-202, UCA 41-12s-301 to 412
- Medicaid provider enrolled to provide non-medical transportation services. Minimum of $500,000.00 Per Incident Per Occupant Personal Liability Insurance coverage.

Provider Specifications for Service
NCW Service Name: Transportation – Non-Medicaid – Per Mile
HCPCS Billing Code: S0215
Billing Modifier: U8
Provider Qualifications:

- Must have a current business license; and
- Non-Medical Transportation AND Valid Driver's License
- Registered and insured vehicle: UCA 53-3-202, UCA 41-12s-301 to 412
- Medicaid provider enrolled to provide non-medical transportation services. Minimum of
- $500,000.00 Per Incident Per Occupant Personal Liability Insurance coverage.

Provider Specifications for Service
NCW Service Name: Transportation – Non-Medicaid – Public Transit Pass
HCPCS Billing Code: T2004
Billing Modifier: U8
Provider Qualifications:

- Must be a Medicaid provider enrolled to provide NCW Case Management Services.

Personal Budget Assistance

Service Definition:

Personal budget assistance helps with financial matters, fiscal training, supervision of financial resources, savings, retirement, earnings and funds monitoring, monthly check writing, bank reconciliation, budget management, tax and fiscal record keeping and filing, and fiscal interaction on behalf of the individual.

The purpose of this services is to offer opportunities for waiver clients to increase their ability to provide for their own basic needs, increase their ability to cope with day to day living, maintain more stability in their lives and maintain the greatest degree of independence possible, by providing timely financial management assistance to waiver participants in the least restrictive setting, for those individuals who have no close family or friends willing to take on the task of assisting them with their finances.

Limits on the Amount, Frequency or Duration of This Service

The Personal Budget Assistance provider must assist the NCW participant or the participant's designated representative in reviewing their finances/budget at least monthly, must maintain documentation of this review and must submit the budget review documentation to the Case Management Agency for review on a monthly basis. The services provided in this service will not duplicate FMS services (i.e., tax and fiscal filing).

Representative payee services designated through a mental health authority or through Social Security Administration are excluded from payment under Personal Budget Assistance.

Provider Specifications for Service

NCW Service Name: Personal Budget Assistance
HCPCS Billing Code: H0038
Billing Modifier: U8
Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Personal Budget Assistance; and
- Must demonstrate an ability to perform the tasks ordered by the case management agency.

Personal Emergency Response System

Service Definition:

An electronic device that enables an individual to secure help in an emergency through a connection to a signal response center that is staffed by trained professionals on a 24 hour per day, seven days a week basis.

Personal Emergency Response Systems (PERS) Response Center Service

- Provides ongoing access to a signal response center that is staffed twenty-four hours per day, seven days a week by trained professionals responsible for securing assistance in the event of an emergency.

Personal Emergency Response System (PERS) Purchase, Rental & Repair

- Provides an electronic device of a type that allows the individual to summon assistance in an emergency. The device may be any one of a number of such devices but must be connected to a signal response center.

Personal Emergency Response System (PERS) Installation, Testing & Removal Provides installation, testing, and removal of the PERS electronic device by trained personnel.

This service may also be used for the reimbursement of GPS (Global Positioning Systems) devices for an individual who has a documented health and safety risk. The supply and use of a device with GPS tracking will only be provided with the approve of the person-centered planning team and with the informed consent of the individual or their legal representative.

Limits on the Amount, Frequency or Duration of This Service

No Limits

Provider Specifications for Service

NCW Service Name:	Personal Emergency Response System
HCPCS Billing Code:	S5162- Purchase, rental & repair S5160- Installation, testing & removal S5161- Monthly response center service
Billing Modifier:	U8

Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Personal Emergency Response System Services; and
- Personal Emergency Response System equipment suppliers must have FCC registration of equipment placed in the homes of waiver clients; or
- Installers must demonstrate an ability to properly install and test specific equipment being handled; or
- Response Centers must be staffed and in operation 24 hours per day, 7 days per week.

Respite Services

Service Definition

Care provided to give relief to, or during the absence of, the normal care giver. Respite care may include hourly, daily and overnight support and may be provided in the individual's place of residence, a facility approved by the State which is not a private residence, or in the private residence of the respite care provider.

Limits on the Amount, Frequency or Duration of This Service

Payments are not made for room and board except when provided as a part of overnight respite care in a facility approved by the State and enrolled as a NCW Respite Care provider. In the case of respite care services that are rendered in a facility overnight, this service will be billed under a specific Respite Care- Overnight, Out of Home, Room and Board Included billing code (H0045). Each Respite Care-Overnight, Out of Home, Room and Board Included episode is limited to a period of 13 consecutive days or less not counting the day of discharge. The number of Respite Care -Overnight, Out of Home, Room and Board Included episodes may not exceed three in any calendar year.

For facility based respite care that is not provided overnight, the provider should bill using the rate (S5150) The services is limited to a maximum of five hours of support per day.

Respite care provided in the client's own home or in the private residence of the respite care provider should be reimbursed using the hourly rate (S5150) and is limited to a maximum of five hours of support per day.

Respite care is not available for those receiving Adult Residential Services.

Provider Specifications for Service

NCW Service Name:	Respite Care -
HCPCS Billing Code:	Respite Care – Routine (hourly) S5150
Billing Modifier:	U8

Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Respite Care Services; and
- Adult Day Care providers must be licensed in accordance with R501-12-1; or
- Home Health Agencies must be licensed in accordance with R432-700; or
- Nursing Facilities must be licensed in accordance with R432-150; or
- Assisted Living Facilities must be licensed in accordance with R432-270; or
- Residential Treatment Facilities must be licensed in accordance with R501-19-13.

Provider Specifications for Service

NCW Service Name:	Respite Care – Overnight, Out of Home, Room & Board included
HCPCS Billing Code:	H0045
Billing Modifier:	U8

Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Respite Care – Overnight, Out of Home, Room & Board Included; and
- Nursing Facility providers must be licensed in accordance with R432-150; or
- Assisted Living Facility providers must be licensed in accordance with R432-270; or
- Residential Treatment Facilities must be licensed in accordance with R501-19-13.

Specialized Medical Equipment, Supplies and Supplements

Service Definition

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service covers items necessary for life support including prescribed nutritional supplements, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan.

Limits on the Amount, Frequency or Duration of This Service

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Coverage includes the costs of maintenance and upkeep of equipment, training the participant or caregivers in the operation and/or maintenance of the equipment or the use of a supply, and the performance of assessments to identify the type of equipment needed by the participant.

Items may only be provided under this service when prescribed by a physician or other appropriate health care provider (such as a physician's assistant or advanced practice registered nurse or other medical care providers with prescriptive authority).

Provider Specifications for Service

NCW Service Name:	Specialized Medical Equipment, Supplies & Supplements
HCPCS Billing Code:	T2029
Billing Modifier:	U8

Provider Qualifications:

- Must be a Medicaid provider enrolled to provide NCW Medical Equipment, Supplies and Supplements; and
- Non-durable medical equipment, supplies and supplements providers must have a current business license; or
- Durable medical equipment and supply providers must have a current business license as a DME provider and must have a National Supplier Clearinghouse Letter from CMS.

Supportive Maintenance

Service Definition

Services defined in 42 CFR 440.70 that are provided when home health aide services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from home health aide services furnished under the State plan. Services are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.

Limits on the Amount, Frequency or Duration of This Service

Supportive maintenance services will only be ordered after full utilization of available State Plan home health services by the participant.

Provider Specifications for Service

NCW Service Name:	Supportive Maintenance Services
HCPCS Billing Code:	T1021

Billing Modifier: U8

Provider Qualifications:

- Must have a current business license;
- Must be a Medicaid provider enrolled to provide NCW Supportive Maintenance; and
- Must be a licensed home health agency in accordance with UAC R432-700

12 SERVICE PROCEDURE CODES

The New Choices Waiver HCPCS codes can be found on the Medicaid website at the following location: https://medicaid.utah.gov/ltc/nc-providers/. Providers must refer to the service authorization form provided by the assigned case management agency for each waiver participant to know the HCPCS code that can be billed.

13 MANDATORY ADULT PROTECTIVE SERVICES REPORTING REQUIREMENTS

All suspected incidents of abuse, neglect or exploitation must be reported in accordance with Utah State Law 76-5-111, Utah Code annotated 62A-3-305 and State Rule R510-302.

1. Any person who has reason to believe that any vulnerable adult has been the subject of abuse, neglect, or exploitation shall immediately notify Adult Protective Services intake or the nearest law enforcement agency. When the initial report is made to law enforcement, law enforcement shall immediately notify Adult Protective Services intake. Adult Protective Services and law enforcement shall coordinate, as appropriate, their efforts to provide protection to the vulnerable adult.

2. When the initial report or subsequent investigation by Adult Protective Services indicates that a criminal offense may have occurred against a vulnerable adult, it shall notify the nearest local law enforcement agency. That law enforcement agency shall initiate an investigation in cooperation with Adult Protective Services.

3. Anyone who in good faith makes a report or otherwise notifies a law enforcement agency, the division, or Adult Protective Services of suspected abuse, neglect, or exploitation is immune from civil and criminal liability in connection with the report or other notification.

4. Any person who willfully fails to report suspected abuse, neglect, or exploitation of a vulnerable adult is guilty of a class B misdemeanor.

5. Under circumstances not amounting to a violation of Section 76-8-508, a person who threatens, intimidates, or attempts to intimidate a vulnerable adult who is the subject of a report, a witness, the person who made the report, or any other person cooperating with an investigation conducted pursuant to this chapter is guilty of a class B misdemeanor.

6. The physician-patient privilege does not constitute grounds for excluding evidence

regarding a vulnerable adult's injuries, or the cause of those injuries, in any judicial or administrative proceeding resulting from a report made in good faith pursuant to this part.

7. An adult is not considered abused, neglected, or a vulnerable adult for the reason that the adult has chosen to rely solely upon religious, nonmedical forms of healing in lieu of medical care.

14 CONTACT PHONE NUMBERS

Adult Protective Services (DHS/DAAS)	**Adult Protective Services** **Salt Lake County 1-801-538-3567** **All other counties 1-800-371-7897** Please be prepared to offer the following information: • Name, address, and phone number of victim(s). • Identifying information of the victim such as: birth date, social security number, age, ethnicity, etc. • Name, address, and phone number of alleged perpetrator (if applicable). • Identifying information regarding alleged perpetrator (if applicable). • Your name, phone number and address. • Provide information on any disability, health problem or mental illness. • Reason for concern (alleged abuse, neglect or exploitation). (note: all information is not necessary, but helpful)
Disenrollment	**Utah Department of Health** Division of Medicaid and Health Financing NCW Program Office PO Box 143112 Salt Lake City Utah 84114-3112 Fax: 801-323-1586 newchoiceswaiver@utah.gov
Medicaid Constituent Services	**Medicaid Constituent Services Representative** Phone: 801-538-6417 Toll Free: 1-877-291-558 Fax: 801-323-1586 Email: medicaidmemberfeedback@utah.gov
Health Program Representatives	https://medicaid.utah.gov/health-program-representatives/

Incident Reporting	**Utah Department of Health** Division of Medicaid and Health Financing NCW Program Office Attn: New Choices Waiver Incident Reporting PO Box 143112 Salt Lake City Utah 84114-3112 Fax: 801-323-1586 ncwincidents@utah.gov	
Medicaid ACO Health Plans	**Healthy U**	Phone: 1-888-271-5870 or 1-801-587-6480 https://uhealthplan.utah.edu/medicaid/
	Molina Healthcare	Phone: 1-888-483-0760 https://www.molinahealthcare.com/
	SelectHealth Community Care	Phone: 1-800-538-5038 https://selecthealth.org/plans/medicaid
	Steward Health Choice Utah	Phone: 1-877-358-8797 https://www.stewardhealthchoiceut.org/
Medicaid Client Education	https://medicaid.utah.gov/medicaid-members/	
Medicaid Information Line	801-538-6155 or 1-800-662-9651 https://medicaid.utah.gov/	
New Choices Waiver Program Office	Salt Lake City area: 1-801-538-6155, option 6 Outside Salt Lake City: 1-800-662-9651, option 6 Fax: 1-801-323-1586 Email: newchoiceswaiver@utah.gov Website: https://medicaid.utah.gov/ltc/nc/	
Request for Hearing	**Utah Department of Health** Director's Office / Formal Hearings Division of Medicaid and Health Financing PO Box 143105 Salt Lake City Utah 84114-3105 Fax: 801-536-0143	

Utah Medicaid Provider Manual

Home and Community-Based Services Waiver for Individuals with Physical Disabilities

Division of Integrated Healthcare

Updated July 2020

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1 General information

This manual is designed to be used in conjunction with the Utah Medicaid provider manual, Section I: General Information.

1-1 General policy

Under Section 1915(c) of the Social Security Act, a state may request approval through the federal Centers for Medicare and Medicaid Services (CMS) to "waive" certain statutory requirements in order to use Medicaid funds for an array of home and community-based services (HCBS) provided to eligible recipients as an alternative to institutional care. Since June 1, 1998, the State of Utah has provided Medicaid reimbursed home and community-based waiver services to individuals with physical disabilities. The Division of Integrated Healthcare (DIH) received approval from CMS through a waiver renewal process to continue operating the Home and Community-Based Services Waiver for Individuals with Physical Disabilities (PD waiver) through June 30, 2016. The approval includes:

The waiver of comparability requirements in subsection 1902(a)(10)(B) of the Social Security Act. In contrast to Medicaid State Plan service requirements, under a waiver of comparability, the state is permitted to provide covered waiver services to a limited number of eligible individuals who meet the state's criteria for Medicaid reimbursement in a nursing facility (NF).

Waiver services need not be comparable in amount, duration or scope to services covered under the State Plan. However, each year the state must demonstrate that the waiver is a cost-effective or "cost-neutral" alternative to institutional NF services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded NF services.

Waiver of institutional deeming requirements in section 1902(a)(10)(C)(I)(III) of the Social Security Act. Under the waiver of institutional deeming requirements, the State uses more liberal eligibility income and resource calculations when determining recipients' Medicaid eligibility.

The State Medicaid Agency (SMA) has ultimate administrative oversight and responsibility for the PD waiver program. The day to day operations have been delegated to the Department of Human Services (DHS), Division of Services for People with Disabilities (DSPD), through an interagency agreement with the SMA. This agreement and the State Implementation Plan (SIP) describe the responsibilities that have been delegate to DSPD as the Operating Agency (OA) for the waiver program.

1-2 Acronyms and definitions

For purposes of the PD waiver, the following acronyms and definitions apply:

CMS: Centers for Medicare and Medicaid Services

DHS: Department of Human Services

DIH: Division of Integrated Healthcare

DHHS: Department of Health and Human Services

DSPD: Division of Services for People with Disabilities

HCBS: Home and community-based services

MAR: Maximum allowable rate

NF: Nursing facility

NOA: Notice of action

OA: Operating agency

PCSP: Person centered support plan

PHI: Personal and Protected Health Information

PII: Personal Identifiable Information

RFS: Request for services

PD: Physical disabilities

SIP: State Implementation Plan

SMA: State Medicaid Agency

1-3 CMS approved State Implementation Plan

The CMS approved SIP for the PD waiver serves as the state's authority to provide HCBS to the target group under its Medicaid plan. The SIP and all attachments constitute the terms and conditions of the program.

This manual does not contain the full scope of the SIP. To understand the full scope and requirements of the PD waiver, providers should refer to the SIP. In the event provisions of this manual are found to be in conflict with the SIP, the SIP will take precedent.

2 Provider participation

Refer to provider manual, Section I: General Information for provider enrollment information.

2-1 Provider enrollment

Home and community-based waiver services for participants with physical disabilities are covered benefits only when delivered by a provider enrolled with the SMA to provide the services as part of the PD waiver. In addition to this Medicaid provider agreement, all providers of PD waiver services must also have a current contract with DHS/DSPD.

Any willing provider that meets the qualifications defined in the PD waiver SIP may enroll at any time to provide a PD waiver service by contracting DSPD. DSPD will

facilitate completion and submission of the required Medicaid provider application and completion of the required local contract. The provider is only authorized to provide the waiver services specified in Attachment A of the Medicaid provider agreement submitted by the provider.

2-2 Provider reimbursement

Providers will be reimbursed according to the specified reimbursement rate(s) contained in the negotiated contract with DSPD.

Providers may only claim Medicaid reimbursement for services that are authorized by the administrative case manager on the approved PCSP. Claims must be consistent with the amount, frequency and duration authorized by and documented on the PCSP.

2-3 Standards of service

Providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, the terms and conditions of the PD waiver SIP and the terms and conditions contained in the DSPD contract.

2-4 Data security and privacy

Providers are expected to take steps to ensure that all personal information related to the individual being served is protected. This includes both Personal Health Information (PHI) as well as Personally Identifiable Information (PII). Providers should use appropriate administrative, technical and physical safeguards to preserve the integrity, confidentiality, and availability of PHI/PII that they create, receive, maintain or transmit. This includes using encrypted/secure email, fax, or other HIPAA compliant methods to transmit documents containing information about the individual being served. Providers shall ensure there is limited and controlled access to PHI/PII. In the performance of its services and operations, the provider shall make efforts to use, disclose and request only the minimum amount of PHI/PII considered reasonably necessary. The provider shall also identify and protect against reasonably anticipated threats to the security or integrity of the information, protect

against reasonably anticipated, impermissible uses or disclosures; and ensure compliance by their workforce.

2-5 Breach reporting/data loss

Providers must report to DSPD and DIH, either by email or telephone, any breach or loss of PHI/PII. This report should be completed not more than 24 hours after the provider knows or should have reasonably known about the breach. The provider must also submit a report in writing/by email to DSPD within 5 business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

2-6 Provider rights to a fair hearing

The DHHS affords hearing rights to providers who have experienced any adverse action taken by DHHS/DIH, or by the OA. Providers must submit a written request for a hearing to DHHS in order to access the hearing process. Please refer to the DHHS/DIH provider manual, General Information, Section I, Chapter 6-15, Administrative review/fair hearing.
Adverse actions that providers may appeal include:

1. Actions relating to enrollment as a PD waiver provider,
2. Contract reimbursement rates,
3. Sanctions or other adverse actions related to provider performance, or
4. Improper conduct by DSPD in performing delegated PD waiver responsibilities.

2-7 Electronic visit verification

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, are effective for Utah Medicaid beginning July 1, 2019. EVV requirements apply to all personal care services and home health care services provided under a 1915 (c) Home and Community-Based Waiver.

Choice of reporting systems for EVV are by provider preference, but must meet all federal requirements, including the standards set in the Health Insurance Portability Accountability Act. The state will not implement a mandatory model for use. All

provider choice EVV systems must be compliant with requirements of the Cures Act including:

1. type of service performed;
2. individual receiving the service;
3. date of the service;
4. location of service delivery;
5. individual providing the service;
6. time the service begins and ends; and
7. the date of creation of the electronic record.

Additional information including technical specifications for file creation/submission and EVV resources can be found at https://medicaid.utah.gov/evv

3 Service availability

Home and community-based waiver services are covered benefits only when provided to an individual:

1. With physical disabilities who has established eligibility for state matching funds through DHS in accordance with UCA 62A-5;
2. Who has been determined to meet the eligibility criteria defined in the current CMS approved PD waiver SIP;
3. Pursuant to a written Person Centered Support Plan (PCSP).

3-1 Eligibility for PD waiver services

Home and community-based waiver services are covered benefits only for a limited number of eligible Medicaid recipients who require the level of care provided in NF, or the equivalent care provided through the PD waiver. In determining whether the applicant has mental or physical conditions that meet this level of care requirement, the individual responsible for assessing level of care shall document that the applicant meets the criteria as established in Utah Administrative Code, Title R414-502-3, Utah Medicaid program.

The individual responsible for the assessment will also document that the applicant meets the following additional targeting criteria:

1. 18 years of age or older;
2. Has at least one personal attendant trained (or willing to be trained) and available to provide the authorized waiver services in a residence that is safe and can accommodate the personnel and equipment (if any) needed to adequately and safely care for the individual;
3. Is medically stable, has a physical disability and requires, in accordance with a physician's written documentation, at least 14 hours per week of personal assistance services (as described in Appendix B of the PD waiver SIP) in order to remain in the community and prevent unwanted institutionalization. For purposes of the PD waiver, the applicant's qualifying disability and need for personal assistance services are attested to by a medically determinable physical impairment which the physician expects will last of a continuous period of not less than 12 months and which has resulted in the applicant's functional loss of two or more limbs. The physical impairment must also be to such an extent that the assistance of another trained person(s) is required in order to accomplish activities of daily living and instrumental activities of daily living.
4. Has decision making capability, as certified by a physician, of selecting, training, and supervising their own attendant(s) (Individuals possessing decision making capability, but having communication deficits or limited English proficiency may select a representative to communicate decisions on the individual's behalf).
5. Has the capacity to manage their own financial and legal matters.

If a person is eligible for more than one of the waivers operated by the Division of Services for People with Disabilities (DSPD), DSPD will educate the individual about their choices and will advise the individual about which of the waivers will likely best meet their needs.

An individual will not be enrolled if it is determined during the eligibility assessment process that the health, welfare, and safety of the individual cannot be maintained through the PD waiver.

Inpatients of hospitals, nursing facilities, or intermediate care facilities for people with intellectual disabilities are not eligible to receive waiver services (except as specifically permitted for discharge planning in the 90-day period prior to their discharge to the PD waiver). The term intermediate care facilities for people with intellectual disabilities, which is used in this document, is equivalent to intermediate care facilities for persons with mental retardation (ICFs/MR) under federal law.

3-2 Applicant freedom of choice of NF or PD waiver

Medicaid recipients who meet the eligibility requirements of the PD waiver may choose to receive services in a NF or through the PD waiver if available capacity exists, to address health, welfare, and safety needs.

If no available capacity exists in the PD waiver, the applicant will be advised that he or she may access services through a NF or may wait for open capacity to develop in the PD waiver.

If available capacity exists in the PD waiver, a pre-enrollment screen of health, welfare, and safety needs will be completed by a PD waiver representative. The applicant will be advised of the preliminary needs identified and given the opportunity to choose to receive services to meet the identified needs through a NF or the PD waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the individual record.

Once the individual has chosen to enroll in the PD waiver and the choice has been documented, subsequent review of choice of program will only be required at the time a substantial change in the participant's condition results in a change in the written PCSP. It is, however, a PD waiver participant's option to choose institutional NF care at any time and voluntarily disenroll from the PD waiver.

3-3 PD waiver participant freedom of choice

Upon completion of the comprehensive assessment instrument, the participant in participation with the administrative case manager will participate in the development of the PCSP to address the participant's identified needs.

The waiver participant, and their legal representative if applicable, will be given the opportunity to choose the providers of waiver services identified on the PCSP if more than one qualified provider is available to render the services. The participant's choice of providers will be documented in the PCSP.

The administrative case manager will review the contents of the written PCSP with the participant prior to implementation. If the participant is not given the choice of HCBS as an alternative to NF care, is denied the PD waiver services(s) of their choice or is denied the waiver provider(s) of their choice, the administrative case manager will provide an opportunity for a fair hearing, under 42 CFR Part 431, Subpart E.

Subsequent revision of the participant's PCSP as a result of annual re-assessment or significant change in the participant's health, welfare, or safety requires proper notice to the participant as described above.

3-4 Termination of home and community-based waiver services

When the need arises, participants are separated from the Home and Community Based waiver program through a disenrollment process.

The disenrollment process is a coordinated effort between DIH and DSPD that is expected to facilitate the following:

1. Appropriate disenrollment and movement among waiver programs when applicable;
2. Effective utilization of waiver program potential;
3. Effective discharge and transition planning;
4. Provision of information, affording participants the opportunity to exercise all applicable waiver rights; and
5. Program quality assurance/quality improvement measures.

All of the various circumstances for which it is permissible for DSPD to disenroll a participant from the waiver program can be grouped into three distinct disenrollment categories.

A. Voluntary disenrollments are cases in which participants, or their legal representatives when applicable, choose to initiate disenrollment from the waiver. Disenrollments are also considered voluntary when the waiver participant enters a skilled nursing facility for a stay of less than 90 days and chooses not to transition back to the original waiver program. This includes cases in which the participant transitions to another waiver program form the skilled nursing facility. Voluntary disenrollments require administrative case managers to notify the DSPD PD waiver program manager. DSPD, either through the program manager or other authorized designee, will in turn send written notification to the DIH within 10 days from the date of disenrollment. No DIH prior review or approval of the decision to disenroll is required. Documentation will be maintained by DSPD and should include a written statement signed by the participant or their legal representative when applicable detailing their intent to disenroll from the PD waiver program as well as discharge planning activities completed by the administrative case manager with the waiver participant as part of the disenrollment process.

B. Pre-approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from the waiver for any of the following reasons:

1. Death of the participant;
2. Participant is determined ineligible for Medicaid services by the Department of Workforce Services as a result of no longer meeting the financial requirements for Medicaid eligibility; or
3. Participant enters a skilled nursing facility for a stay of more than 90 days.

Pre-approved involuntary disenrollments require administrative case managers to notify the DSPD PD waiver program manager. DSPD, either through the program manager or other authorized designee, will in turn send written notification to DIH within 10 days from the date of disenrollment. No DIH prior review or approval of the decision to disenroll is required as the reasons for pre-approved involuntary disenrollment have already been approved by the SMA. Documentation will be

maintained by DSPD, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process when appropriate.

C. Special circumstance disenrollments are cases in which participants are disenrolled from the waiver for reasons that are non-routine in nature. These cases require prior review and approval by DIH and involve circumstances that are specific to the participant involved. Examples of this type of disenrollment include:

1. Participant no longer meets the institutional NF level of care requirements for the waiver;
2. Participant's health and safety needs cannot be met by the waiver program's services and supports;
3. Participant has demonstrated non-compliance with the agreed upon PCSP and/or is unwilling to negotiate a PCSP that meets minimal safety standards;
4. Participant has demonstrated non-compliance with a signed participant agreement with DSPD; and/or
5. Participant, or their legal representative when applicable, requests a transfer of the participant from the PD waiver directly to another waiver program when a stay at a nursing facility has not been involved; and/or
6. Participant's whereabouts are unknown for more than 30 days and participant has not yet been determined ineligible for Medicaid services by the Department of Workforce Services.

The special circumstance disenrollment review process will consist of the following activities:

1. The administrative case manager shall compile information to articulate the disenrollment rationale.
2. The administrative case manager will then submit disenrollment rationale information to their DSPD PD waiver program manager for review of the documentation of administrative case management activities and of the disenrollment recommendation.
3. If DSPD management staff concurs with the recommendation, a request for disenrollment approval will be forwarded to DIH for a final decision.

4. DIH will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources, have been fully utilized to meet the participant's health and safety needs.
5. DIH may facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.
6. A DIH final disenrollment decision will be communicated in writing to both the administrative case manager and the state-level program management staff.

If the special circumstance disenrollment request is approved by DIH, the administrative case manager will provide the participant, or their legal representative when applicable, with the required written notice of action (NOA).

The administrative case manager will initiate discharge planning activities sufficient to assure a smooth transition to an alternate Medicaid program and/or to other services. Discharge planning activities shall be documented in the participant's case record.

3-5 Fair hearings

A participant and their legal representative, if applicable, will receive a written NOA form 522 and hearing request form 490S, from the administrative case manager if the participant is:

1. Denied a choice of institutional NF or waiver program,
2. Found ineligible for the waiver program,
3. Denied access to the provider of choice for a covered waiver service, or
4. Experiences a denial, reduction, suspension, or termination in waiver services in accordance with R539-2-5.

The NOA delineates the participant's right to appeal the decision through an informal hearing process at DHS or an administrative hearing process at the Department of Health and Human Services (DHHS), or both. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions.

An aggrieved individual may request a formal hearing within 30 calendar days form the date written notice is issued or mailed, whichever is later. DIH may reinstate

services for participants or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than ten (10) calendar days after the date of action.

Appeals related to establishing eligibility for state matching funds through DSPD/DHS in accordance with UCA 62A-5 will be addressed through the DHS hearing process. Decisions made through DHS may be appealed to DHHS strictly for procedural review. Appealed decisions demonstrating that DHS followed the fair hearing process will be upheld by DHHS as the final decision.

Documentation of notices and the opportunity to request a fair hearing is kept in the individual's case record/file and at DSPD – State Office.

Informal dispute resolution

DSPD has an informal dispute resolution process. This process is designed to respond to a participant's concerns without unnecessary formality. The dispute resolution process is not intended to limit a participant's access to formal hearing procedures; the participant may file a request for hearing any time in the first 30 days after receiving an NOA. Examples of the types of disputes include but are not limited to concerns with a provider of waiver services, concerns with the amount, frequency, or duration of services being delivered, concerns with provider personnel, etc.

Attempts to resolve disputes are completed as expeditiously as possible. No specific timelines have been identified as some issue may be resolved very rapidly while other more complex issues may take a greater period of time to resolve.

4 Administrative case management

4-1 Administrative case manager qualifications

Case management in the PD waiver is an administrative function rather than a covered PD waiver service and is performed by employees of DSPD. Qualified administrative case managers shall be licensed in the State of Utah as a registered nurse in accordance with Title 58, Occupational and Professional Licensing, Utah

Code Annotated, 1953 as amended, and have at least one year of paid experience working with individuals with severe physical disabilities at the time of hire.

4-2 Administrative case management and the PCSP

The PCSP is the mechanism through which all necessary PD waiver services (as determined during the initial and ongoing comprehensive needs assessment process) are detailed in terms of the amount, frequency, and duration of the intervention to be provided to meet identified objectives.

The amount, frequency and duration of each service listed within the PCSP is intended to provide a budget estimate of the services required to meet the assessed needs of each participant over the course of a plan year. Utah Medicaid recognizes that a participant's needs may change periodically due to temporary or permanent conditions which may require changes to the annual PCSP budget.

The administrative case manager is responsible to monitor service utilization for each participant under their care. When the administrative case manager determines that a participant may require an increase in services, a request for services (RFS) must be submitted to the PD waiver program manager for approval.

The annual PCSP budget is the sum of all approved services within the PCSP including additional services authorized through an approved RFS that are added to the PSCP over the entire plan year. In this way, Utah Medicaid applies an annualized aggregate to the PCSP budget.

Services may not exceed the amount allotted through the annual PCSP budget. Billing in excess of the annual PCSP budget will be subject to recovery of funds.

4-3 Assessment instrument

The Minimum Data Set – Home Care serves as the standard comprehensive instrument.

5 Self-directed employee model

The self-directed employee model requires the PD waiver participant to use a financial management services provider (fiscal agent) as an integral component of the PD waiver services to assist with managing the employer-related financial responsibilities associated with the self-directed employee model. The fiscal agent is an agency-based provider that assists the PD waiver participant and his or her representatives, when appropriate, in performing a number of employer-related tasks without being considered the common law employer of the service providers.

Tasks performed by the fiscal agent include documenting service workers' qualifications, collecting service worker time records, preparing payroll for participants' service workers, and withholding, filing, and depositing federal, state, and local employment taxes.

Participant employed service workers complete a time sheet for work performed. The participant confirms the accuracy of the time sheet, signs it, and forwards it to the fiscal agent for processing. The fiscal agent files a claim for reimbursement to the Medicaid PRISM system, through the DHS CAPS system, completes the employer-related responsibilities, deducts the established administrative fee, and forwards payment directly to the service worker for the services documented on the time sheet.

6 Waiver covered services rate setting methodology

DHS has entered into an administrative agreement with DHHS/DIH to set 1915(c) HCBS waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915(c) HCBS PD waiver program and other applicable Medicaid rules. There are four principle methods used in setting the DHS Maximum Allowable Rate (MAR) level. Each method is designed to determine a fair market rate. The four principle methods include:

1. existing market survey or cost survey of current providers
2. component cost analysis
3. comparative analysis
4. community price survey

Annual MAR schedules may be held constant or modified with a cost-of-living adjustment for any or all of the PD waiver covered services in lieu of completing one of the four principle methods depending on the budget allocation approved by the Utah State Legislature for the applicable fiscal year.

The State Medicaid Agency will maintain records of changes to the MAR authorized for each PD waiver covered service to document the rate setting methodology used to establish the MAR.

7 Service procedure codes

The procedure codes listed below are covered by Medicaid under the waiver for individuals with physical disabilities.

Waiver Service	Code	Unit of Service
Financial management services	T2040	Per month
Medication dispenser	T2029	Per episode
Medication dispenser (monthly fee)	T2028	Per month
Personal attendant services	S5125	15 minute
Personal emergency response systems (install)	S5160	Per episode
Personal emergency response systems (monthly fee)	S5161	Per month
Personal emergency response systems (purchase)	S5162	Per episode

8 Incident reporting protocol

I. Purpose:

The State Medicaid Agency (SMA) has the administrative authority over all 1915(c) Medicaid Home and Community-Based Services (HCBS) Waivers (waivers). Waiver programs must provide adequate and appropriate services that safeguard the health and welfare of all enrolled participants. Waiver programs must also assure financial

accountability for funds expended for HCBS services. While these responsibilities are delegated to the Operating Agencies (OA), the SMA retains final authority and has the final responsibility to: 1) assure that appropriate actions have taken place when a critical incident or event occurs; and 2) in cases where appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard participants.

The Critical Incidents and Events Program is a collaborative effort between the OAs for each of the 1915(c) waivers and the SMA. The program has two levels. Level one describes the critical incidents/events that are required to be reported by the OA to the SMA for investigation, resolution and closure. Level two describes the critical incidents/events that are required to be reported to the OA for investigation, resolution and closure.

This standard operating procedure stipulates:

1. Level one incidents and events required to be reported to the SMA;
2. Level two incidents and events that are required to be reported to the OA;
3. The agency responsible for completing the review; and
4. Associated reporting requirements.

II. Reportable critical incidents/events

Level One Incidents and Events – Reportable to the SMA

The following list of the incidents/events (incidents) must be reported by the OA to the SMA. This is not an all- inclusive list. Other incidents that rise to a comparable level must be reported to the SMA.

1. Unexpected hospitalization

Admission to the hospital for medical treatment related to one or more of the following reasons:

a) Injuries that result in the loss of physical or mental function (i.e. loss of limb, paralysis, brain injury or memory loss);
b) Alleged/substantiated abuse or neglect;
c) Attempted suicide;

d) Medication errors;
e) Self-injurious behavior;
f) Serious burns; and/or
g) Substance abuse.

2. Exploitation (either alleged or substantiated)

Unfairly taking advantage of a participant due to his/her age, health, and/or disability including:

a) Serious and/or patterned/repeated event(s)- involving a single participant; or
b) Involving multiple participants.

3. Human rights violations

a) Serious infringements of participant human rights (jeopardizing the health and safety of the participant);
b) Exceptions:
    i. Restrictive/intrusive intervention(s) clearly defined in individualized behavior support plans and/or care plan/person centered support plans pursuant to 42 CFR §441.301(c)(4)(5); and
    ii. Emergency behavioral interventions as defined by Utah Administrative Code, Title R539-4-6.

4. Incidents involving the media or referred by elected officials

Incidents that have or are anticipated to receive public attention (i.e., events covered in the media or referred by the Governor, legislators, or other elected officials).

5. Missing persons

For reporting purposes, the following participants are considered to be missing:

a) Participants who have been missing for at least 24 hours; or
b) Regardless of the number of hours missing – any participant who is missing under unexplained, involuntary or suspicious circumstances and is believed to be in danger because of age, health, mental or physical disability, environment or weather or who could be in the company of a potentially dangerous person or some other factor that places the participant in peril.

6. Unexpected deaths

All deaths are considered unexpected with the exception of:

a) Participants receiving hospice care; and/or
b) Deaths due to natural causes, general system failure or terminal/chronic health conditions.

A death related to an adverse event that occurs while the participant is receiving treatment in an in-patient facility, which is regulated by Health Facilities Licensing and Certification, should be reported as an unexpected death, the QA/SMA team may opt not to require an investigation. (Reportable to Health Facilities Licensing)

7. Waste, fraud or abuse of Medicaid funds

Alleged or confirmed waste, fraud or abuse of Medicaid funds:

a) Perpetrated by the provider; or
b) Perpetrated by the participant.

8. Law enforcement involvement

Charges filed against the participant for activities resulting in the:

a) Hospitalization of another (i.e., aggravated assault);
b) Death of another; and/or
c) Abuse and or exploitation of a vulnerable person, due to age, health, and/or disability.

9. Private Health Information (PHI)/Personal Identifiable Information (PII) Security Breach

Any activity that could potentially put sensitive information at risk of unauthorized use, access, disclosure, or modification.

Procedure for Reporting to the State Medicaid Agency:

1. On the first business day after a critical incident has occurred*, a representative from the OA will notify a member of the SMA Quality Assurance Team via email, telephone or in person. If the OA has any question about whether a case meets the criteria for reporting to the SMA, the OA will contact the SMA for technical assistance.

2. Within ten business days after notification, the OA will submit a completed Critical Incident Investigation form to the SMA.
3. Within five business days after receiving the Critical Incident Investigation form the SMA will review the investigation form submitted by the OA and will contact the OA if additional information or action is required.
4. When the SMA determines the investigation is complete, the SMA will document any findings or corrective action requirements on the SMA portion of the investigation form. The SMA will send the OA a copy of the finalized document, closing the case. In some cases, the SMA may continue to monitor findings or corrective actions.
5. Within two weeks after closing the case, the SMA will notify the participant or the participant's representative of the investigation results. A copy of the notification letter will be provided to the OA. The following types of incidents are excluded from the notification letter requirement: suicide attempt, missing person, death and investigations that conclude with disenrollment and/or are not concluded within six months of the original incident date.

∗ In some cases, it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

<u>Level Two Incidents and Events - Reportable to the OA</u>

The following incidents must be reported by providers, participants and/or their representatives to the OA, but are not required to be reported to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the OA.

1. Unexpected medical treatment (requiring immediate medical treatment at an emergency room)

Medical treatment related to one or more of the following reasons:

a) Abuse/neglect/exploitation (either alleged or substantiated);
b) Medication errors; and/or

c) Substance abuse.

2. Abuse/neglect/exploitation (either alleged or substantiated)

a) Exploitation of a participant's funds or property;
b) Theft and/or diverting of a participant's medication(s); and/or
c) Sexual assault/abuse/exploitation (regardless of medical treatment).

3. Human rights Violations

Such as:

a) Unauthorized use of restrictive interventions – including but not limited to restraints (physical, mechanical, or chemical);
b) Misapplied restrictive interventions, (included in the BSP);
c) Unauthorized use of seclusion;
d) Unwelcome infringement of personal privacy rights; and/or
e) Violations of individual rights to dignity and respect.
f) Exceptions:
   i. Restrictive/intrusive intervention(s) clearly defined in individualized behavior support plans and/or care plan/person centered support plans pursuant to 42 CFR §441.301(c)(4)(5); and
   ii. Emergency behavioral interventions as defined by Utah Administrative Code, Title R539-4-6.

Operating Agencies are responsible to ensure providers are compliant with 42 CFR §441.301(c)(4)(5)

4. Attempted suicides

An attempted suicide which did not result in the participant being admitted to a hospital. (Suicide attempts do not include suicidal thoughts or threats without actions)

5. Compromised working or living environment

An event in which the participant's working or living environment (e.g., roof collapse, fire, etc.) is compromised and the participant(s) require(s) evacuation.

6. Law enforcement involvement

a) Participant(s)

i. Criminal charges filed (Not including those reportable to the SMA)

b) Staff

i. Criminal charges filed (Make report to APS/CPS when necessary).

ii. When staff is issued a moving violation while transporting participant(s).

For this category, the date of the incident will be recorded as the date on which the filing of charges occurred.

7. Unexpected hospitalization

Admission to the hospital for medical treatment related to one or more of the following reasons:

a) Injuries
b) Aspiration
c) Choking

These do not include medical diagnoses that pose an expected risk for aspiration or choking. Also excluded from this category are self-injurious behavior or injuries resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a participant that resulted in admission to a hospital for medical treatment (which is reportable to the SMA).

Procedure for Reporting to the Operating Agency

1. On the first business day after a critical incident has occurred*, a representative from the case management or support coordination agency (case manager) will notify the OA via email, telephone or in person.
2. Within ten business days after notification, the case manager will submit a completed critical incident investigation form to the OA.
3. Within five business days after receiving the Critical Incident Investigation form the OA will review the investigation form submitted by the case manager and will contact the case manager if additional information or action is required.
4. When the OA determines the investigation is complete, the OA will document any findings or corrective action requirements on the OA portion of the investigation form. The OA will send the case manager a copy of the finalized document,

closing the case. In some cases, the OA may continue to monitor findings or corrective actions.

5. Within two weeks after closing the case, the case manager will notify the participant or the participant's representative (in person, phone or in writing) of the investigation results and document notification in the participant's record. The following types of incidents are excluded from the notification requirement: suicide attempt, death, and investigations that conclude with dis-enrollment and/or are not concluded within six months of the original incident date.

* In some cases, it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

III. Required reports

OA quarterly report

The OA will submit a waiver specific quarterly report to the SMA, no later than one month after the end of the quarter (October 31, January 31, April 30, July 31) that includes:

1. name of the participant
2. date of the incident
3. date the incident was reported to the OA
4. category of the incident: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
5. brief summary of the incident and its resolution
6. date the case was closed
7. brief description of any corrective action required of the case manager or other provider

OA annual report

The OA will submit a waiver specific annual report to the SMA, no later than two months after the end of the fiscal year (August 31) that includes:

1. total number of incidents
2. number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
3. number of incidents that resulted in corrective action by the case manager or other provider
4. number of corrective actions that were implemented
5. number of incidents where the participant/representative was informed of the investigation results, and the number of incidents where the contact was made within 14 days of the investigation closure
6. summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
    a) If trends were noted, the report will include a description of the process improvement steps that will be implemented

State Medicaid Agency annual report

For incidents that are reportable to the SMA, the SMA will submit an annual report to the State Medicaid Director and OA Division Directors that includes:

1. For each waiver:
    a) number of incidents
    b) number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
    c) number of incidents that resulted in corrective action by the OA, case manager or other provider
    d) number of corrective actions that were implemented

2. Summary of all waivers:
    a) number of incidents
    b) number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
    c) number of incidents that resulted in corrective action by the case manager or other provider

d) number of corrective actions that were implemented
e) summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
    i. If trends were noted, the report will include a description of the process improvement steps that will be implemented

Utah Medicaid Provider Manual

Home and Community-Based Services Waiver for Technology Dependent, Medically Fragile Individuals

Division of Integrated Healthcare

Updated July 2020

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1 General information

Section 1915 (c) of the Social Security Act permits states to offer, under a waiver of statutory requirements, a Medicaid-funded home and community-based services (HCBS) Waiver to eligible individuals as an alternative to facility-based care. Utah's HCBS Medicaid Waiver for technology dependent/medically fragile individuals (Tech Dependent Waiver) was initially approved by the Centers for Medicare and Medicaid Services effective January 1, 1995, for a three-year period and has been continuously reauthorized at five year intervals since 1998. Admission to the Tech Dependent Waiver is limited to individuals who meet the targeting criteria found in Chapter 2-1 of this manual.

Federal approval includes authorization to "waive" Medicaid comparability requirements found at section 1902(a)(10)(B) of the Social Security Act. This allows the state to "target" Medicaid reimbursed home and community-based services to a limited number of technology dependent, medically fragile individuals. Additionally, the state is authorized to waive certain income and resource rules found in Section 1902(a)(10)(c)(I)(III) of the Act when determining eligibility for the Tech Dependent Waiver.

1-1 Purpose

Medical technology makes it possible to enhance the lives of medically fragile individuals with complex needs. Historically, many families have found it necessary to place a medically fragile individual in facility-based settings in order to obtain needed services and supports. Utah's Tech Dependent Waiver program is designed to offer these individuals and their families an option to premature or unnecessary facility-based placements. Under the Tech Dependent Waiver program, individuals who would otherwise require a level of care provided in a nursing facility (NF) may instead be offered the choice to receive Medicaid reimbursed services at home and in their community. Tech Dependent Waiver recipients are eligible to receive home and community-based services in addition to traditional medical services covered by Medicaid and other private insurers.

1-2 Tech Dependent Waiver administration and operation

1. **Division of Integrated Healthcare: administrative authority and responsibilities**

The Division of Integrated Healthcare (DIH) is the single state agency responsible to administer and supervise the administration of the Utah Medicaid program including waiver programs. State funds appropriated by the Utah legislature to the DIH are used to match federal Medicaid funds in order to cover the costs of the Tech Dependent Waiver program.

The DIH retains final administrative authority for the Tech Dependent Waiver as it currently exists or is hereafter amended.

2. **Division of Family Health and Preparedness: operational authority and responsibilities**

The Division of Family Health and Preparedness (DFHP) is designated as the state's Maternal and Child Health Title V agency and has the statutory authority and responsibility to provide and/or arrange for the provision of services to children and youth with special health care needs. Under an interagency agreement with the DIH, the DFHP provides "waiver case management" and other essential activities necessary to ensure the effective and efficient, day to day operations of the Tech Dependent Waiver program.

1-3 Acronyms, initials, and definitions

For purposes of the Tech Dependent Waiver, the following definitions apply:

Applicant: A child who has applied for services under the Tech Dependent Waiver but who has not yet been determined eligible, or not yet received approval, for services under the Tech Dependent Waiver.
Certification: Level of care determination
Child: An individual under the age of 21
DFHP: The Division of Family Health and Preparedness within the Utah Department of Health and Human Services

DIH: The Division of Integrated Healthcare within the Utah Department of Health and Human Services
HCBS: Home and community-based services
ICF/ID: Intermediate care facility for people with intellectual disabilities. ICF/ID is equivalent to and replaces all instances of ICF/MR (intermediate care facility for the mentally retarded), as described under federal law.
Medicaid eligibility worker: A qualified employee of the Department of Workforce Services who determines categorical and financial eligibility for Medicaid.
NF: Nursing facility
Plan of care: The plan of care describes all of the waiver services the recipient is assessed to need and is authorized by the RN waiver coordinator.
Prior authorization: Authorization received before services are provided.
RN waiver coordinator: A qualified employee of the DFHP who performs required case management activities under the Tech Dependent Waiver.
Recertification: Periodic review of the level of care
Recipient: An individual who qualifies for and receives services under the Tech Dependent Waiver.
Tech Dependent Waiver or waiver services: Utah's HCBS Medicaid Waiver program for technology dependent/medically fragile individuals and services covered under this waiver.
Travis C. Waiver: A historical name for Utah's HCBS Medicaid Waiver program for technology dependent/medically fragile individuals
Waiting list: List of names identified as potential future recipients. The waiting list is utilized when the number of applicants, for the Tech Dependent Waiver, exceeds the number of approved openings.

1-4 Data security and privacy

Providers are expected to take steps to ensure that all personal information related to the individual being served is protected. This includes both Personal Health Information (PHI) as well as Personally Identifiable Information (PII). Providers should use appropriate administrative, technical and physical safeguards to preserve the integrity, confidentiality, and availability of PHI/PII that they create, receive, maintain or transmit. This includes using encrypted/secure email, fax, or other HIPAA

compliant methods to transmit documents containing information about the individual being served.

Providers shall ensure there is limited and controlled access to PHI/PII. In the performance of its services and operations, the provider shall make efforts to use, disclose and request only the minimum amount of PHI/PII considered reasonably necessary. The provider shall also identify and protect against reasonably anticipated threats to the security or integrity of the information, protect against reasonably anticipated, impermissible uses or disclosures; and ensure compliance by their workforce.

1-5 Breach reporting/data loss

Providers must report to DFHP and DIH, either by email or telephone, any breach or loss of PHI/PII. This report should be completed not more than 24 hours after the provider knows or should have reasonably known about the breach. The provider must also submit a report in writing/by email to DFHP within 5 business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

2 Service availability

Home and community-based waiver services for technology dependent, medically fragile individuals are covered benefits only when provided in accordance with the four criteria listed below.

1. To individuals eligible for the waiver and residing in the State of Utah;
2. To individuals who are not inpatients of a hospital, NF, or intermediate care facility for people with intellectual disabilities (ICF/ID);
3. Pursuant to a written plan of care;
4. Through a qualified, enrolled Medicaid provider as described in Chapter 3, Scope of service.

Details concerning the eligibility process and these four criteria are explained in the remainder of this chapter.

2-1 Eligible individuals

1. To be eligible for services under the Tech Dependent Waiver, the technology dependent, medically fragile individual must meet all six of the following "targeting criteria":
   a) Be under the age of 21 at the time of admission;
   b) Qualify for Medicaid based on his or her income and resources;
   c) Have at least one care giver trained (or willing to be trained) and available to provide care in a home that is safe and able to accommodate the necessary medical equipment and personnel needed to safely care for the individual;
   d) Meet admission criteria for NF care;
   e) Choose to receive home and community-based services; and
   f) Require skilled nursing or rehabilitation services (or a combination of both) at least five days per week. The services ordered must be, singly or in the aggregate, so inherently complex that they can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. For purposes of this waiver, the inherent complexity of services is evidenced by the individual's dependence on one or more of the following:
      i. Daily dependence on a mechanical ventilator;
      ii. Daily dependence on tracheostomy-based respiratory support (or, at reevaluation, dependence within the past 6 months on tracheostomy-based respiratory support);
      iii. Daily dependence on Continuous Positive Airway Pressure (C-PAP) or Bi-level Positive Airway Pressure (Bi-PAP); or
      iv. Dependence on intravenous administration of nutritional substances or medications through a central line, which the physician anticipates will be necessary for a period of at least 6 months.

2. An individual's eligibility for benefits and services under this waiver can continue as long as he or she continues to meet the targeting criteria.

2-2 Access to the Tech Dependent Waiver

The first point of contact for all waiver services is the DFHP RN waiver coordinator. Prior to an applicant receiving waiver services, the RN waiver coordinator must:

1. Certify that the applicant meets the level of care requirements, and that there are feasible alternatives available under the Tech Dependent Waiver;
2. Ensure the applicant has been determined financially eligible for Medicaid based on waiver eligibility requirements; and
3. Offer the eligible applicant the choice of waiver services or NF services.

2-3 Level of care determination

1. The RN Waiver coordinator, through consultation with the child's medical home and other health professionals, and with the assistance of the applicant and/or the applicant's legal representative, will obtain pertinent information needed to thoroughly evaluate the applicant's medical condition and technology.

2. An applicant meets level of care determination (certification) criteria when documentation supports the following:

   a) The applicant's condition and technology needs meet the targeting criteria defined in Chapter 2-1, Eligible individuals; and
   b) The applicant's needs can be appropriately met in the community with the currently available waiver and other state plan services.
3. Individuals who meet the Tech Dependent Waiver targeting criteria but whose needs cannot be met appropriately in the community with waiver and other available state plan services will receive written notice from the RN waiver coordinator specifying the reason(s) for ineligibility, and the applicant's rights to request a hearing. Hearing rights are described in Chapter 2-10.
4. To support the certification, the following documentation must be included in the applicant's file:
   a) Comprehensive assessment completed by the RN waiver coordinator which documents the individual's medical history, current technologies, treatments, services and identified needs.

b) The Waiver Level of Care Evaluation Form and the Initial and Annual Level of Care/Freedom of Choice Certification Form.
c) Other pertinent medical information which supports that the individual meets the waiver targeting criteria and the required NF level of care.

2-4 Medicaid eligibility determination

1. Once an applicant has been certified by the RN waiver coordinator as meeting the Tech Dependent Waiver targeting and level of care criteria specified in Chapters 2-1 and 2-3, he or she will be referred by the RN waiver coordinator (using completed HCF-927 form) to the Department of Workforce Services, for a determination of Medicaid eligibility.
2. The Medicaid eligibility worker will contact the family and RN waiver coordinator to obtain all necessary documentation to complete the Medicaid application. The eligibility worker will notify the RN waiver coordinator of the Medicaid eligibility determination, again using the form 927.

2-5 Individual's freedom of choice

1. Once an applicant has been certified by the RN waiver coordinator to meet the certification criteria for the waiver and the eligibility worker has determined the individual meets Medicaid categorical and financial eligibility requirements, the applicant or his or her legal representative will be:

   a) Informed by the RN waiver coordinator of feasible and available services under the waiver;
   b) Advised if there is a waiting list for admission to waiver services (refer to Chapter 2-6, Limit on number of Tech Dependent Waiver recipients); and
   c) Offered the choice of NF or home and community-based waiver services.

2. If the eligible applicant chooses NF services, the RN waiver coordinator will provide the applicant with information and assistance necessary to access such facilities.

3. If the applicant chooses home and community-based waiver services and there is an available opening, the RN waiver coordinator will notify the eligibility worker

to open the case and the effective date of waiver services. The applicant will then be given the opportunity to choose the provider(s) of waiver services if more than one qualified provider is available to render the services.

4. The RN waiver coordinator and the applicant, or legal representative, must document the applicant's decision by completing the Initial and Annual Level of Care/Freedom of Choice Certification Form.

2-6 Limit on number of Tech Dependent Waiver recipients

Dependent Waiver is limited. When the number of applicants for the Tech Dependent Waiver exceeds the number of approved openings (or "replaceable slots"), a waiting list will be established. Generally, priority for admission to the Tech Dependent Waiver from the waiting list will be given to the applicant with the highest numerical ranking based on the following:

Targeting Condition(s)	Weight Factor
Trach/Ventilator dependent	18
Bi-PAP > 18 hours/day	9
Trach Dependent	8
C-PAP/Bi-PAP	2* See (note)
Central Line	2* See (note)

*NOTE: In considering these conditions, if the applicant is receiving skilled nursing care 3 or more times per week, add 2 points; if the applicant is receiving enteral feeding or total parenteral nutrition, add 1 point.

Length of time on the waiting list will be used in determining who is selected if more than one applicant has the same "highest" score.

RN waiver coordinators have discretion to consider extraordinary psycho-social or medical needs of an applicant/family when establishing priority for admission to the Tech Dependent Waiver. In such cases, documentation will be maintained by the RN waiver coordinator to include: 1) a description of the specific, extraordinary psycho-social/medical need(s) of the applicant/family member; 2) feasible alternatives

(including formal and informal support systems and services) considered/available at the time to help meet the extraordinary need(s) and maintain the child in the community while waiting for Tech Dependent Waiver coverage; 3) an estimate of the likelihood of 'imminent' out-of-home placement of the child if Tech Dependent Waiver admission is delayed; and 4) the RN waiver coordinator's judgment regarding the potential risks to the applicant's/caregiver's health and welfare if Tech Dependent Waiver admission is delayed.

Discretionary priority for admission will only be authorized when the RN waiver coordinator's documentation indicates one or more of the following: 1) the applicant/care-giver lacks any feasible/available family or community based support; 2) the applicant is at imminent risk of out-of-home placement; or 3) there is a likelihood that the health and welfare of the applicant/care-giver will be compromised by delaying admission and there are no others ahead of the applicant on the waiting list with equal or greater 'priority needs'.

2-7 Prior authorizations and plan of care

1. All waiver services must be authorized by a written plan of care developed by the RN waiver coordinator with input from the recipient and/or the recipient's legal guardian, and others as appropriate, prior to the receipt of waiver services. The plan of care describes the waiver services that the individual needs, and the non-waiver services the individual is receiving. The plan of care includes the type, amount, duration and estimated frequencies of waiver services and the provider(s) who will furnish the services.

2. The plan of care is reviewed as frequently as necessary to ensure it meets the needs of the individual. A formal review of the plan is required at least every 6 months and must be completed by the RN waiver coordinator during the calendar month in which it is due.

2-8 Plan of care unit calculation

1. The comprehensive care plan is intended to be an estimate of the service units required to meet the assessed needs of each recipient over the course of the plan of care year. DIH recognizes that a recipient's needs may change periodically due

to temporary or permanent conditions which may require amendments to the recipient's care plan.

2. DFHP is responsible to monitor service utilization for each recipient for whom DFHP created a comprehensive care plan. When DFHP determines that the assessed service needs of a recipient exceed the amount that has been approved on that recipient's existing plan of care, DFHP should submit an amendment to increase the number of units to meet the need. Amendments must be made prior to the expiration of the plan of care.

3. The plan of care year is the sum of all approved units including amendments over the entire year. In this way, Utah Medicaid applies an annualized aggregate of all plan of care units.

4. Providers may not exceed the annualized aggregate of all approved plan of care units. Billing in excess of the approved number of units will be subject to recovery of funds by Utah Medicaid.

2-9 Periodic review of the level of care

1. The RN waiver coordinator must periodically conduct a comprehensive reassessment (recertification) to document the individual’s current level of care and to assure that home and community-based waiver services remain a feasible alternative to facility-based care and continue to meet the individual's needs. The recertification updates and documents the individual’s medical history and current technology as well as psycho-social needs. Recertification of the individual’s level of care must occur at least once a year (12 months from the individual’s entry into the waiver or within 12 months of the most recent level of care determination). Recertification must be completed within the calendar month in which it is due.

2. The recertification provides the information necessary for the RN waiver coordinator to determine whether the recipient continues to meet the Tech Dependent Waiver targeting criteria or not. If the RN waiver coordinator

determines that the recipient continues to meet the Tech Dependent Waiver targeting criteria and chooses to continue receiving home and community-based waiver services, the RN waiver coordinator will recertify the recipient's Tech Dependent Waiver level of care. If the RN waiver coordinator determines that the recipient no longer meets the Tech Dependent Waiver targeting criteria or the recipient chooses NF placement rather than home and community-based services, the recipient will not be recertified.

2-10 Reduction or termination of home and community-based services

The RN waiver coordinator will provide written notices with appeal rights to the recipient or legal representative when taking an adverse action resulting in a denial, reduction, suspension or termination of home and community-based waiver services.

1. When the need arises, participants are separated from the home and community-based waiver program through a disenrollment process.

    a) The disenrollment process is a coordinated effort by DFHP staff that is expected to facilitate the following:

        i. Verification that the disenrollment is appropriate for the waiver participant;
        ii. Movement among waiver programs (when applicable);
        iii. Ensuring effective utilization of waiver program services;
        iv. Effective discharge and transition planning;
        v. Distribution of information to participants describing all applicable waiver rights; and
        vi. Program quality assurance.

2. All of the various circumstances for which it is permissible for individuals to be disenrolled from the waiver program can be grouped into three distinct disenrollment categories.

    a) <u>Voluntary disenrollments</u> are cases in which participants, or their legal

representative (when applicable), choose to initiate disenrollment from the waiver. Disenrollments are also considered voluntary when the waiver participant enters a skilled nursing facility for a stay of less than 90 days and chooses not to transition back to the original waiver program. This includes cases in which the participant transitions to another waiver program from the skilled nursing facility.

Voluntary disenrollments are managed by DFHP RN waiver coordinators and do not require approval by DIH.

Additional documentation will be maintained DFHP that includes a written statement signed by the participant, or their legal representative (when applicable) describing their intent to disenroll from the waiver program. This documentation should also outline discharge planning activities completed by the RN waiver coordinator with the waiver participant as part of the disenrollment process.

b) Pre-Approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from the waiver for any of the following reasons including:
   i. Death of the participant;
   ii. Participant has been determined to no longer meet the financial requirements for Medicaid program eligibility by the Department of Workforce Services;
   iii. Participant enters a skilled nursing facility, and the expected length of stay will exceed 90 days (as verified by a physician); or
   iv. Pre-Approved involuntary disenrollments require that RN waiver coordinators notify DIH within 10 days from the date of disenrollment. No DIH prior review or approval of the decision to disenroll is required, as the reasons for pre-approved involuntary disenrollment have already been approved. Documentation will be maintained by the RN waiver coordinator, detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process when appropriate.

c) <u>Special circumstance disenrollments</u> are cases in which participants are involuntarily disenrolled for reasons that are non-routine in nature and involve circumstances that are specific to the participant. These cases require prior review and second level approval DIH. Examples of this type of disenrollment include:
   i. Participant no longer meets the level of care requirements for the waiver;
   ii. Participant's health and safety needs cannot be met by the waiver program's services and supports;
   iii. Participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a plan of care that meets minimal safety standards;
   iv. Participant has demonstrated non-compliance with a signed health and safety agreement with Tech Waiver or the case management agency; or
   v. Participant's whereabouts are unknown for more than 30 days, and a decision regarding ongoing financial eligibility from the Department of Workforce Services has not been rendered.

The special circumstance disenrollment review process will consist of the following activities:

1. The RN waiver coordinator shall compile information to articulate the disenrollment rationale;
2. This information will then be submitted to DIH for review of the support coordination activities, as well as the disenrollment recommendation;
3. DIH will review and assure that all State Plan, waiver, non-waiver and other available services/resources have been fully utilized to meet the participant's needs;
4. DIH/DFHP may facilitate meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment; and
5. DIH will communicate a final disenrollment decision to the DFHP.

If the special circumstance disenrollment request is approved, DFHP will provide the participant, or their legal representative (when applicable), with the required written notice of action (NOA) and right to fair hearing information.

The case management agency will initiate discharge planning activities sufficient to assure a smooth transition to an alternate Medicaid program and/or to other services. Discharge planning activities shall be documented in the participant's case record.

2-11 Fair hearings

Waiver applicants and recipients will be given the opportunity for a hearing if:

1. Determined eligible but not offered the choice of facility-based care or community-based waiver services;
2. Denied the home and community-based waiver services of their choice;
3. Denied the waiver provider(s) of their choice if more than one provider is available to render the service(s); or
4. The RN waiver coordinator takes an adverse action as described in Chapters 2-9 and 2-10 of this manual.

3 Scope of service

Waiver recipients are eligible to receive all regular State Plan Medicaid program benefits such as private duty nursing services, pharmaceuticals, and medical equipment and supplies. In addition, when necessary to prevent nursing facility placement and delivered pursuant to an approved plan of care, the following waiver services are available:

Skilled nursing respite care: Provided on behalf of the technology dependent recipient for the purpose of relieving the primary caregiver(s) from the stress of providing continuous care.

Family support services: Includes counseling and child-life services provided to the recipient and/or family members to help them cope with the stress that goes with the daily care of their technology dependent family member.

In-home feeding therapy: Assessment and treatment services provided by a speech or occupational therapist to promote oral intake and self-feeding.

Home health certified nursing assistant: Provided under the waiver when home health aide services are required on the same day as a State Plan home health service (and may be provided at the same time).

Financial management services: Authorized in conjunction with respite services when using the family-directed services model to facilitate employment of registered nurses by the individual or family.

Family directed support: Designed to provide education and instruction for waiver families to ensure they are prepared to manage their own respite services and providers.

Extended private duty nursing: Authorized for recipients 21 years of age and older who are denied Medicaid State Plan private duty nursing solely based on age [no longer eligible for the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program].

Details concerning coverage of these services are contained in the remainder of this chapter.

3-1 Skilled nursing respite care

1. Definition
   Skilled nursing respite care is an intermittent service provided on behalf of an eligible individual to relieve the primary care giver from the stress of providing continuous care, thereby avoiding premature or unnecessary placement in a facility-based care setting. Skilled nursing respite care may be provided by a Medicaid-enrolled home health agency or through the family directed service

model. Skilled nursing respite care coverage includes an initial RN assessment to establish a new client. Skilled nursing respite care may be provided in the home or other approved community settings.

2. Qualified providers
   Qualified respite care providers include:
   a) Medicaid-enrolled, licensed home health agencies which:
      i. Employ or contract with registered nurses, licensed practical nurses (licensed in accordance with Title 58, Occupational and Professional Licensing, Utah C ode Annotated, 1953 as am ended) and home health aides (certified in accordance with Utah Administrative Code R 432-700-22); and
      ii. Are capable of providing respite care services to technology dependent, medically fragile individuals in their homes and other approved community-based settings.
   b) Registered nurses in the State of Utah which:
      i. Are licensed in accordance with Title 58, Chapter 31b, Part 3, Occupational and Professional Licensing, Utah Code Annotated 1953 as amended (records kept by FMS);
      ii. Complete and pass a background and criminal investigation check (records kept by FMS);
      iii. Are covered under an individual nursing malpractice insurance policy (records kept by FMS);
      iv. Have a current basic CPR certification (records kept by FMS);
      v. Are enrolled with a financial management agency; and
      vi. Demonstrate ability to perform the necessary skilled nursing functions to safely care for the recipient (parent/guardian/client responsible for completing this function).

3. Reimbursement for services
   Respite care services must be prior authorized by the RN waiver coordinator and be based on the needs of the individual and family. The RN waiver coordinator in conjunction with the family and other professionals, if necessary, will determine

the appropriate level of respite provider, the location and number of units that will be authorized.

4. Procedure codes for home health agency respite care

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
RN, per 15 min	T 1005	U7		58 – Home Health Agency
RN (2 clients in home), per 15 min	T 1005	U7	TN	
LPN, per 15 min	T 1005	U7	TE	
Home Health Aide, per 15 min	T 1005	U7	52	

5. Procedure codes for family directed (individual) respite care

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
Family Directed RN Respite	T1005		U7	

3-2 Family support services

1. Definition

Family support services include counseling and child life services. These supportive services are provided to the waiver recipient and/or family members and are designed to guide and help them cope with the recipient's illness and the related stress that accompanies the continuous, daily care. Family support services provide

families, including siblings, with various methods and means to express themselves in ways that can bridge differences in age, language, abilities and cultural boundaries. Through support and coping strategies, the family is enabled to manage their stress which improves the likelihood that the recipients will continue to be cared for in the community.

a) Family counseling provides counseling and emotional support to assist with psychosocial, spiritual, and economic needs. Examples beyond supportive need include accessing community resources, decision-making, anticipatory and end-of-life planning.
b) Child life services enable the waiver recipient and sibling(s) expressive outlets for dealing with stress and emotional issues. Child life specialists use various mediums, including art, music, play, and other forms of expression that are age and developmentally appropriate to facilitate communication of thoughts and feelings related to an illness, specific procedure or event.
c) All family support services are provided pursuant to a comprehensive assessment and treatment plan.

2. Qualified providers

a) Medicare/Medicaid certified and enrolled home health agencies and family counseling centers that employ or contract with a licensed MSW, LCSW and child life specialists who have a minimum of a bachelor's degree, specialized training, and relevant work experience.
b) The Maternal and Child Health agency, and other qualified individuals or agencies only with approval of the State's Maternal and Child Health agency.

3. Reimbursement for services
a) Services are authorized by the waiver coordinator on the basis of family need. Whenever possible, the provider must contact the waiver coordinator in advance of the counseling session to obtain authorization. If the provider delivers services to a family in crisis, the provider must notify the waiver

coordinator within 3 working days of the emergency to request authorization for payment of the service.

b) Family support services are limited to recipients and family members. Family members are defined as the persons who live with or directly provide care to the individual, and may include a parent, spouse, children, relatives, foster family, or in-laws. Family members do not include individuals who are employed to care for the individual.

4. Procedure codes

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
Child Life Services, per 15 minutes	H 2032	U7		46 - Agency, and 58 - Home Health Agency
Counseling, per 15 minutes	T 1027	U7		46 - Agency, and 58 - Home Health Agency

3-3 In-home feeding therapy

1. Definition

In-home feeding therapy is a service provided by a qualified professional to enhance the ability of an individual who cannot obtain adequate nutrition through ordinary means (oral intake of adequate food and nutritional substances). A licensed speech therapist or occupational therapist collaborates with the recipient's medical home and other professionals to assess function and provide options and instruction on promoting oral intake, evaluates self-feeding skills and modification of equipment for self-feeding and develops and instructs the caregiver on an in-home feeding program.

2. Qualified providers
   a) Medicare/Medicaid certified and enrolled home health agencies that employ or contract with licensed speech therapists and licensed occupational therapists with demonstrated ability to perform in-home feeding therapy.
   b) The State's Maternal and Child Health agency and agencies under contract with the Maternal and Child Health agency.

3. Reimbursement for services

In-home feeding therapy must be prior authorized by the RN waiver coordinator and be included in the plan of care. Services will be authorized on the basis of assessed need.

4. Procedure codes

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
In-Home Feeding Therapy per 15 minutes	G 0270	U7		46 - Agency, and 58 - Home Health Agency

3-4 Home health certified nursing assistant

1. Definition

The Home health certified nursing assistant will provide services under the waiver when home health aide service are required on the same day as a State Plan home health nursing service (and may be provided at the same time). The certified nursing assistant will be employed by a home health agency, supervised by an RN, and have the following responsibilities:

a) Provide only those services written in the home health agency's plan of care and receive written instructions from the RN supervisor;
b) Perform normal household services essential to health care at home;
c) Make occupied or unoccupied beds;
d) Perform basic diagnostic activities such as vital signs;
e) Perform activities of daily living as written in the home health agency's plan of care;
f) Observe and record food and fluid intake when ordered;
g) Change dry dressings according to written instructions from the RN supervisor;
h) Administer emergency first aid;
i) Write clinical notes in individual patient records; and

j) Provide social interaction and reassurance to the recipient and family in accordance with the home health agency's plan of care. Write clinical notes in individual patient records.

The Home Health Certified Nursing Assistant shall not perform duties defined as the practice of nursing according to Utah Code 58-31B. When providing home health certified nursing assistant services for recipients under the waiver program, a paid nursing professional, a trained parent or legal guardian, or a designated caregiver trained by the parent, guardian or responsible person must be present in the home. The home health certified nursing assistant shall not be left alone to care for the technology dependent/medically fragile recipient.

2. Qualified providers

Medicare/Medicaid certified and enrolled home health agencies that employ certified nursing assistants.

3. Reimbursement for services

Home health certified nursing assistant services must be prior authorized by the waiver coordinator and be included in the plan of care. Services will be authorized on the basis of assessed need.

4. Procedure codes

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
Home Health Certified Nursing Assistant per visit	T1021	U7		58 - Home Health Agency

3-5 Financial management services

1. Definition

This service will be authorized in conjunction with waiver services under the approved family-directed services model. Services rendered under this definition include those to facilitate the employment of approved and qualified providers by the individual or family. Services include: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, (c) Medicaid claims processing and reimbursement distribution, and (d) providing monthly accounting and expense reports to the family and RN waiver coordinators.

2. Qualified providers

Medicaid enrolled financial management agencies in compliance with state and local licensing, accreditation and certification requirements (Utah Code R58-26a).

3. Reimbursement for services

Financial management services must be prior authorized by the waiver coordinator and be included in the plan of care.

4. Financial management services reimbursement

Reimbursement for self-administered services includes reimbursement for all mandatory employer payroll taxes, and workman's compensation insurance premiums. These costs should be paid in addition to the self-administered service rate established between the waiver participant and the employee. For example, if a waiver participant negotiates an hourly wage of $10 per hour with their self-administered services employee, mandatory employer burden costs (e.g. Social Security and Medicare taxes, Federal Unemployment Taxes, and Worker's Compensation Insurance premiums) are paid in addition to the $10 per hour wage. The employee's income tax withholding should be deducted from the negotiated wage.

5. Procedure codes

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
Financial Management Services per month	T2040	U7		

3-6 Family directed support

1. Definition

This service is designed to ensure waiver families are prepared to manage their own respite service and providers. Family directed support services include:

a) Information to ensure that the recipient/family understands the responsibilities in directing their own care;
b) Instruction in how to effectively communicate with service providers;
c) Instruction in the management of service providers including interviewing, selecting, scheduling, termination, time sheeting, and evaluating performance;
d) Information on individual rights, filing grievances, and risk management;
e) Advocacy training;
f) Developing emergency plans; and
g) Developing forms and maintaining documentation.

Family directed support services do not include educational, vocational or prevocational components.

2. Qualified providers

a) Clinical social worker licensed in the State of Utah, per Utah Code 58-60 Part 2, who is enrolled as a Medicaid Waiver provider with demonstrated ability to perform family directed support functions.
b) Medicare/Medicaid certified and enrolled family counseling centers who employ clinical social workers licensed in the State of Utah per Utah Code 58-60 Part 2 with demonstrated ability to perform family directed support

functions.

c) Medicaid-enrolled financial management agencies in compliance with state and local licensing, accreditation and certification requirements (Utah Code R58-26a).

3. Reimbursement for services

Family directed support services must be prior authorized by the RN waiver coordinator and be included in the plan of care.

4. Procedure codes

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
Family Directed Support per session	S5111	U7		

3-7 Extended private duty nursing

1. Definition

Extended private duty nursing services will be authorized for recipients 21 years of age and older who are denied Medicaid state plan private duty nursing solely based on age [no longer eligible for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program].

Eligibility and access for this service are based on the following State Plan requirements:

a) The recipient must require more than four continuous skilled nursing hours of care per day;
b) The recipient must have a written physician order for private duty nursing service; and

c) Providers shall submit prior authorization request to the RN waiver coordinators with the required medical documentation (Home Health Agency Form 485, the Medicaid approved PDN acuity grid and skilled nursing assessment form, nursing notes and other relevant documentation) which demonstrates the need for the service.

2. Qualified provider

Medicare/Medicaid certified and enrolled licensed home health agencies who:

a) Employ or contract with registered nurses and licensed practical nurses (licensed in accordance with Title 58, Occupational and Professional Licensing, Utah Code Annotated, 1953 as amended).
b) Are capable of providing private duty nursing services to technology dependent, medically fragile individuals in their homes.

3. Reimbursement for services

Extended private duty nursing services will be prior authorized by the RN waiver coordinators. Limits on the amount, frequency and/or duration are specified in the individual's plan of care and are based on assessed needs.

4. Procedure codes

Unit of Service	Procedure Code	Modifier 1	Modifier 2	Provider Type(s)
RN - Extended Private Duty Nursing	T1000	U7		58 - Home Health Agency
LPN - Extended Private Duty Nursing	T1000	TE	U7	58 - Home Health Agency

4 Record keeping

1. All home and community-based waiver service providers must develop and maintain written documentation for each billed service that indicates the

following:

a) The name of the individual;
b) The specific services rendered as they relate to the plan of care;
c) The date each service was rendered;
d) The amount of time it took to deliver the service(s);
e) The setting in which the services were rendered (e.g., home, office, etc.); and
f) The qualified individual who rendered the services.

2. The record must be kept on file and made available as requested for state or federal auditing and assessment purposes.

5 Procedure codes

The following list of procedure codes is a summary of codes covered by Medicaid under the Home and Community-Based Waiver for Technology Dependent, Medically Fragile Individuals. All services are limited to the provider types noted for each procedure code.

PROCEDURE CODE	MODIFIER 1	MODIFIER 2	DESCRIPTION	PROVIDER TYPE
 T1005 T1005 T1005	 U7 TE 52	 U7 U7	**Respite Care, Agency** RN, per 15 min LPN, per 15 min HH Aide, per 15 min	58 – Home Health Agency
T1005	U7	TN	RN, per 15 min (2 clients in home)	58- Home Health Agency
T1005 T1005	U7 U7		**Respite Care, Family-Directed** RN, per 15 min	

			RN, per 15 min (2 clients in home)	
H2032 T1027	U7 U7		**Family Support Services** Child Life Service, per 15 min Counseling, per 15 min	46 – Agency and 58 – Home Health Agency
G0270	U7		**In-Home Feeding Therapy** Speech Therapist, per 15 min Occupational Therapist, per 15 min	46 – Agency and 58 – Home Health Agency
T1021	U7		**Home Health Certified Nursing Assistant** Certified Nursing Assistant, per visit	58 – Home Health Agency
T2040	U7		**Financial Management Services** per month	
S5111	U7		**Family Directed Support** per session	
T1000 T1000	U7 TE	 U7	**Extended Private Duty Nursing** RN, per 15 min LPN, per 15 min	58 – Home Health Agency

5-1 Electronic visit verification

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, are effective for Utah Medicaid beginning July 1, 2019. EVV requirements apply to all personal care services and home health care services

provided under a 1915 (c) Home and Community-Based Waiver.

Choice of reporting systems for EVV are by provider preference, but must meet all federal requirements, including the standards set in the Health Insurance Portability Accountability Act. The state will not implement a mandatory model for use. All provider choice EVV systems must be compliant with requirements of the Cures Act including:

1. type of service performed;
2. individual receiving the service;
3. date of the service;
4. location of service delivery;
5. individual providing the service;
6. time the service begins and ends; and
7. the date of creation of the electronic record.

Additional information including technical specifications for file creation/submission and EVV resources can be found at https://medicaid.utah.gov/evv

6 Incident reporting protocol

I. Purpose:

The State Medicaid Agency (SMA) has the administrative authority over all 1915(c) Medicaid Home and Community-Based Services (HCBS) Waivers (waivers). Waiver programs must provide adequate and appropriate services that safeguard the health and welfare of all enrolled participants. Waiver programs must also assure financial accountability for funds expended for HCBS services. While these responsibilities are delegated to the operating agencies (OA), the SMA retains final authority and has the final responsibility to 1) assure that appropriate actions have taken place when a critical incident or event occurs; and 2) in cases where appropriate safeguards were not in place, that an analysis is conducted and appropriate strategies have been implemented to safeguard participants.

The Critical Incidents and Events Program is a collaborative effort between the OAs for each of the 1915(c) waivers and the SMA. The program has two levels. Level one

describes the critical incidents/events that are required to be reported by the OA to the SMA for investigation, resolution and closure. Level two describes the critical incidents/events that are required to be reported to the OA for investigation, resolution and closure.

This standard operating procedure stipulates:

1. Level one incidents and events required to be reported to the SMA;
2. Level two incidents and events that are required to be reported to the OA;
3. The agency responsible for completing the review; and
4. Associated reporting requirements.

Reportable critical incidents/events

Level one incidents and events – reportable to the SMA

The following list of the incidents/events (incidents) must be reported by the OA to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the SMA.

1. Unexpected hospitalization

Admission to the hospital for medical treatment related to one or more of the following reasons:

a) Injuries that result in the loss of physical or mental function. (i.e. loss of limb, paralysis, brain injury or memory loss);
b) Alleged/substantiated abuse or neglect;
c) Attempted suicide;
d) Medication errors;
e) Self-injurious behavior;
f) Serious burns; and/or
g) Substance abuse.

2. Exploitation (either alleged or substantiated)

Unfairly taking advantage of a participant due to his/her age, health, and/or disability.

a) Serious and/or patterned/repeated event(s)- involving a single participant,
b) Involving multiple participants.

3. Human rights violations

a) Serious infringements of participant human rights (jeopardizing the health and safety of the participant);

b) Exceptions;

i. Restrictive/intrusive intervention(s) must be clearly defined in individualized behavior support plans and/or care plan/person centered support plans pursuant to 42 CFR §441.301(c)(4)(5).

ii. Emergency behavioral interventions as defined by Utah Administrative Code, Title R539-4-6 are not considered a human rights violation.

4. Incidents involving the media or referred by elected officials

Incidents that have or are anticipated to receive public attention (i.e., events covered in the media or referred by the Governor, legislators, or other elected officials).

5. Missing persons

For reporting purposes, the following participants are considered to be missing:

a) Participants who have been missing for at least 24 hours; or

b) Regardless of the number of hours missing – any participant who is missing under unexplained, involuntary or suspicious circumstances and is believed to be in danger because of age, health, mental or physical disability, environment or weather or who could be in the company of a potentially dangerous person or some other factor that places the participant in peril.

6. Unexpected deaths

All deaths are considered unexpected with the exception of:

a) Participants receiving hospice care; and/or

b) Deaths due to natural causes, general system failure or terminal/chronic health conditions.

A death related to an adverse event that occurs while the participant is receiving treatment in an in-patient facility, which is regulated by Health Facilities Licensing and Certification, should be reported as an unexpected death, the QA/SMA team may opt not to require an investigation. (Reportable to Health Facilities Licensing)

7. Waste, fraud or abuse of Medicaid funds

Alleged or confirmed waste, fraud or abuse of Medicaid funds

a) Perpetrated by the provider, or
b) Perpetrated by the participant.

8. Law enforcement involvement

Charges filed against the participant for activities resulting in the:

a) Hospitalization of another (i.e., aggravated assault),
b) Death of another; and/or
c) Abuse and or exploitation of a vulnerable person, due to age, health, and/or disability.

9. Private Health Information (PHI)/Personal Identifiable Information (PII) security breach

Any activity that could potentially put sensitive information at risk of unauthorized use, access, disclosure, or modification.

Procedure for Reporting to the State Medicaid Agency:

1. On the first business day after a critical incident has occurred[1], a representative from the OA will notify a member of the SMA quality assurance team via email, telephone or in person. If the OA has any question about whether a case meets the criteria for reporting to the SMA, the OA will contact the SMA for technical assistance.
2. Within ten business days after notification, the OA will submit a completed Critical Incident Investigation form to the SMA.
3. Within five business days after receiving the Critical Incident Investigation form the SMA will review the investigation form submitted by the OA and will contact the OA if additional information or action is required.
4. When the SMA determines the investigation is complete, the SMA will document any findings or corrective action requirements on the SMA portion of the investigation form. The SMA will send the OA a copy of the finalized document,

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[1] In some cases, it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The SMA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

closing the case. In some cases, the SMA may continue to monitor findings or corrective actions.

5. Within two weeks after closing the case, the SMA will notify the participant or the participant's representative of the investigation results. A copy of the notification letter will be provided to the OA. The following types of incidents are excluded from the notification letter requirement: suicide attempt, missing person, death and investigations that conclude with disenrollment and/or are not concluded within six months of the original incident date.

Level Two Incidents and Events - Reportable to the OA

The following incidents must be reported by providers, participants and/or their representatives to the OA, but are not required to be reported to the SMA. This is not an all-inclusive list. Other incidents that rise to a comparable level must be reported to the OA.

1. Unexpected medical treatment (requiring immediate medical treatment at an emergency room)

Medical treatment related to one or more of the following reasons:

   a) Abuse/neglect/exploitation (either alleged or substantiated);
   b) Medication errors; and/or
   c) Substance abuse.

2. Abuse/neglect/exploitation (either alleged or substantiated)
   a) Exploitation of a participant's funds or property;
   b) Theft and/or diverting of a participant's medication(s); and/or
   c) Sexual assault/abuse/exploitation (regardless of medical treatment).
3. Human rights violations

Such as:

   a) Unauthorized use of restrictive interventions – including but not limited to restraints (physical, mechanical, or chemical);
   b) Misapplied restrictive interventions, (included in the BSP);
   c) Unauthorized use of seclusion; and/or
   d) Unwelcome infringement of personal privacy rights;
   e) Violations of individual rights to dignity and respect.

f) Exceptions
   i. Restrictive/intrusive intervention(s) must be clearly defined in individualized behavior support plans and/or care plan/person centered support plans pursuant to 42 CFR §441.301(c)(4)(5).
   ii. Emergency behavioral interventions as defined by Utah Administrative Code, Title R539-4-6, are not considered a human rights violation.

Operating Agencies are responsible to ensure providers are compliant with 42 CFR §441.301(c)(4)(5)

4. Attempted suicides

An attempted suicide which did not result in the participant being admitted to a hospital. (Suicide attempts do not include suicidal thoughts or threats without actions)

5. Compromised working or living environment

An event in which the participant's working or living environment (e.g., roof collapse, fire, etc.) is compromised and the participant(s) require(s) evacuation.

6. Law enforcement involvement

a) Participant(s)
   i. Criminal charges filed (not including those reportable to the SMA)

b) Staff
   i. Criminal charges filed (make report to APS/CPS when necessary).
   ii. When staff is issued a moving violation while transporting participant(s).

For this category, the date of the incident will be recorded as the date on which the filing of charges occurred.

7. Unexpected hospitalization

Admission to the hospital for medical treatment related to one or more of the following reasons:

a) Injuries
b) Aspiration
c) Choking

These do not include medical diagnoses that pose an expected risk for aspiration or choking. Also excluded from this category are self-injurious behavior or injuries resulting in loss of physical or mental function such as a loss of limb, paralysis, brain injury or memory loss experienced by a participant that resulted in admission to a hospital for medical treatment (which is reportable to the SMA).

Procedure for Reporting to the Operating Agency

1. On the first business day after a critical incident has occurred[2], a representative from the case management or support coordination agency (case manager) will notify the OA via email, telephone or in person.
2. Within ten business days after notification, the case manager will submit a completed Critical Incident Investigation form to the OA.
3. Within five business days after receiving the Critical Incident Investigation form the OA will review the investigation form submitted by the case manager and will contact the case manager if additional information or action is required.
4. When the OA determines the investigation is complete, the OA will document any findings or corrective action requirements on the OA portion of the investigation form. The OA will send the case manager a copy of the finalized document, closing the case. In some cases, the OA may continue to monitor findings or corrective actions.

Within two weeks after closing the case, the case manager will notify the participant or the participant's representative (in person, phone or in writing) of the investigation results and document notification in the participant's record. The following types of incidents are excluded from the notification requirement: suicide attempt, death, and investigations that conclude with disenrollment and/or are not concluded within six months of the original incident date.

Required reports

OA quarterly report

The OA will submit a waiver specific quarterly report to the SMA, no later than one month after the end of the quarter (October 31, January 31, April 30, July 31) that includes:

1. name of the participant
2. date of the incident
3. date the incident was reported to the OA

[2] In some cases, it will not be possible to report the incident by the next business day after occurrence. In those cases, the incident must be reported the first business day after discovery. The OA will review cases that are reported after discovery to evaluate whether the case should have been reported after occurrence, and if so, where the breakdown in reporting occurred.

4. category of the incident: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
5. brief summary of the incident and its resolution
6. date the case was closed
7. brief description of any corrective action required of the case manager or other provider

OA annual report

The OA will submit a waiver specific annual report to the SMA, no later than two months after the end of the fiscal year (August 31) that includes:

1. total number of incidents
2. number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
3. number of incidents that resulted in corrective action by the case manager or other provider
4. number of corrective actions that were implemented
5. number of incidents where the participant/representative was informed of the investigation results, and the number of incidents where the contact was made within 14 days of the investigation closure
6. summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
    a) If trends were noted, the report will include a description of the process improvement steps that will be implemented

State Medicaid Agency annual report

For incidents that are reportable to the SMA, the SMA will submit an annual report to the State Medicaid Director and OA Division Directors that includes:

1. For each waiver:
    a) number of incidents
    b) number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type

c) number of incidents that resulted in corrective action by the OA, case manager or other provider
d) number of corrective actions that were implemented

2. Summary of all waivers:
   a) number of incidents
   b) number of incidents by category: incidents such as abuse/neglect/exploitation, law enforcement involvement, medication errors and unexpected hospitalization should be further categorized by type
   c) number of incidents that resulted in corrective action by the case manager or other provider
   d) number of corrective actions that were implemented
   e) summary analysis of whether any systemic trends were noted that may require additional intervention or process improvement steps
      i. If trends were noted, the report will include a description of the process improvement steps that will be implemented.

Utah Medicaid Provider Manual

Home Health Services

Division of Integrated Healthcare

Updated September 2024

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1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to Section I: General Information.

1-1 Home health services

Medicaid covers skilled nursing, physical therapy, and home health aides for categorically and medically needy members.

Occupational therapy, speech-language pathology and audiology, and private duty nursing services are covered for pregnant members and those eligible for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program when medically necessary.

Home health services are a benefit of the Utah Medicaid Program as described in this section. Home health services are medically necessary, part-time, intermittent health care services provided to eligible members in settings defined by 42 CFR Part 440.70 when they are medically necessary, cost-effective, and consistent with the member's medical need.

Home health services must be based on a physician's order and a documented plan of care. The home health care provided must require the skills of technical or professional personnel such as a registered nurse (RN), licensed practical nurse (LPN), trained and certified home health aide, physical therapist, occupational therapist, or speech pathologist.

The goals of home health care are to:

1. minimize the effects of disability or pain,
2. promote, maintain or protect health, and

3. prevent premature or inappropriate institutionalization while allowing the member to live in their place of residence with dignity and independence.

The home health agency should effectively coordinate services to meet the members' medical needs in their place of residence. When a skilled home health nurse is authorized to provide a service, other medically necessary services should be provided at the same time. Additional visits will not be authorized for services which could be provided during other visits.

Home health service must be supervised by a registered nurse employed by an approved, Medicare-certified home health agency.

2 Health plans

Information specific to ACOs can be found in Section I: General Information, Chapter 2, Health plans.

Refer to Section I: General Information Chapter 1-7, Fee-for-service and managed care, for information regarding Accountable Care Organizations (ACOs) and how to verify if a Medicaid member is enrolled in an ACO.

3 Provider participation and requirements

To enroll as a Medicaid home health provider, refer to Section I: General Information Chapter 3, Provider participation and requirements.

4 Record keeping

Refer to Section I: General Information, Chapter 4, Record keeping.

5 Provider sanctions

Refer to Section I: General Information, Chapter 5, Provider sanctions.

6 Member eligibility

It is the responsibility of the provider to verify the member's eligibility prior to every rendered service. For additional information regarding member eligibility refer to Section I: General Information Chapter 6, Member eligibility.

7 Member responsibilities

For information on member responsibilities including establishing eligibility and co-payment requirements refer to Section I: General Information, Chapter 7, Member responsibilities.

8 Programs and coverage

8-1 Definitions

Definitions of terms used in other Medicaid programs are available in Section I: General Information of the Utah Medicaid provider manual. Definitions specific to the content of this manual are provided below.

Clinical note: A notation of contact with a member written and dated by a member of the health team. It describes signs and symptoms, treatment and drugs administered and the member’s reaction, and any changes in physical, emotional condition, or other health information.

Home health agency visit: A personal contact in the member’s place of residence for providing a covered service.

Home health agency or home care agency: A public agency or private organization licensed by the Department as a home health agency under the authority of Utah Code Title 26, Chapter 21, and in accordance with Utah Administrative Code R432-700. a home health agency is primarily engaged in providing skilled nursing service and other therapeutic services.

Home Health Aide (HHA) or Certified Nursing Assistant (CNA): Services provided by a person selected and trained to assist with routine care not requiring specialized

nursing skill and closely supervised by a registered nurse. Home health aide services must be provided by a Medicare-certified and Utah State licensed home health agency through an established plan of care.

Home health assessment visit: Made by a registered nurse initially or at recertification to assess the member's overall condition; to determine the adaptability of the member's place of residence to the provision of health care and the capability of the member to participate in his own care; and to identify family support systems or individuals willing to assume responsibility for care when the member is unable to do so.

The outcome of the assessment visit is a documented plan of care based on the physician's written orders and the registered nurse's assessment.

Plan of care: A written plan developed and prescribed by the member's ordering practitioner in cooperation with the home health agency staff. The plan is designed for the agency to adequately meet the specific needs of the member in their place of residence. The approved plan must be retained in the agency's permanent record for the member.

Private Duty Nursing (PDN): Private duty nursing is an optional program which is covered within the home health program for members who meet specified criteria and require more than four continuous hours of skilled nursing care per day.

Private duty nursing acuity grid: A form developed by the State of Utah to assist the assessing RN to determine the acuity level of the beneficiary.

Progress note: Progress note means a written notation, dated and signed by a member of the health team, which summarizes facts about care furnished and the member's response during a given period.

Skilled nursing: Nursing services are specifically skilled services used in the treatment of an acute illness or injury or exacerbation of a chronic illness.

Summary report: Summary report means the compilation of the pertinent factors of a member's clinical notes and progress notes from the previous certification period that is submitted to the member's physician.

Supervision or supervisory visit: Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity.

Supportive maintenance home health: A level of hands-on service which requires minimal assistance, observation, teaching or follow-up essential to health care.

8-2 General coverage

Home health services are covered only when provided to a member who is under the care of a physician. Home health services must comply with Utah Administrative Code R414-1-30. The physician writes the orders on which an assessment is based and plan of care established, certifies the medical necessity for home health services, and provides supervision of cares. Home health care is physician-directed and must be furnished by or under the supervision of a registered nurse.

Home health services require prior authorization except for the initial and 60-day recertification assessments.

Refer to the Coverage and Reimbursement Code Lookup for additional covered services.

Home health services include:

1. Skilled services
    a) Nursing services (RN or LPN)
    b) Speech-language
    c) Physical therapy
    d) Occupational therapy
    e) Medical supplies
    f) IV therapy

   g) Home health aide (see 8-9.1 Home health aides for related policy)
2. Supportive maintenance services
   a) Skilled nursing
   b) Home health aide
3. Capitated home health services
4. Private duty nursing

Criteria for each service are described in the remainder of this manual.

8-3 Nursing service

Nursing services, as defined in the Utah Nurse Practice Act, are covered when provided on a part-time basis by a home health agency. Part-time or intermittent services are usually services for a few hours a day several times a week.

Occasionally, more services may be provided for a limited time when recommended by a physician and included in the approved plan of care. Skilled nursing service is the expert application of nursing theory, standardized procedures and medically delegated techniques by a registered nurse (RN) to meet the needs of a member in his or her residence, using professional judgments to independently solve member care problems.

Highly skilled nursing levels of care occur where the severity of illness and intensity of service are such that the attendance of a family or professional caregiver is necessary on a consistent basis; specialized equipment is required to support activities of daily living; and abilities are severely limited by medical needs, treatment, supportive equipment and the need for physical assistance; and the skill required can only be provided by a licensed RN or LPN.

Teaching is limited to four visits in the first certification period.

The registered nurse makes the initial assessment and recertification visits, regularly reevaluates the member's nursing needs, initiates the plan of care, makes necessary revisions, provides services requiring substantial and specialized nursing skill, initiates appropriate preventive and rehabilitative nursing procedures,

prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the member's condition and needs, counsels the member and family in meeting nursing and related needs, participates in in-service programs, and supervises and teaches other nursing personnel.

8-3.1 Assessment visit

An in-depth physical and psychosocial assessment must be made by a registered nurse initially or at recertification to assess the member's overall condition, needs, adaptability of the member's place of residence to the provision of health care, capability of the member to participate in his or her own care, identify family support systems or persons willing to assume responsibility for care when the member is unable, and establish a plan for delivery of care.

The home health agency may conduct an initial assessment visit on the reasonable expectation that a member's needs can be met adequately in their place of residence. The outcome of the assessment visit is a documented plan of care based on the physician's written orders and the registered nurse's assessment.

8-3.2 Plan of care

The plan of care is a written plan developed and prescribed by the member's ordering practitioner in cooperation with the home health agency staff. The plan is designed for the agency to adequately meet the specific needs of the member in their place of residence. The approved plan must be retained in the agency's permanent record for the member.

The plan of care developed in consultation with the agency staff must cover the following:

1. Diagnoses
2. Mental status
3. Types of service
4. Medical equipment and supplies required
5. Frequency of visits

6. Rehabilitation potential
7. Functional limitations
8. Activities permitted
9. Nutritional requirements
10. Medications
11. Treatments and therapies
12. Discharge planning or referral
13. Other identified appropriate services
14. Clinical documentation supporting the member needs for care, e.g., discharge summary, history and physical, operative notes, physician’s written summary of need, etc.

8-3.3 Reassessment

At least every sixty (60) days, the member must undergo reassessment. The physician must review the new plan of care and recertify the need for continuing home health care. Medicaid must approve an updated plan of care at least every 60 days. A 60-day summary of care from the previous certification period must be included on every care plan after the initial authorized period. Exceptions to this requirement are located in Chapter 8-8 IV, enteral, and parenteral therapy administration.

The average member is served by home health for 60-75 days. As the 60-day time frame nears, the home health agency should determine the need for continued care and complete a new prior authorization request. Include all information and documentation as was initially required. This reassessment can take place no more than five days prior to, or two days after, the previous certification period expires.

Home health care services must be administered by agency staff only as ordered by a physician and approved in the plan of care. All changes shall be made in writing and signed by the physician or by a registered nurse on the staff of the agency receiving the physician's oral order. All oral orders must be subsequently documented in writing on or before the next plan review. All changes in orders for legend drugs and narcotics must be signed by the physician.

If the member does not require home health care for the entire 60-day period, service should be discontinued as appropriate.

8-4 Physical therapy services

Physical therapy services are covered through home health when the setting is the most appropriate and cost effective. Physical therapy services must be medically necessary and essential to improve the functional ability of a member with a temporary or permanent disability associated with accidents, injury, illness, birth defects, or prematurity. The goal of physical therapy in the home is to improve the ability of the beneficiary, through the rehabilitative process, to function at a maximum level.

Physical therapy must be provided under physician orders, in accordance with an established plan of care, and provided by a licensed, qualified physical therapist or physical therapy assistant employed directly by or under contract with a home health agency.

There must be an expectation that with treatment, the member’s medical condition will improve in a predictable period of time. Physical therapy delivery by a home health agency is not an option for the convenience of physician, family, or therapist. Outpatient service must be considered for any continuing service beyond the initial intervention.

Before physical therapy is provided by the home health agency, prior authorization must be requested with submission of an initial assessment that includes, but is not limited to:

1. A plan of care based on physician orders for medically necessary services to be provided.
2. Member information, history, current medical findings, diagnosis and severity of the medically oriented disorder or disability.
3. A factual evaluation and statement of the function present and prognosis for reasonable and predictable improvement.

4. Expected goals and objectives for the member that may reasonably be achieved in a predictable period of time using professionally appropriate standards.
5. The specific treatments or modalities to be used, frequency of treatment sessions, and anticipated duration of the physical therapy service.

The plan of care and progress toward goals must be reviewed by the nurse reviewer every 60 days and reviewed and recertified by the ordering practitioner every 6 months. Requests for continued service will be evaluated by consultants and nursing staff on a case-by-case basis. A new plan of care must be submitted with a prior authorization request, and must include the following information:

1. A medical evaluation from the physician including any change in medical condition and prognosis.
2. A status/progress report from the physical therapist clearly stating progress made toward meeting previous goals. Continued service is questionable if there is no progress.
3. Physician orders, goals objectives, treatment methods and frequency of continued service requested. Goals must include teaching family caregivers to work with the member on a daily basis so that improvement can be maintained.
4. Medical problems the member may have that support or justify continued service.
5. Anticipated transition to outpatient service.
6. If the member is in the Tech Dependent Waiver or Early Intervention Programs, the information must be included with the request. Physical therapy services are non-covered for the following:
   a) Social or educational limitations without medical diagnosis.
   b) Conditions where there is no documented potential for improvement.
7. Non-therapeutic repetitive or reinforcing procedures.

8-5 Occupational therapy services

Occupational therapy services are covered through home health when the setting is

the most appropriate and cost effective. Occupational therapy is a benefit available for pregnant members and those eligible for the EPSDT program.

Occupational therapy services must be medically necessary and essential to treat problems associated with accidents, injury, illness, birth defects or prematurity. Therapy should maximize the developmental or functional needs of member performance to include any or all of the following:

1. Self-help skills
2. Adaptive behavioral skills
3. Sensory skills
4. Fine motor skills
5. Postural development

Evaluation and treatment services are available to correct or ameliorate physical and/or emotional deficits.

Occupational therapy must be provided under physician orders, in accordance with an established plan of care, and provided by a licensed, qualified occupational therapist or certified occupational therapy assistant employed directly by or under contract with the home health agency.

There must be an expectation that with treatment, the member's medical condition will improve in a predictable period of time. Occupational therapy delivery by a home health agency is not an option for convenience of physician, family or therapist. Outpatient service must be considered for any continuing service beyond the initial intervention.

Typical activities related to occupational therapy are:

1. Perceptual motor activities;
2. Exercises to enhance functional performance; kinetic movement activities;
3. Guidance in the use of adaptive equipment; and
4. Other techniques related to improving fine motor development.

Before therapy services are provided by the home health agency, prior

authorization must be requested with submission of an initial assessment that includes, but is not limited to:

1. A plan of care based on physician orders for medically necessary services to be provided.
2. Member information, history, current medical findings, diagnosis and severity of the medically oriented disorder or disability.
3. A factual evaluation and statement of the function present and prognosis for reasonable and predictable improvement.
4. Expected goals and objectives for the member that may reasonably be achieved in a predictable period of time using professionally appropriate standards.
5. The specific treatments or modalities to be used, frequency of treatment sessions, and anticipated duration of the physical therapy service.

The plan of care and progress toward goals must be reviewed by the nurse reviewer every 60 days and reviewed and recertified by the ordering practitioner every 6 months. Requests for continued service will be evaluated by consultants and nursing staff on a case-by-case basis. A new plan of care must be submitted with a prior authorization request, and must include the following information:

1. A medical evaluation from the physician including any change in medical condition and prognosis.
2. A status/progress report from the occupational therapist clearly stating progress made toward meeting previous goals. Continued service is questionable if there is no progress.
3. Physician orders, goals objectives, treatment methods and frequency of continued service requested. Goals must include teaching family caregivers to work with the member on a daily basis so that improvement can be maintained.
4. Medical problems the member may have that support or justify continued service.
5. Anticipated transition to outpatient service.
6. If the member is in the Tech Dependent Waiver or Early Intervention Programs, the information must be included with the request.

Occupational therapy services are non-covered for the following:

1. Social or educational limitations without medical diagnosis.
2. Conditions where there is no documented potential for improvement.
3. Non-therapeutic repetitive or reinforcing procedure.
4. Non-pregnant adults.

8-6 Speech-language pathology and audiology services

Speech-language services are covered under home health when the setting is the most appropriate and cost effective. Speech-language pathology and audiology services are available to eligible pregnant and EPSDT members when determined to be medically necessary.

Speech-language services must be essential to treat problems associated with birth defects, prematurity, illness, accidents or injury. All services must be provided under physician orders, in accordance with a plan of care, and provided by a licensed, qualified speech-language therapist employed directly by or on contract to a home health agency. There must be an expectation that with treatment, the member's medical condition will improve in a predictable period of time. Speech-language services delivery by a home health agency are not an option for the convenience of physician, family or therapist. Outpatient service must be considered for any continuing service beyond the initial intervention.

Before services are provided, the home health agency must request prior authorization and submit an initial assessment that includes, but is not limited to:

1. Plan of care based on physician orders
2. Current medical findings and diagnosis
3. Identification of any previous treatment provided
4. Anticipated goals and methods of treatment clearly stated
5. Amount, duration and frequency of services
6. Prognosis

The plan of care and progress toward goals must be reviewed by the nurse reviewer every 60 days and reviewed and recertified by the ordering practitioner every 6 months. Requests for continued service will be evaluated by consultants and nursing staff on a case-by-case basis. A new plan of care must be submitted with a prior authorization request, and must include the following information:

1. A medical evaluation from the physician including any change in medical condition and prognosis.
2. A status/progress report from the speech-language therapist clearly stating progress made toward meeting previous goals. Continued service is questionable if there is no progress. The speech-language therapist is responsible to recommend discontinuation of treatment when continued progress is not evident.
3. Goals, objectives, treatment methods and frequency of continued service requested. Goals must include teaching family caregivers to work with the member on a daily basis so that improvement can be maintained.
4. Medical problems the member may have that support or justify continued service.
5. Anticipated transition to outpatient service.
6. If the member is on the Tech Dependent Waiver or Early Intervention Programs, the information must be included with each request.

Speech-language services are non-covered for the following:

1. Social, educational or developmental limitations without medical diagnosis.
2. Chronic conditions which cannot benefit from communication services or where there is no potential for improvement.
3. Non-therapeutic routine, repetitive or reinforcing procedures
4. Non-pregnant adults.

8-7 Medical supplies

Medical supplies for home health services are included in the coverage of the initial visit related to the start of care and are not separately reportable.

Medical supplies included in the plan of care are subject to coverage and prior authorization requirements of the medical supplies and durable medical equipment services program. Refer to the Medical Supplies and Durable Medical Equipment provider manual and the Coverage and Reimbursement Code Lookup for additional information about this program.

8-8 IV, enteral, and parenteral therapy administration

The administration of enteral, parenteral, and IV therapy is covered as a home health service either in conjunction with skilled or supportive maintenance care or as the only service provided. Refer to the Pharmacy Services and Medical Supplies and Durable Medical Equipment provider manuals for coverage policy regarding these services.

8-8.1 IV therapy and parenteral therapy

Long-term IV access, such as PICC or central line placement, is required when a member requires administration of IV antibiotics for a 7-10 day period or parental nutrition therapy. IV dressing changes are covered once every 7-day period. Members with documented risk of infection or that are pregnant are excluded from this requirement and can have a visit every three days for peripheral line maintenance when medically appropriate.

Skilled nursing is appropriate for IV placement, demonstration of IV medication delivery; blood draws associated with infusion therapy, or teaching. Medical necessity of administration in the home health setting and the member's condition and must be established based on the appropriateness diagnosis. The plan of care for infusion therapy must include:

1. Name of the substance
2. Dose (quantity)
3. Frequency
4. Duration

8-9 Supportive maintenance service

The supportive maintenance level of service includes skilled nursing and

home health aides. These services are available to the member with nursing care needs that have stabilized to the point that there are few significant changes occurring in the plan of care. The member demonstrates limitations or significant disability that requires assistance with activities of daily living (ADL) and could be totally bed bound or subject to nursing facility admission without the assistance. Care and service needs are based on physician orders and an approved plan of care, with review and recertification completed by the home health agency and the physician, every 60 days. Teaching, assessment, observation, and monitoring by a skilled nurse must be accompanied by hands on care.

Supportive maintenance levels of care occur where the member demonstrates chronic limitations or significant disability requiring assistance with ADLs or specialized equipment which may require ongoing observation, teaching, and hands on follow-up care. Care needs should be relatively stable, supportive in nature, and long-term. The member is typically capable of leaving their place of residence to attend school, sheltered workshops, work or to receive other medically necessary services. Assistance may be needed multiple times per day.

Examples of members with diagnosis(es) requiring this level of care include, but are not limited to:

1. Paraplegia
2. Quadriplegia
3. Degenerative neurological diseases
4. Newly diagnosed diabetics with acute high-risk diabetic complications; and
5. Those with multi-system problems requiring a skilled service or acute monitoring.

8-9.1 Home health aids

Home health aide related services are covered when medically necessary and part of an ongoing plan of care. The member’s severity of illness and required

intensity of service must be such that the skills of a home health aide meets their needs on a consistent basis, at an appropriate skill level.

Home health aide visits can occur daily one or more times per day with coverage determinations based on a member's medical needs.

1. Home health aide visits that are required once per day allow for up to two hours of related services and are reported using HCPCS code T1021 - Home health aide or certified nurse assistant, per visit
    a) If the nurse determines, after the initial 60-day certification period, that services requested are due to a chronic condition, and Medicaid determines that the condition is expected to continue for a period of at least one year, once daily service may be authorized for a 180-day period.
    b) If the member's condition improves, and the member does not require the service for the entire 180-day authorization period, it is the responsibility of the home health agency to notify the Medicaid prior authorization unit of the change in condition.
    c) Approval of the 180-day period requires a physician's order and documented plan of care reviewed by the home health agency every 60 days in accordance with 42 CFR 440.70. Home health agencies are responsible for maintaining a record of the required 60-day review within the member's medical record and is subject to post-payment review by Medicaid.
2. Extended home health aide services may be medically necessary in situations when a member requires home health aide services multiple times per day. When medically indicated, each visit may be for one hour with a maximum of four visits per day, based on the member's medical need. These services do not qualify for the 180-day certification period. Report services using HCPCS code S9122 - Home health aide or certified nurse assistant, providing care in the home; per hour. These services require:
    a) The member needs assistance with ADLs more than once daily
        i. Assistance with ADLs are needed to prevent bed confinement or nursing home admission.

   b) The member's medical care needs should be stabilized to the point that significant changes to the plan of care are not required.
   c) The plan of care needs are based on a physician's orders and an approved plan of care with review and recertification every 60 days in accordance with 42 CFR 440.70.
3. When two members in the home are receiving services, care needs will be evaluated as a total package, and service units will be adjusted and authorized as a total package. Two aides will not be approved for service except under extreme circumstances or changing care needs requiring additional service by individual care givers. Duplicate payment will not be approved under any circumstances if only one care giver goes to the home and provides the total units of care for both members.

8-10 Capitated home health service

A member may be eligible for the long-term capitated home health program when documented, diagnosed medical conditions require extensive services or substantial physical assistance with activities of daily living but little skilled care.

Capitated home health care provides service for members with paraplegia and quadriplegia who require little skilled care and need long term maintenance with activities of daily living, along with other services, usually twice a day. Once a member is approved for capitated home health care, the reimbursement is based on the cost of nursing facility care per day. The home health agency provides the required care to meet the member's needs without billing for each service or visit.

Criteria considered by Medicaid prior authorization staff include:

1. Orders must be established by the physician and outlined in an approved plan of care.
2. Service needs are greater than six months.
3. Service needs require at least 120 aide visits in a consecutive 90-day period.
4. Medical condition and intensity of service must be judged to be at the level that can be provided safely in the home health setting.

5. Nursing intervention is required at least every two months to provide a skilled service.
6. Prior authorization is required for the capitated home health care program regardless of when the previous prior authorization was given. Medicaid may authorize services under this program for up to six months, or until there is a change in the member's condition.
7. Approval of the 180-day period, per federal regulations, requires a physician's order and plan of care reviewed by the agency every 60 days. Agencies will be responsible for maintaining a record of the required 60-day review within the member's home health record and will be subject to possible post-payment review by Medicaid.
8. The home health agency must submit a new recertification request every 180 days.

Note: As with any other plan of care, any change in the member's condition or care needs requires immediate evaluation and reconsideration of the service authorization. The capitated service represents a daily rate. No other home health services can be provided or billed when the member is receiving service under the capitated program.

8-11 Private Duty Nursing (PDN)

PDN service is an optional program for the purpose of preventing prolonged institutionalization of a member. As an optional program, PDN is a non-covered program for Medicaid members except EPSDT eligible members.

In certain cases, if agency staff determine that the proposed PDN services are both medically appropriate and more cost effective than alternative services, the agency may exceed the limitation of PDN coverage beyond EPSDT eligible members.

8-11.1 Eligibility, coverage, and limitations

PDN services are covered when criteria are met and determined to be medically necessary. PDN is only available if a parent, guardian, or primary care giver is able to perform the medical skills necessary to ensure quality of

care and a safe environment for the periods of time when PDN service is not provided.

PDN services are for medically necessary skilled nursing needs of the member that meet the following criteria:

1. The member is the only intended recipient of the PDN service.
2. Skilled management by a licensed nurse is required.

PDN is not covered for:

1. Custodial or sitter care to ensure compliance with treatment.
2. The care is not intended for other members of the household.
3. The care is a duplication of care covered under another service or funding source.
4. Respite care to allow the caregiver to go to work or sleep.
5. Behavioral or eating disorders.
6. Observation or monitoring for medical conditions not requiring skilled nursing.

8-11.2 Requirements

Coverage of PDN requires:

1. Prior authorization every 180 days
2. Member requires greater than 4 hours of skilled nursing care per day while in transition from the hospital to the home health setting
    a) In these cases, the period of PDN coverage is provided to allow sufficient training of the caregiver.
3. Member requires greater than 4 hours of skilled nursing care per day as part of their ongoing care needs
    a) In these cases, the period of PDN coverage is provided, based on quality and cost effectiveness of care, as a means to minimize the need for prolonged institutionalization.
4. Member is dependent on mechanical ventilation
    a) For these members, PDN may be provided during active weaning, or when weaning is not appropriate, as an ongoing service based on quality and cost effectiveness of care in order to minimize the

need for prolonged institutionalization.

8-11.3 Requested documentation

The following documentation must be submitted for consideration or reconsideration for PDN services. All requested forms and documentation must be submitted together.

1. A written physician order that establishes the need for PDN service.
2. A completed prior authorization request form with supporting medical documentation that demonstrates the need for the service.
3. A plan of care consistent with the member's diagnosis, severity of illness, and intensity of service.
4. A 60-day summary of care from the previous certification period must be included with the care plan after the initial authorized period.
5. Verification that the caregiver receives the specialized training necessary to provide hands-on care.
6. A completed PDN acuity grid, with adequate supporting documentation to justify the member's score.

8-11.4 PDN acuity grid

The PDN acuity grid is used to determine medical necessity and to qualify and quantify the number of PDN hours that a member may receive.

The PDN acuity grid must reflect the average daily care given by licensed nursing professionals during the previous certification period or for initial authorization period. For the initial authorization period, needs are estimated based on care required during the final days of hospitalization.

After the initial authorization period, current comprehensive documentation to make a determination must be submitted. Documentation may include:

1. Nursing progress notes
2. Flow sheets for skills, medications, etc.
3. All other types of agency-created forms used to document patient care

All submitted documents are compared for consistency. The PDN acuity grid must be substantiated by the medical documentation submitted.

The PDN acuity grid can be found on the Utah Medicaid Forms webpage.

8-11.5 Scoring the PDN acuity grid

If a member is discharged from the hospital, the PDN acuity grid is submitted based on an estimate of the care needed, the discharge orders, or other documents from the hospital. After the initial care period, ongoing care needs are determined by documentation from the previous 60 days of care.

If during a recertification period or after transition from hospital to the home health setting, continued PDN care is not substantiated, it is expected that the member will be given time to seek alternative care from community resources.

8-11.6 PDN acuity grid score and PDN hours

Score	Maximum allowable covered hours per day
21-35	12
36-45	14
46-51	16
56^{+} and over	18

If 20 points or less:

1. And the member is being transitioned off 9 hours, then 832 units will be approved to the home health agency for the certification period. During this time, it is expected that discharge planning occurs.
2. When a member's tracheostomy is decannulated, up to 5 hours of daily nursing care may be approved during the first 24-72 hours after decannulation.

8-11.7 Guidelines for decrease in quantity of PDN services over time

Active weaning occurs as follows, when indicated by PDN grid scores:

1. Physician ordered.
2. The member's family, caregiver, or similar education related to weaning.
3. The PDN nurse shall attempt to wean the member from a device or service and will identify and document any new issues that arise during the process.
4. The active weaning process is to be followed after the member is initially discharged from the hospital, as caregivers gain sufficient expertise to assure safe ongoing care.
5. The number of nursing hours approved will be decreased, as care needs decrease. Maximum hours will be reduced every certification period as the home health setting is established and organized.
6. The goal of active weaning is to have the member to 8 hours of PDN a day within a four-month period.
7. PDN service ends once the caregivers are given sufficient training to meet the member's needs and fewer than four hours of skilled nursing are needed.
8. Standard home health services (visits) may be accessed for members who require fewer than four hours of home health skilled nursing service.

8-11.8 Guidelines for increase in quantity of PDN services over time

An increased number of hours of PDN services may be authorized when acute exacerbations of illness require a temporary increase in skilled care. Additional documentation may be requested to support the request for increased hours. The member may receive up to 20-24 hours of PDN care daily, if authorized, only under the following circumstances:

1. After initial hospital discharge, for up to 14 days to enable the care giver(s) to become trained on procedures
2. After a subsequent hospitalization, for up to 14 days to allow care giver(s) training in any new procedures or changes in care
3. An increased number of hours may also be requested if the primary care

giver is unable to provide care due to caregiver illness or temporary incapacity, as documented by that caregiver's medical provider. Examples of temporary incapacitation may include severe illness, hospitalization, or injury that prevents normal physical functioning. In such cases, increased PDN coverage will be limited to a period not to exceed 30 days and is intended to provide care while alternative caregivers can be identified and trained.

8-11.9 Prior authorized hours may not be banked

The banking, saving, or accumulation of unused, authorized hours to be used later for the convenience of the family or agency is not permitted.

Home health agencies may adjust or combine PDN hours within a 7-day period based on the needs of the family. Combing PDN hours should not be a common practice and it is not permissible to combine PDN hours because the agency could not staff a shift.

1. Any adjustment or combining of PDN hours must meet the physician's orders and those orders take precedence in determining the daily care.
2. This policy change does not allow an HHA provider to omit a required daily service on one day only to combine it with another day's services.
3. PDN hours cannot be combined, adjusted, or accumulated for periods of time that the member is hospitalized or otherwise under the care of another provider who meets the PDN service requirements.
4. In the event of unexpected illness or injury, requiring additional PDN services, submit an additional PA requesting approval to exceed the previously approved units or hours.

8-11.10 Billing PDN

The following provides billing information for PDN services:

1. Private duty/independent nursing service(s), licensed, up to 15 minutes is billable with the correct code. LPN rendered service are reported with TE modifier. Service performed by and LPN reimburse at 78% of the fee

schedule.

2. When two members in the home are receiving services, care needs will be evaluated as a total package based on physician orders and time study.
    a) Service units will be adjusted and authorized as a total package.
    b) Two nurses will not be approved for service except under extreme circumstances and new critical care needs requiring additional service by individual caregivers.
    c) A differential payment will be provided to the private duty-nursing service when the total units of care apply to more than one beneficiary. For differential reimbursement, submit the appropriate modifier (UN) on the claim to indicate care provided for more than one beneficiary.

9 Non-covered services and limitations

9-1 Non-covered services

Medicaid does not cover home health services in the following situations:

1. Home health care provided to a member capable of self-care.
2. Home health care provided to a member residing in a hospital, skilled nursing facility or intermediate care facility.
3. Personal care services, except as determined necessary in providing skilled care.
4. Housekeeping or homemaking services.
5. Skilled nursing or supportive maintenance service visits without hands-on-care.
6. Respite care.
7. Care for social needs.
8. A visit to supervise a home health employee. (A supervision visit is considered an administrative expense for the home health agency.)
9. Medical supplies, except where indicated.
10. Palliative care for speech, occupational, and physical therapy.

9-2 Limitations

The following limitations apply to home health services:

1. Home health care is limited to one visit per day, except in limited circumstances.
2. RN assessment/reassessment is limited to one every 60 days. This limitation is subject to post payment review for appropriate use.
3. The RN assessment / reassessment must be coordinated with the home health aide visits so that members receiving periodic home health aide care are seen on a different date from the RN assessment. Only members requiring supportive daily home health care to meet their ADL requirements may receive the RN assessment visit on the same date as the home health care aide visit.
4. If providing a skilled service an aide cannot provide, an RN/LPN may bill for a brief visit that takes place on the same day as home health aide visits. The services must be prior authorized.
5. Visits on the same day by a personal care aide and a home health aide are not covered.
6. Skilled nursing for observation, monitoring, and on-going assessments must be accompanied by hands-on care.
7. PRN visits by an RN are limited to two in a 30-day period.
8. An acute skilled nursing care visit by an RN is limited to twice a day for a maximum of 21 visits. It is limited to the first month of service unless the member reverts to an acute phase of a chronic condition.
9. Teaching visits are limited to four per certification period in skilled nursing. Teaching visits for supportive maintenance nursing must include hands-on care.
10. Supportive maintenance nursing for medicine box prefills are to cover a two-week period of time unless there is a documented, medically necessary reason for weekly visits.
11. A plan of care exceeding established limits will not be approved.
12. Home health service must be cost effective. It must cost less over the long-term to provide the required care and service in the member's home than it would cost to meet the medical needs in a nursing facility or other institutional setting.

13. Wound management: during the initial nursing assessment, instructions for simple dressing changes must be provided to the member and care giver. When the member meets the requirements for home health nursing service and requires dressing changes for complex wounds, home health wound management requires submission of a complete wound assessment at the onset of care and weekly wound assessments throughout the certification period. Non-healing wounds require additional medical management.
14. Discharge from the home health agency and readmission is only appropriate when the member has left the home for hospitalization or a skilled nursing facility and is returning to home health care services. There will be no carryover hours. A new nursing assessment must be completed. The prior authorization nurse will determine whether additional nursing hours are needed during the recertification.

10 Prior authorization

Prior authorization (PA) may be required for certain services. Failure to obtain prior authorization may result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization before providing services. Exceptions may be made, with appropriate documentation, if the service provided is emergent or the member is retro-eligible for the dates of service requested.

Further prior authorization information is provided in the provider manual, Section I: General Information. Code specific coverage and prior authorization requirements are provided on the Coverage and Reimbursement Code Lookup.

To request prior authorization the home health agency must submit the physician's written order requesting care, the plan of care resulting from those orders, and a request for prior authorization form for all home health services beyond the initial visit, including therapies. Approval must be received before additional services are given. The level of service, skilled, supportive, or maintenance, is established and approved based on the prior authorization

request.

Prior authorization is not required for the initial comprehensive nursing assessment or the nursing assessment required at recertification. A recertification assessment every 60 days is a federal requirement with reimbursement limited to one every 60 days. All other home health services require prior authorization. Recertification requests must be submitted every 60 days. The member cannot be discharged if the deadline for re-certification has been missed. Certification periods must be consecutive.

Prior authorization is required for a physical, occupational, or speech therapy assessment. The assessment determines if the member is able to receive necessary services in the outpatient setting. Therapy visits are limited to the most appropriate, cost-effective place of service. The home health setting cannot be chosen for the convenience of the therapist or family.

Prior authorizations for home health services are provider specific. This means that only the agency that applied for and received the prior authorization may use the authorization number. If another agency assumes responsibility for serving the beneficiary, that agency must apply for and receive a separate prior authorization.

The location of the member must be documented in the request for home health services (i.e., own home, group home, assisted living center).

Retro authorization must be requested with a PA request form, physician order for care, and nursing documentation of visit for all PRN nursing visits.

When the nursing assessment indicates a Medicaid member may qualify for home health services, complete the prior authorization request through PRISM with supporting medical documentation that demonstrates the need for the service within 10 business days of the nursing assessment. Documentation must be submitted at the time of the request, or the request will be returned. Prior authorization forms can be found on the Utah Medicaid website Forms section.

11 Billing Medicaid

For general information related to billing Medicaid refer to Chapter 11, Billing Medicaid, of the Section I: General Information provider manual for additional billing instructions.

Medicaid provides enhancements to the home health reimbursement rate when travel distances to provide service are extensive. The enhancement is available only in rural counties where round-trip travel distances from the care giver's base of operations are in excess of 50 miles.

Rural counties are defined as counties other than Weber, Davis, Salt Lake, and Utah. The member must reside in the same or an adjacent rural county as the provider.

An enhancement factor is applied to home health services rendered for residents living in San Juan or Grand County. This enhancement is irrespective of the distances traveled and is in lieu of the rural area exceptions provided for other rural counties.

See Chapter 12, Coding, for guidance related to claims submitted for these services.

11-1 Calculating the number of units billed to each beneficiary

Home health services requiring minimal time and performed for multiple persons in the same location shall be billed with the appropriate modifier as noted below.

Number of members served	Applied modifier
2	UN
3	UP
4	UQ
5	UR
6^+	US

11-2 Calculation

Divide the total number of units by the total number of members served.
The resulting number of units is billed to each member along with the appropriate

modifier to indicate the service was shared. If the units do not divide among the members served into whole numbers, then allocate and bill the remainder units among the members until used.

Example: 4 members received a total of 11 units is calculated and billed as follows:

11/4 = 2.75
Member 1 = 3
Member 2 = 3
Member 3 = 3
Member 4 = 2

11-3 Electronic visit verification requirement

This policy is effective as of January 1, 2023.

In accordance with Utah Administrative Code R414-522 and section 12006 of the 21st Century CURES Act, providers of Home Health must comply with Electronic Visit Verification (EVV) requirements. Providers may select the system of their choosing, provided it captures the following data elements and is compliant with the standards set in the Health Insurance Portability Accountability Act (Utah Medicaid Provider Manual Home Health Services, Updated October 2019, Page 20 of 21, Section 2).

EVV systems must the collect the minimum information:

1. type of service performed;
2. individual receiving the service;
3. date of the service;
4. location of service delivery;
5. individual providing the service;
6. time the service begins and ends; and
7. the date of creation of the electronic record.

Additional information, including technical specifications for file creation/submission can be found at https://medicaid.utah.gov/evv.

12 Coding

12-1 Rural counties

To receive the rural home health travel enhancement, file the claim using an applicable, approved service code with a modifier "TN".

Modifier TN is used for rural counties other than San Juan and Grand County members.

See Chapter 11, Billing Medicaid, for guidance related to the conditions required for enhancements to the home health reimbursement rate

12-1.1 San Juan or Grand County exception

An enhancement factor is applied to home health services rendered for residents living in San Juan or Grand County. This enhancement is irrespective of the distances traveled and is in lieu of the rural area exceptions provided for other rural counties.

To receive the rural home health travel enhancement, file the claim using an applicable approved service code with the appropriate modifier.

Modifier	Recipients	Zone
UA	Aneth and Hatch Trading Posts Mexican Hat Montezuma Creek	1
UB	Monument Valley	2
TN	Rural counties (Counties other than Weber, Davis, Salt Lake, and Utah)	NA

Resource table

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

For information regarding:	
Administrative Rules	Utah Administrative Code Table of Contents Utah Administrative Code, Title R414-1, Utah Medicaid Program Utah Administrative Code, Title R414-14, Home Health Services Utah Administrative Code, Title R414-40, Private Duty Nursing Service
General information including: Billing Fee for service and managed care Member eligibility Prior authorization Provider participation	Section I: General Information Claims Managed Care: Accountable Care Organizations Utah Medicaid Prior Authorization Administrative Rules Eligibility Requirements. R414-302. Medicaid General Provisions. R414-301. Program Benefits and Date of Eligibility. R414-306. Utah Medicaid Program. R414-1.
Information including policy and rule updates: Medicaid Information Bulletins (Issued bimonthly), Medicaid Provider Manuals, Utah State Bulletin (Issued on the 1st and 15th of each month)	Utah Medicaid Official Publications Utah State Bulletin
Medicaid forms including: Private Duty Nursing Acuity Grid Private Duty Nursing Acuity Grid (printable)	Utah Medicaid Forms webpage

Medical supplies and DME	Medical Supplies and Durable Medical Equipment Provider Manual Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70.
Modifiers	Section I: General Information
Patient (member) Eligibility Lookup Tool	Eligibility Lookup Tool
Prior authorization	Submitting a Prior Authorization Request
Provider portal access	Provider Portal Access
Provider training	Utah Medicaid Provider Training
References including: Social Security Act Code of Federal Regulations Utah Code	42 CFR 440.70 Social Security Act 1905(a) Social Security Act 1861 (r) Utah Annotated Code Title 58

Utah Medicaid Provider Manual

Hospice Care Services

Division of Integrated Healthcare

Updated March 2023

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1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General information.

Medicaid follows the federal guidelines for hospice care services as outlined in 42 CFR 418.

1-1 Hospice care services

Hospice care services are covered for eligible Medicaid members when determined to be medically necessary as outlined in this manual. Hospice care services come from recognizing that a member's terminal condition warrants a change in focus from curative care to palliative care. Hospice care services may be provided by an enrolled Medicaid hospice agency certified by Medicare in accordance with 42 CFR 418.

2 Health plans

Information specific to Managed Care Entities (MCE) can be found in Section I: General Information , Chapter 2, Health plans.

For more information about Prepaid Mental Health Plans (PMHP), refer to Section I: General Information Chapter 2-1.2, Prepaid mental health plans, and the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual.

Refer to Section I: General Information Chapter 1-7, Fee for service and managed care, for information regarding Managed Care Entities (MCE) and how to verify if a Medicaid member is enrolled in an MCE.

A list of MCEs and PMHPs with which Medicaid has a contract to provide health care services is found on the Medicaid website Managed Care: Accountable Care Organizations.

If a member is enrolled in a MCE and has elected hospice care before being admitted to a nursing facility or ICF/ID, the MCE is responsible to reimburse the hospice agency for both the hospice care and the room and board until the member is disenrolled from the MCE.

3 Provider participation requirements

To enroll as a Medicaid Provider refer to Section I: General Information Chapter 3, Provider participation and requirements.

3-1 Provider credentials

A hospice agency must have a valid Medicaid enrollment in place in order to be reimbursed for hospice care services provided to Medicaid members. The effective date will be the date a complete application has been submitted in PRISM, unless the hospice agency requests an earlier effective date to align with the date of Medicare hospice certification. Even if a provider requests retroactive enrollment, Medicaid will only approve retroactive enrollment up to 120 days earlier than the date when the complete Medicaid application is submitted.

At the time of a change of ownership, the previous owner's provider agreement terminates as of the effective date of the change of ownership. Medicaid accepts all waivers granted to hospice agencies by the Centers for Medicare and Medicaid Services as part of the Medicare certification process.

4 Record keeping

Refer to Section I: General Information, Chapter 4, Record keeping.

5 Provider sanctions

Refer to Section I: General Information, Chapter 5, Provider sanctions.

6 Member eligibility

It is the responsibility of the provider to verify the member's eligibility prior to every rendered service. For additional information regarding member eligibility refer to Section I: General Information Chapter 6, Member eligibility.

Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member responsibilities

For information on member responsibilities including establishing eligibility and copayment requirements refer to Section I: General Information, Chapter 7, Member responsibilities.

8 Programs and coverage

For additional information regarding hospice care services, see Utah Administrative Code R414-14A-5. Hospice Care. Service Coverage or 42 CFR 418.64 Condition of Participation: Core Services. Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

Hospice agencies must provide the essential core services listed in this section. Frequency of services must be based upon an individualized assessment of need as determined by the attending physician and the treatment team, and as specified in the plan of care. A hospice agency may use contracted staff to supplement hospice employees during periods of peak patient loads or other extraordinary circumstances. The hospice agency remains responsible for the quality of services provided by contracted staff.

1. The hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.

2. Nursing care provided by or under the supervision of a registered nurse.
3. Medical social services provided by a qualified social worker under the direction of a physician.
4. Administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice agency.
5. Counseling services for the individual and family members or other persons caring for the person at home.

The following additional services must also be provided directly by, or made available by, the hospice agency whenever it is deemed appropriate and necessary by the treatment team and ordered by the attending physician.

Bereavement counseling consists of counseling services provided to the individual's family after a member's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

Special modalities: chemotherapy, radiation therapy, and other modalities may be used if it is determined, by the member's treatment team, that these services are needed for palliation. This determination is based on the member's condition and the hospice agency's caregiving philosophy. No additional Medicaid payment will be made regardless of the cost of the services.

8-1 Definitions

Attending physician means a physician who is a doctor of medicine or osteopathy; or

1. A nurse practitioner or physician assistant who meets proper training, education, and experience requirements within their scope of licensing, and
2. Is identified by the member, when they elect to receive hospice care, as having the most significant role in determining and delivering the member's medical care.

Adult means a member who is 21 years of age or older.

Cap period means the 12-month period, ending September 30, used in the application of the cap on overall hospice reimbursement specified in 42 CFR 418.309.

Concurrent care means that a pediatric member, receiving hospice care, may also continue to receive curative treatment.

Continuous home care day means a day in which a member, who has elected to receive hospice care at home, receives a minimum of 8 aggregate hours of care from the hospice agency during a 24-hour day, which begins and ends at midnight. The 8 hours of care must be predominately nursing care provided by either a registered nurse or a licensed practical nurse.

The Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT) means a federally mandated program that provides comprehensive and preventive health care services for children age birth through 20 years who are enrolled in Traditional Medicaid.

General inpatient care day means a day when a member with elected hospice care receives general inpatient care for pain control or acute or chronic symptom management that is not manageable in their place of residence or another outpatient setting.

Hospice agency means an agency licensed under the provisions of Rule R432-750 and is primarily engaged in providing hospice care to terminally ill individuals.

Hospice care services means an approach to caring for terminally ill members that stresses palliative care as opposed to curative care. In addition to meeting the member's medical needs, hospice care services address the physical, psychosocial, and spiritual needs of the member, as well as the psychosocial needs of the member's family/caregiver. The emphasis of hospice care services is on keeping the member at home with family and friends as long as possible.

Inpatient respite care day means a day when a member with elected hospice care receives short-term inpatient care necessary to relieve family members or other persons caring for the member at their place of residence.

Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care addresses physical, intellectual, emotional, social, and spiritual needs while facilitating patient autonomy, access to information, and choice.

Pediatric means a member who is under 21 years of age.

Pediatric hospice agency means an enrolled hospice agency that has trained employees in providing hospice care to patients who are younger than 21 years of age.

Representative means an individual who has been authorized under state law to make health care decisions on behalf of the member, including initiating, continuing, refusing, or terminating medical treatments for a member who cannot make the decisions for themselves.

Terminally ill means a medical prognosis to live no more than 6 months if the illness runs its ordinary course.

8-2 Nursing facilities or Intermediate Care Facilities for people with Intellectual Disabilities (ICFs/ID)

When an individual residing in a nursing facility or ICF/ID elects hospice care, the hospice and the facility must enter into a written agreement which defines the roles and responsibilities of each entity. The hospice agency is responsible for professional management of the member's hospice care and the facility agrees to provide room and board. Room and board include all services typically administered in a nursing facility, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a member's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.

An agreement between the hospice agency and the nursing facility must include the requirements found in 42 CFR 418.112.

For a member receiving hospice care, while residing in a nursing facility, it is the responsibility of the hospice agency to notify the nursing facility of a hospice revocation per 42 CFR 418.28. The notice must be in writing and the hospice agency must provide it to the nursing facility on or before the revocation date.

Hospice agencies are reimbursed in accordance with the methodology found in the State Plan for members residing in nursing facilities and ICF/ID.

The hospice agency will receive its routine daily rate plus an allowance for the facility's room and board:

1. For adults, the room and board allowance is 95% of the facility's Medicaid per diem rate for each hospice member in that facility. If there is no per diem rate available for the facility, the room and board allowance is 95% of the statewide average.
2. For EPSDT members, reimbursement is 100% of the Medicaid per diem rate. If there is no per diem rate available for the facility, the room and board allowance is 100% of the statewide average.

The hospice agency receives Medicaid's payment and must, in turn, reimburse the facility for room and board. The facility cannot bill Medicaid separately.

8-2.1 Member cost of care contributions

When a hospice member in a nursing facility has a monetary obligation to contribute to their cost of care in the facility, the facility will continue to collect and retain the contribution the same as for a non-hospice nursing facility member.

The hospice agency will bill Medicaid for the room and board at the daily per diem rate of that nursing care facility.

8-3 General inpatient care

Short-term general inpatient (GIP) care in a participating hospice inpatient unit, hospital, skilled nursing facility, ICF/ID, or other long-term care facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be necessary for pain control, or acute, or chronic symptom management which cannot be provided in a home or other outpatient setting. A member's preference to die in a hospital or in another inpatient setting is not an allowable criterion for GIP care. GIP may not be used due to the breakdown of the primary caregiver's living arrangements or the collapse of other sources of support for the member.

8-4 Respite

Inpatient respite care is an option that may be furnished for up to 5 consecutive days at a time to provide short term relief for the family members or others that are caring for the member at home. Inpatient respite care is not available to members who are residents of nursing facilities, ICFs/ID, or freestanding hospice inpatient units. Clinical notes must reflect that this need clearly exists, and that inpatient respite care is not being used for any other purpose such as for work or schooling for the caregiver.

8-5 Medical supplies and durable medical equipment

Medical supplies and equipment, used primarily for the relief of pain and symptom control related to the terminal illness are covered under hospice care services. Medical supplies must be included in the written plan of care. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the member's terminal illness. Equipment is provided by the hospice for use in the patient's home while they are under hospice care.

8-6 Home health aide and homemaker services

Home health aide and homemaker services furnished by qualified aides; home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by

the member, such as changing the bed, or light cleaning and laundering essential to the comfort and cleanliness of the member. Aide services must be provided under the general supervision of a registered nurse.

8-7 Physical therapy, occupational therapy, and speech-language pathology

Physical therapy, occupational therapy, and speech-language pathology services provided for purposes of symptom control or to enable the member to maintain activities of daily living and basic functional skills are covered under hospice care services.

8-8 Continuous home care

Continuous home care is provided only during a period in which a member requires at least 8 aggregate hours of primarily nursing care in a 24-hour day in order to manage an acute medical crisis and to maintain the member at home (a 24-hour day begins and ends at midnight). The 8 aggregate hours of care must be predominately (more than half) comprised of nursing care provided by either a registered nurse or licensed practical nurse. Homemaker and aide services may also be provided to supplement the nursing care.

Extended stay residents of nursing facilities are not eligible for continuous home care services.

8-9 Access requirements

Hospice care services must meet the requirements relating to certification of terminal illness and the member's election of hospice care, as described in this chapter.

8-9.1 Certification of terminal illness

The hospice agency must obtain written certification by an attending physician that a member is terminally ill. The certification of a terminal condition must be based on a face to face encounter by an attending physician conducted no more than 15 calendar days prior to the effective date of hospice election Hospice agencies are not reimbursed for hospice care until the physician's certification is complete.

Underlying conditions may not be used as qualifying terminal diagnoses for hospice care. Hospice agencies must use ICD-10-CM coding guidelines and code first the condition determined by the certifying physician to be the most contributory to a prognosis of 6 months or less. A diagnosis of debility or failure to thrive in adults does not meet eligibility criteria for the coverage of hospice care services. Underlying conditions can be reported as other diagnoses contributing to the prognosis of 6 months or less.

If written certification is not obtained within 2 calendar days following the initiation of hospice care, a verbal certification may be made within 2 days following the initiation of hospice care, with a written certification not later than 30 days after care is initiated.

8-9.2 Election of hospice

Election statements are designed and supplied to members by hospice agencies and must include the following elements:

1. Identification of the specific hospice that will provide the hospice care,
2. The member’s (or legal representative’s) acknowledgment that they have been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the member’s terminal illness,
3. For adult members, acknowledgment that the member waives certain Medicaid services,
4. The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement,
5. Information on individual cost-sharing for hospice services,
6. Notification of the individual’s (or legal representative’s) right to receive an election statement addendum, as set forth by 42 CFR 418.24 (c), if there are conditions, items, services, and drugs the hospice has determined to be unrelated to the individual’s terminal illness and related conditions and would not be covered by hospice,

7. Acknowledgment that the member (or legal representative) may revoke the election of the hospice benefit at any time in the future. Adults must also acknowledge that revocation of hospice benefits will result in restoration of Medicaid benefits that were waived at the time of hospice election,
8. Information on the beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), including the right to immediate advocacy and BFCC-QIO contact information, and
9. Signature of the member or legal representative.

Pediatric hospice agencies must have distinct election statements designed specifically for members under 21 years of age. This election statement must inform pediatric members and their legal representatives that by electing hospice care:

1. They do not forfeit curative care that would otherwise be available to them through the Medicaid State Plan.
    a) Only services that are not part of the hospice rate can be billed separately. This election statement must also inform them that upon turning 21 years of age, they will no longer have concurrent care benefits and will be subject to the rules governing adults who have elected Medicaid hospice care.

If the member is not physically or mentally capable, or if the member is under 18 years of age, an election statement may also be filed by a representative authorized by state law to elect or revoke hospice care or terminate medical care on behalf of a terminally ill individual.

Medicaid payment for hospice care is not available prior to the day that the election was filed. The effective date of the election may be the first day of hospice care or a later date but may be no earlier than the date of the election statement.

An election to receive hospice care remains effective through the initial election period and through the subsequent election periods without a break in care as long as the patient:

1. Remains in the care of a hospice,
2. Does not revoke the election, and
3. Is not discharged from the hospice.

A member may elect to receive hospice care during one or more of the following election periods:

1. An initial 90-day period,
2. A subsequent 90-day period, or
3. An unlimited number of subsequent 60-day periods.

8-9.3 Dual eligibility

A member dually enrolled in Medicare and Medicaid must elect the hospice benefit for both Medicare and Medicaid in accordance with 42 CFR 418.21 and 418.24. The member must receive hospice coverage under Medicare primarily. Election for the Medicaid hospice benefit provides the member coverage for Medicare coinsurance and room and board expenses while admitted to a Medicare-certified nursing facility, intermediate care facility for people with an intellectual disability (ICF/ID), or freestanding hospice facility.

8-9.4 Rights waived to some Medicaid services for adult members

Medicaid does not separately cover modalities for palliative purposes as this is the responsibility of the hospice agency. For the duration of an election for hospice care services, an individual waives rights to Medicaid payments for the following services:

1. Hospice care provided by a hospice agency other than the hospice agency designated by the individual (unless provided under arrangements made by the designated hospice agency).
2. Coverage of services for illnesses or conditions unrelated to the member's terminal illness is non-covered through the hospice benefit.
    a) Such services are covered ancillary to hospice benefits when provided by an appropriate provider or facility.

3. Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected, or a related condition, or that are equivalent to hospice care except for services provided by:
    a) The designated hospice agency,
    b) Another hospice agency under arrangements made by the designated hospice agency, and
    c) The individual's attending physician if that physician is not an employee of the designated hospice agency or receiving compensation from the hospice agency for those services.

8-9.5 Concurrent care for members under 21 years of age

For the duration of the election of hospice care, pediatric members may only receive hospice care that is:

1. Provided by the designated hospice agency, or
2. Provided under arrangements made by the designated hospice agency.

Pediatric members who elect to receive hospice care services may also receive concurrent Medicaid State Plan services for the terminal illness and other related conditions.

Medicaid does not separately cover any modalities for palliative purposes as this is the responsibility of the hospice agency.

1. Services provided outside of the hospice benefit shall be reported directly to Medicaid for coverage.
2. Hospice agencies are not responsible for reimbursing other providers or facilities for life-prolonging services rendered to pediatric members.

Hospice agencies performing pediatric care shall develop a training curriculum to ensure that the hospice's interdisciplinary team members, including volunteers, are adequately trained to provide hospice care services. Staff members and volunteers who provide pediatric hospice care services shall receive training before providing hospice services and at least annually thereafter.

1. The training shall include the following pediatric-specific elements:
    a) Growth and development,
    b) Pediatric pain and symptom management,
    c) Loss, grief, and bereavement for pediatric families and the child,
    d) Communication with family, community, and interdisciplinary team,
    e) Psycho-social and spiritual care of children,
    f) Coordination of care with the child's community,
    g) Medicaid adopts the National Hospice and Palliative Care Organization's (NHPCO) standards for pediatric hospice services.

A plan of care must be established by the interdisciplinary group. At least one of the persons involved in development of the initial plan must be an appropriately licensed practitioner acting within their scope of practice. The plan of care must be consistent with the hospice philosophy of care. This plan must be established on the same day as the face to face assessment and certification if the day of assessment and certification is to be a covered day of hospice care.

8-9.6 Revocation of hospice benefits

The member (or legal representative) may revoke the election of hospice care at any time. To revoke the election of hospice care, the member or representative must give the hospice a signed statement revoking the election of hospice care for the remainder of that election period with the date revocation is to be effective. The individual forfeits the remainder of the election period. Signed statements must include the following information:

1. A signed statement that the member or representative revokes the member's election for Medicaid coverage of hospice care,
2. The date that the revocation is to be effective, which may not be earlier than the date that the revocation is made, and

3. An acknowledgment signed by the patient or the patient's representative that the patient will forfeit Medicaid hospice coverage for any remaining days in that election period.

Upon revocation of the election of Medicaid coverage of hospice care for a particular election period, a member:

1. Is no longer covered under Medicaid for hospice care,
2. Resumes Medicaid coverage for the benefits waived (for adult members), and
3. May at any time elect to receive hospice coverage for any other hospice election periods that they are eligible to receive.

Hospice agencies may not encourage adult members to temporarily revoke hospice care services solely for the purpose of avoiding financial responsibility for Medicaid services that have been waived at the time of hospice election.

8-9.7 Change in hospice agency

A member or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received. The change of the designated hospice is not a revocation of the election for the period in which it is made. To change the designation of a hospice agency, the member must file a statement with the hospice agency from which care has been received and with the newly designated hospice agency on or before the effective date of the change. The statement must include the following information:

1. The name of the hospice agency from which the member has received care,
2. The name of the hospice agency from which the member plans to receive care, and
3. The date the change is to be effective.

8-9.8 Provider initiated discharge from hospice care

Hospice agencies may not initiate discharge of a patient from hospice care except in the following circumstances:

1. The member moves out of the hospice agency's geographic service area or transfers to another hospice agency by choice.
2. The hospice agency determines that the patient no longer meets the eligibility criteria for hospice.
3. The hospice agency determines that the member's behavior (or the behavior of other persons in the patient's home) is disruptive, abusive, or uncooperative to the extent that delivery of care to the member or the ability of the hospice to operate effectively is seriously impaired. This type of discharge is called "for cause." When it becomes necessary to discharge for cause, the following steps must be taken prior to discharge:
    a) Advise the member that a discharge for cause is being considered,
    b) Make a diligent effort to resolve the problem(s) that the patient's behavior or situation presents,
    c) Ascertain that the discharge is not due to the member's use of necessary hospice care services, and
    d) Document the problem and efforts to resolve the problem in the member's medical record.

Before discharging a patient for any reason, the hospice agency must obtain a physician's written discharge order from the hospice agency's medical director. If a patient also has an attending physician, the hospice agency must consult the physician before discharge and the attending physician must include the review and decision in the discharge documentation.

A member, upon discharge from the hospice during a particular election period, for reasons other than immediate transfer to another hospice:

1. Is no longer covered under Medicaid for hospice care,
2. Resumes Medicaid coverage of the benefits waived during the hospice coverage period; (for adult members), and

3. May at any time elect to receive hospice care if the member is again eligible to receive the benefit in the future.

The hospice agency must have in place a discharge planning process that considers the prospect that a patient's condition might stabilize or otherwise change if that patient cannot continue to be certified as terminally ill. The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because the patient is no longer terminally ill.

If the hospice agency or Medicaid determines that a member is not terminally ill while receiving hospice care under this manual, the member is not responsible to reimburse Medicaid. If Medicaid denies reimbursement to the hospice agency, the hospice agency may not seek reimbursement from the member.

8-9.9 Notifications

The hospice agency is responsible for notifying Medicaid whenever a member is enrolled in hospice care, whenever a member is discharged from hospice care, whenever a member moves into a nursing facility, intermediate care facility for people with intellectual disabilities (ICF/ID), or freestanding inpatient hospice facility, or whenever there has been a change in hospice agencies. When any of these events occurs, the hospice agency must submit the following applicable documents to Medicaid within 10 calendar days:

1. A completed Hospice Admission Record Request, a copy of the signed election statement, a copy of the initial plan of care when a member becomes retroactively eligible for Medicaid and hospice care, and a copy of the physician’s certification statement whenever a member is enrolled in hospice care and for each election period thereafter,
2. A copy of the completed Hospice Admission Record Request and revocation statement whenever a member chooses to revoke hospice benefits,

3. A copy of the member’s written statement at the time of a change to a different hospice agency, and
4. A copy of the completed Hospice Admission Record Request indicating the effective date of the discharge. If the discharge is “for cause,” providers must attach a copy of the written discharge order signed by the hospice agency’s medical director. Providers must also send to DIH a written summary describing the “for cause” reason of discharge and any supporting documentation to show that the provider satisfied the required steps prior to discharging the member from hospice care.

9 Non-covered services and limitations

Coverage of services for illnesses or conditions unrelated to the member’s terminal illness, is non-covered through the hospice benefit, rather, such services are covered ancillary to hospice benefits when provided by an appropriate provider or facility.

Hospice agencies are not permitted to engage in unsolicited direct marketing to prospective members. Hospice agencies are free and welcome to engage in marketing strategies such as mass outreach and advertisements but are not permitted to approach a prospective member or legal representative unless the member or legal representative explicitly requests information from a particular hospice agency. Hospice agencies must refrain from offering incentives or other enticements to persuade a prospective member to choose that provider for hospice care.

10 Prior authorization

All enrollments into hospice care services, excluding room and board, must be prior authorized.

Prior authorization can only be approved for the duration of defined election periods. The hospice agency shall maintain documentation to support the requirement that the service provided was medically necessary and complied with an established plan of care.

To request hospice services, the hospice agency must submit a Hospice Admission Record Request through PRISM. The request must include the elections statement, the certification of terminal illness, and clinical records supporting the hospice election, including plan of care.

A hospice agency may begin service for a new Medicaid hospice member for a grace period up to 10 calendar days before submitting the Hospice Prior Authorization Request Form to Medicaid. This is known as the prior authorization grace period. Hospice requests may be approved no more than the 10 days prior to the date a complete hospice request is received.

Post-payment for hospice care services will follow the criteria outlined in the Section I: General Information Manual, Chapter 10-3, Retroactive authorization, while a member is in Medicaid pending status.

In order to claim service intensity add-on (SIA) payments for direct face-to-face services rendered by a registered nurse or social worker during the last 7 days of a patient's life, hospice agencies must submit the Post-Authorization Request for Service Intensity Add-On Form to Medicaid before the end of 180 calendar days following the patient's death. Along with the required form, hospice agencies must also submit copies of nursing and social worker notes for the dates of service listed and any other records that document the amount of time requested. Each face to face encounter must be reported with start and end times, which may require listing multiple service lines for each of the possible 7 dates of service.

11 Billing

For general information related to billing Medicaid refer to Chapter 11, Billing Medicaid, of the Section I: General Information provider manual for additional billing instructions.

Billing instructions

Hospice agencies will bill the room and board for NFs or ICFs/ID in the same manner as for other hospice care services on a CMS 1500 or UB-04. Hospice providers are also

required to report the location of where services are rendered to ensure appropriate payment.

1. For electronic billing of the 837 professional claim, complete the service facility location name, 2310C loop.
2. For claims submitted on a paper CMS 1500 form, report the service facility location information in boxes 32, 32a, and 32b.

12 Coding

Hospice providers should use the following codes when reporting hospice care services:

1. T2042 Routine home care - daily (the same code applies to the higher base rate and the lower base rate)
2. T2043 Continuous home care – hourly (minimum of 8 hours)
3. T2044 Inpatient respite care - daily
4. T2045 General inpatient care - daily
5. T2046 Long-term care facility room and board - daily
6. G0155 Service Intensity Add-on – per quarter hour (maximum of 4 hours per day)

13 Reimbursement

Medicaid must provide payment for hospice care in accordance with the methodology set forth in the Utah Medicaid State Plan.

13-1 Hospice care rates

Hospice care services (including room and board) are reimbursable to the hospice agency. Medicaid payments for hospice care services are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. However, Medicaid will not apply the aggregate caps used by Medicare. The rates will be based on the Medicare rates for Utah which are unique to each geographic region in the state. Providers should bill the rate that

applies to the geographic region where the member resides, not the geographic region of the provider's address.

Medicaid establishes reimbursement rates for the following categories:

1. Routine home care,
    a) Room and board is reimbursed separately from the routine home care rate when a member resides in a nursing facility, ICF/ID, or freestanding hospice inpatient units.
    b) Service intensity add-on is also reimbursed separately from the routine home care rate.
2. Continuous home care,
3. Inpatient respite care, and
4. General inpatient care.

Reimbursement is made for only one of the categories of hospice care listed above for any day.

Additional information on hospice care rates and date of discharge reimbursement can be found in 42 CFR 418.302 Payment procedures for hospice care., Utah Administrative Rule R414-14A-6 Reimbursement, or Utah Medicaid State Plan Attachment 4.19-B page 28.

13-2 Physician services

Reimbursement to an independent attending physician will be made in accordance with the usual Medicaid reimbursement methodology for physician services and is not based on whether the services are for the terminal illness or an unrelated condition.

Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

The hospice should notify the Division of Integrated Healthcare of the election and the name of the physician who has been designated as the attending physician whenever the attending physician is not a hospice employee.

Residents of nursing facilities, ICFs/ID, or freestanding inpatient hospice units are not eligible to receive in-home physician visits.

13-3 Services not related to terminal illness

If a member seeks medical treatment for illnesses or conditions that are not related to the member's terminal illness, this type of treatment is covered by Medicaid in the usual and customary manner when rendered by an appropriate Medicaid provider (not the hospice agency).

For coordination of care purposes, hospice agencies should be notified whenever a member or a member's representative wishes to seek any medical treatment beyond that which is included in the hospice plan of care.

13-4 Medicaid managed care entities and hospice

If a Medicaid-only member is enrolled in a Medicaid Managed Care Entity (MCE), the hospice selected by the member must have a contract with the MCE. The MCE is responsible to reimburse the hospice for hospice care. Medicaid will not directly reimburse a hospice agency for a Medicaid-only member covered by an MCE.

If a Medicaid-only member enrolled in an MCE elects hospice care before being admitted to a nursing care facility, ICF/ID, or a freestanding hospice inpatient unit, the MCE is responsible to reimburse the hospice agency for both the hospice care and the room and board until the member is disenrolled from the MCE by Medicaid. At the point a determination is made as to whether the enrollee will require care in the nursing facility for greater than 30 days, the MCE will notify Medicaid of the prognosis of extended nursing facility services. Medicaid will schedule disenrollment from the health plan to occur in accordance with the terms of the health plan contract for care provided in skilled nursing facilities.

If a hospice enrollee is covered by Medicare for hospice care, the Medicaid MCE is responsible for the health plan's payment rate less any amount paid by Medicare. The MCE is responsible for payment even if the Medicare covered service is rendered by an out-of-plan provider or was not authorized by the MCE.

The health plan is responsible for room and board expenses of a hospice enrollee receiving Medicare hospice care while the member is a resident of a Medicare-certified nursing facility, ICF/ID, or freestanding hospice facility until the member is disenrolled from the MCE by Medicaid. At the point Medicaid determines that the enrollee will require care in the nursing facility for greater than 30 days, Medicaid will schedule disenrollment from the MCE to occur in accordance with the terms of the health plan contract for care provided in skilled nursing facilities.

The hospice agency is responsible for determining if an applicant for hospice care is covered by a Medicaid MCE prior to enrolling the member, for coordinating services and reimbursement with the MCE during the period the member is receiving the hospice benefit, and for providing notification when the member will be admitted to a nursing facility for a period anticipated to be greater than 30 days.

14 Resource table

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

For information regarding:	
Administrative Rules	Utah Administrative Code Table of Contents Utah Administrative Code, Title R414-1, Utah Medicaid Program Utah Administrative Code, Title R432-750, Hospice Rule Utah Administrative Code, Title R414-14A-5. Hospice Care. Service Coverage.
General information including: Billing Fee for service and managed care Member eligibility	Section I: General Information Claims Managed Care: Accountable Care Organizations

Prior authorization Provider participation	Utah Medicaid Prior Authorization Administrative Rules: Eligibility Requirements. R414-302. Medicaid General Provisions. R414-301. Program Benefits and Date of Eligibility. R414-306. Utah Medicaid Program. R414-1.
Information including policy and rule updates: Medicaid Information Bulletins (MIB) (Issued bimonthly) Medicaid provider manuals Utah State Bulletin (Issued on the 1st and 15th of each month)	Utah Medicaid Official Publications Utah State Bulletin
Medicaid forms including: Hospice Independent Physician Review for Extended Care Form Hospice Post-Authorization Form Service Intensity Add-On (SIA) Form Hospice Admission Record Request	Utah Medicaid Forms
Medical supplies and DME	Medical Supplies And Durable Medical Equipment Provider Manual Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70.
Modifiers	Section I: General Information
Patient (member) eligibility lookup tool	Eligibility Lookup Tool
Prior authorization	Utah Medicaid Prior Authorization

	Hospice Admission Record Request
Provider portal access	Provider Portal Access
Provider training	Utah Medicaid Provider Training
References including: Social Security Act Code of Federal Regulations Utah Code	Social Security Act 1905(a) Social Security Act 1861 42 CFR 418.309 Hospice Aggregate Cap 42 CFR 418.112 Condition of Participation Utah Annotated Code Title 58

Utah Medicaid Provider Manual

Hospital Services

Division of Integrated Healthcare

Updated November 2024

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1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, noting the specific link that is not working and the page number where the link is.

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General information.

1-1 Hospital services

Hospital services are available to eligible Medicaid members with surgical, medical, diagnostic, or level of care needs that require the availability of specialized diagnostic and therapeutic services, and close medical supervision of care and treatment directed toward maintenance, improvement, or protection of health or lessening of illness, disability or pain.

For documenting admission and length of stay, the day of admission to an acute care hospital facility is counted as a full day stay, and the day of discharge is not counted.

2 Health plans

For more information about Accountable Care Organizations (ACOs), refer to Section I: General Information, Chapter 2, Health plans.

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information, Chapter 2-1.2, Prepaid Mental Health Plans, and the Managed Care Manual.

A list of ACOs and PMHPs with which Medicaid has a contract to provide health care services is found on the Medicaid website Managed Care: Accountable Care Organizations.

3 Provider participation and requirements

Refer to Section I: General Information, Chapter 3, Provider participation and requirements.

4 Record keeping

Refer to Section I: General Information, Chapter 4, Record keeping.

5 Provider sanctions

Refer to Section I: General Information, Chapter 5, Provider sanctions.

6 Member eligibility

Refer to Section I: General Information, Chapter 6, Member eligibility, for information about verifying a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member responsibilities

For information on member responsibilities, including establishing eligibility and co-payment requirements, refer to Section I: General Information, Chapter 7, Member responsibilities.

8 Programs and coverage

All hospital inpatient and outpatient services are subject to review by the Department of Health and Human Services and Division of Integrated Healthcare, Office of Healthcare Policy and Authorization (OHPA) for medical necessity and appropriateness of the admission according to R414-1-12 Utilization Review and R414-1-14 Utilization Control.

8-1 Emergency services program for non-citizens

For information on federal regulations, criteria, documentation, and billing, refer to Section I: General Information, Chapter 8, Emergency services program for non-citizens.

8-2 Pharmacy services

For more information on Pharmacy services, refer to Utah Administrative Code R414-60. Medicaid Policy for Pharmacy Program, and the Pharmacy Services Provider Manual.

8-3 Organ transplant services

Organ transplantation services are covered Medicaid services as specified in Utah Administrative Code. R414-10A. Transplant Services Standards.

8-4 Modifiers

Refer to Section I: General Information, Chapter 12-7.3, Modifier used in a claim.

8-5 Complications due to non-covered non-authorized services

Medically necessary services resulting from complications of non-covered or non-authorized procedures are covered, as appropriate within all other applicable rules and regulations.

8-6 Inpatient hospital intensive physical rehabilitation services

Inpatient hospital intensive physical rehabilitation is an intense physical rehabilitation program provided in an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital.

Inpatient intensive physical rehabilitation services are covered for acute conditions from birth through any age and are available one time per event.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible members with chronic conditions may be considered for age-appropriate developmental training. All services are subject to post-payment review by the Office of Inspector General (OIG).

Inpatient intensive physical rehabilitation services are intended to provide the therapy necessary to allow the patient to function without avoidable follow-up outpatient therapy. Therefore, the hospital should provide the maximum therapy services the patient could receive under the Diagnosis Related Group (DRG). Outpatient therapy services requested following inpatient intensive physical rehabilitation services in which the maximum therapy services were not provided, and those services could have been appropriately provided in the inpatient setting, will not be approved without the appropriate committee review.

8-6.1 Non-covered services with limitations

Rehabilitation services are non-covered when:

1. The patient's condition and prognosis meet the requirements of placement in a long-term facility, skilled nursing facility, or outpatient rehabilitation service.
2. The admission is for deconditioning (e.g., cardiac, or pulmonary rehabilitation).

8-6.2 Medical necessity documentation

The clinical record must be maintained on file in accordance with any federal or state law or state administrative rule and made available for state or federal review upon request. Based on CMS and other documentation guidelines, a patient admitted for inpatient intensive physical rehabilitation, the medical record should support the admission as reasonable and necessary. The following items and the information contained in the Quick Reference for Rehabilitation Services table will assist in supporting the admission; however, providers should adhere to all applicable standards in preparing medical documentation:

1. If it is the first admission for this medical event.
2. Appropriate standardized measurement tool scores, including an audiology record for admission, that include speech-language pathology services.
3. The member requires rehabilitation evaluation and management services of intensity, frequency, and duration that qualify them for

inpatient rehabilitation, based on the FIM score or Primary Children's Medical Center score (for EPSDT eligible patients), and other appropriate measurement tools (e.g., ASIA score, Rancho score, Disability Rating Scale (DRS), Walking Index for Spinal Cord Injury (WISCI), Agitated Behavior Scale (ABS) or other equivalent standardized measurement tool scores).

4. The member is medically/surgically stable and requires 24-hour nursing care or supervision by a registered nurse with specialized training in rehabilitation.
5. The member has a reasonable expectation of improvement in activities of daily living appropriate for chronological age and development that will be of significant functional improvement when measured against the member's documented condition at the time of the initial evaluation.
6. The member is mentally and physically ready to learn adaptive techniques, transfer skills, and equipment use appropriate for the level of injury.
7. The member's physical, cognitive, and sensory capacity allows active and ongoing participation in intense, multiple therapy disciplines (physical, occupational, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy, designed to restore function rather than maintain existing function.
8. The generally accepted standard by which the intensity of these services is typically demonstrated in an inpatient intensive physical rehabilitation hospital is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However, this is not the only way that such intensity of services can be demonstrated. The intensity of services may vary. For example, a patient admitted for a hip fracture and undergoing chemotherapy for an unrelated issue may have less intense therapy on those days chemotherapy is administered (Also refer to the CMS Brief Exceptions Policy).

8-6.3 Quick Reference for Rehabilitation Services

Diagnosis	Disease-specific documentation
Spinal injury resulting in paraplegia	The patient has paralysis of two limbs or half of the body related to trauma or disease of the spinal cord. The ASIA score or other standardized measurement tool score must be present in the medical record. May be complicated by: 1. Pressure sores 2. Urological complications (e.g., UTI, dysreflexia) 3. Respiratory complications 4. Contractures 5. Spinal/skeletal instability
Spinal injury resulting in quadriplegia	The patient has paralysis of all four limbs. The ASIA score or other standardized measurement tool score must be present in the medical record. It may be complicated by: 1. Pressure sores 2. Urological complications (e.g., UTI, dysreflexia) 3. Respiratory complications 4. Contractures 5. Spinal/skeletal instability

Traumatic brain injury	The Rancho Classification scale must be in the medical record and must have two or more neurological deficits documented: 1. Dysphagia 2. Dysphasia 3. Paralysis 4. Visual disturbances 5. Cognitive deficit Note: Documentation of well-defined treatment goals for functional improvement. The patient is an evolving Rancho 3 or Rancho 4-6 with behavior management issues.
Stroke (cardiovascular accident)	Treatment must begin within 60 days after onset of stroke, and: 1. The patient has sustained focal neurological deficit. 2. The rehabilitation service is for a separate focal CVA site than a previous admission
Other conditions which may require an intensive inpatient rehabilitation program:	Patients with other conditions must have physical impairment secondary to various problems such as trauma, surgery, chronic disease, and malnutrition. The combination of factors can be expected to improve with a comprehensive physical restoration program. The FIM score or the Primary Children's Medical Center score must be in the record. In addition, other standardized measurement tool scores may be required depending on the diagnosis.
Neurological Defect:	

1. Amyotrophic lateral sclerosis (ALS) **2. Guillain-Barre Syndrome**	
Other Conditions	
Neurological disorders: **1. Multiple Sclerosis** **2. Myelopathy (transverse myelitis infarction)** **3. Myopathy** **4. Parkinson's Disease**	
Congenital deformity (e.g., following dorsal rhizotomy)	
Complex fractures (e.g., hip) or fracture with complicating condition	
Amputation with complication or multiple amputations	The patient must have been mobile before the injury. Supportive documentation must substantiate a rehabilitation stay will be beneficial to the patient. The stump must be healed so that the patient can accomplish physical therapy and rehabilitation education.
Post neurosurgery of brain or spine (e.g., tumor)	Must have a complicated medical condition requiring a physician's close medical supervision with a resulting muscular-skeletal deficit.
Burns	Disability due to burns involving at least 15% of the body
Major multiple trauma (e.g., fractures, amputation)	
Post meningoencephalitis	

8-6.4 Multidisciplinary treatment team

The multidiscipline treatment team may consist of:

1. A rehabilitation physician with specialized training and experience in rehabilitation services.
2. A registered nurse with specialized training or experience in rehabilitation.
3. A social worker or a case manager (or both).
4. A licensed or certified therapist from each therapy discipline involved in treating the member.

Each member of the treatment team must have current patient knowledge as documented in the medical record at the inpatient intensive physical rehabilitation hospital. A rehabilitation physician responsible for making the final decisions regarding the member’s treatment plan in the inpatient intensive physical rehabilitation hospital leads the team.

Within five days of the member's admission to the facility, the following should be complete and documented in the members' medical record:

1. The team evaluation;
2. An estimated length of stay; and
3. Initiation of appropriate discharge planning, including home care assessment.

8-6.5 Billing for inpatient rehabilitation services

Providers submitting claims for inpatient rehabilitation services must report those services per the Medicaid policies in place on the date of discharge. As with all Medicaid policies, this requires providers to know changes in the reporting requirements on the date of discharge, which may vary from the policies in effect on the date of admission.

8-7 Co-payment requirements for hospital services

The Medicaid program may require certain members to pay for services or benefits, referred to as cost-sharing. Cost-sharing amounts may include such items as premiums, deductibles, coinsurance, or co-payments.

Refer to Utah State Plan Attachments 4.18-A through H for additional cost-sharing information.

8-8 Emergency department coverage

The "emergency" designation is based on the principal diagnosis (ICD-10-CM code). The diagnosis primarily responsible for the patient's outpatient service must appear as the principal diagnosis on the claim.

8-9 Ambulatory surgical centers coverage and reimbursement

Ambulatory surgical centers are reimbursed as outlined in the Utah State Plan.

Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

8-10 Laboratory services

CLIA requires entities that perform even one test, including waived tests, to meet certain federal requirements and obtain the appropriate level of certification. If an entity performs laboratory tests, they must register with the CLIA program and can only perform those tests as authorized by their level of certification.

CMS has made available the Clinical Laboratory Improvement Amendments (CLIA) Application For Certification form, CMS-116.

The form should be completed and mailed to the address listed.
Unified State Laboratories:
Public Health Bureau of Laboratory Improvement
4431 South 2700 West
Taylorsville, UT 84129

CLIA regulations require all facilities that perform waived and non-waived testing, to file a separate application for each facility location. Each CLIA certificate represents a facility, and each facility is responsible for complying with the applicable CLIA

requirements. Refer to 42 CFR §493.35(a), §493.43(a) and §493.55(a) for additional information.

Additional information about CLIA and other laboratory services may be found in the Physicians Services Manual, Chapter 8-11, Laboratory services.

8-10.1 Proprietary Laboratory Analysis codes

In accordance with the American Medical Association (AMA) coding guidelines, Proprietary Laboratory Analysis (PLA) codes for propriety laboratory services must be reported, when available, in place of corresponding CPT codes. Do not report PLA codes with corresponding CPT codes. If the PLA code is not available to be used by the billing laboratory, the CPT code should be billed.

8-11 Mental health services

Refer to Section I: General Information, Chapter 2, Prepaid Mental Health Plans, Utah Administrative Code R414-10. Physician Services, Utah Administrative Code R414-36. Behavioral Health Services, and the Behavioral Health Services Provider Manual.

8-11.1 Psychiatric hospitals considered Institutions for Mental Diseases (IMDs)

Admissions to psychiatric hospitals considered IMDs are covered when medically necessary, for up to 60 days, for members ages 21 through 64. No more than 60 calendar days will be authorized per treatment episode. If treatment exceeds 60 days, no part of the stay is eligible for reimbursement.

Enrollment, licensing and certification or accreditation requirements

Coverage of admissions to psychiatric hospitals requires the hospital to be:

1. Enrolled Medicaid providers.
2. Licensed by the Department of Health.
3. Have Medicare certification or be deemed Medicare-certified through accreditation by The Joint Commission.

Prepaid Mental Health Plans (PMHPs), Utah Medicaid Integrated Care (UMIC) Plans or the Healthy Outcomes Medical Excellence (HOME) Program

Inpatient psychiatric hospitalizations are covered through the PMHPs, UMIC Plans, or the HOME program and require prior authorization.

Medicaid fee for service prior authorization (PA) requirements

Psychiatric hospitals must obtain a PA as notification of admission.

The initial PA request must be submitted to the PA department no later than two business days after the admission date and may be approved for up to seven days.

Inpatient stays that exceed seven days require an additional PA.

For these PA requests, the psychiatric hospital must:

1. Submit the most pertinent and recent comprehensive documentation from the medical record for inpatient psychiatric hospital stays and continued stay reviews that must:
    a) Support medical necessity.
    b) Address evidence-based criteria.
    c) Specify the number of additional days being requested (maximum of up to seven days per request).
    d) Include the anticipated discharge date.
2. Submit each additional request to the PA department:
    a) No later than the first requested date of service indicated on the PA request.
    b) No earlier than four calendar days of and including the first requested date of service indicated on the PA request form.

The PA request form can be found at Psychiatric Hospital Inpatient Services, Individuals Age 21-64 Prior Authorization Request Form.

PA requests may be faxed to the PA Unit at (801) 323-1587, or emailed to mentalhealthservicesprior@utah.gov.

9 Non-covered services and limitations

Certain services are non-covered by Medicaid because medical necessity, appropriateness, and cost-effectiveness cannot be readily determined or justified for medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

For more information on non-covered services and limitations, see R414-2A. Inpatient Hospital Services, Rule R414-3A. Outpatient Hospital Services, Utah Administrative Code R414-1. Utah Medicaid Program, and Section I: General Information, Chapter 9, Non-covered services and limitations.

9-1 Limited abortion services

Refer to Section I: General Information, Chapter 9-1, Limited abortion services, and Utah Administrative Code R414-1B. Payment for Limited Abortion Services.

9-2 Experimental, investigational, or unproven medical practices

Refer to Section I: General Information, Chapter 9-3.3, Experimental, investigational, or unproven medical practices, and Utah Administrative Code R414-1A. Medicaid Policy for Experimental, Investigational or Unproven Medical Practices.

9-3 Sterilization and hysterectomy procedures

Sterilization and hysterectomy procedures are limited to those that meet the requirements of 42 CFR 441, Subpart F.

9-3.1 Voluntary sterilization

Voluntary sterilization means an individual decision made by the member, male or female, for voluntarily preventing conception for family planning.

1. Prior authorization must be obtained, by the surgeon, before the service are provided, refer to Utah Medicaid Prior Authorization.
2. The Sterilization Consent Form must be properly executed and submitted before the procedure is performed.

9-3.2 Sterilizations incident to surgical procedures

1. Prior authorization requirements must be met.
2. For hysterectomy procedures, a properly executed Utah Medicaid Hysterectomy Acknowledgement Form must be submitted for all hysterectomy procedures.
3. Refer to the Coverage and Reimbursement Code Lookup for specific codes which require the hysterectomy consent form.

9-4 Reconstructive and cosmetic services

For additional information, refer to Utah Administration Code R414-1-29. Medicaid Policy for Reconstructive and Cosmetic Procedures.

As defined in Utah Administrative Code R414-1-2 (18), medical necessity shall be established through evidence-based criteria.

9-5 Treatment of alcoholism or drug dependency

1. Inpatient hospital care for treatment of alcoholism or drug dependency is limited to medical treatment of withdrawal symptoms associated with drug or alcohol detoxification.
2. Outpatient continuing therapy for treatment of alcoholism or drug dependency must be accessed under the outpatient mental health or psychiatric services benefit as appropriate.
3. Drug and alcohol rehabilitation are not a covered service.

9-6 Inpatient only

Under the current Outpatient Prospective Payment System (OPPS), there are procedure codes that are designated as only payable on inpatient claims. Utah Medicaid follows Medicare's Addendum E to determine which codes are considered inpatient-only. Utah Medicaid may determine that procedures currently listed as inpatient-only may be provided in an outpatient hospital setting.

9-7 Provider Preventable Conditions

Medicaid will not reimburse inpatient hospital claims for Provider Preventable Conditions (PPC) as identified in claims processing. The MS-DRG Grouper identifies PPCs.

Under direction of the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) adopted the term Provider Preventable Condition for use in Medicaid, whereas Medicare retains the use of the term Hospital Acquired Condition (HAC) when describing certain provider preventable conditions for which payment would be prohibited.

To qualify as a PPC, one of the CMS listed HAC diagnoses must develop during the hospitalization. The same diagnoses present on admission are not PPCs. According to correct coding standards, providers must identify each diagnosis Present on Admission (POA) on the claim.

Providers should ensure that all PPC-related diagnoses, services, and charges are noted as “noncovered charges” on the claim. Non-covered charges are not used in calculating hospital reimbursement.

For rural hospitals, non-DRG reimbursed facility claims submitted with an identified HAC code and non-covered charges will be reimbursed. If there are no non-covered charges on the claim, the claim will be denied.

If a DRG reimbursed PPC-related claim results in an outlier payment, it will be denied and medical records will be required. Providers will receive a Remittance Advice (RA) confirming the occurrence of a PPC outlier claim and a request for medical records. Complete medical records for the hospital stay, an “Outlier PPC Medical Record Documentation Submission Form," and an itemized bill (tab de-limited text file or Excel spreadsheet) including a detailed listing of PPC-related charges as non-covered charges, with total charges matching the total charges submitted on the claim, must be submitted within 30 days of the RA notification. In addition, at the time of RA notification, a confirmatory communication may be generated reiterating the occurrence of a PPC and the need for submission of medical records and other required documentation for manual review and claims processing. If the medical

records are submitted within the 30-day period, the claim will be reviewed and, if appropriate, reprocessed and reimbursed. If medical records are not submitted within the 30-day period, the claim will be denied for failure to submit the requested documentation in a timely manner.

Non-outlier claims will continue to be denied with an edit that informs providers that the diagnosis was not Present on Admission (POA). Providers will have the opportunity to submit a corrected claim, selecting the appropriate POA indicator. If the correction is not made, the claim will remain denied.

Providers are required to report PPCs per CMS regulations and Utah Administrative Code R4141. Utah Medicaid Program and R414-2A. Inpatient Hospital Services.

9-8 Outlier days

Review of inpatient "outlier days" is limited to cases where the full payment of the DRG has been made to the hospital. The following exceptions apply:

1. Neonatal admissions assigned to DRG's 789, 790, 791 go into outlier status the day after admission. A length of stay of fewer than 20 days does not require review. Payment will automatically be calculated to include the outlier days.
2. If a case with a stay of fewer than 21 days is submitted in error, the entire case will be reviewed for the severity of illness and intensity of service.
3. When the stay for a Medicaid patient eligible for emergency services only goes into outlier days, the entire record must be submitted with a transmittal sheet for one review. The emergency circumstances and the outlier days can be evaluated in the same review, which benefits both the hospital and the agency.

9-9 Readmissions within 30 days of previous discharge

See Utilization Control and Review Program for Hospital Services in Utah Administrative Rule R414-2A. Inpatient Hospital Services, Rule R414-3A. Outpatient Hospital Services, and R414-112 Utilization Review.

9-10 Exceptions to the 30-day readmission policy

See Utilization Control and Review Program for Hospital Services in Utah Administrative Rule R414-2A. Inpatient Hospital Services, Rule R414-3A. Outpatient Hospital Services, and R414-112 Utilization Review.

9-11 Occupational therapy services

Limited to those cases identified and approved for children through an EPSDT screen, or a special group of services identified and approved through a cooperative occupational therapy/physical therapy program.

Refer to the Medicaid provider manuals for Early and Periodic Screening, Diagnostic and Treatment Services and Physical Therapy and Occupational Therapy Services.

9-12 Outpatient hospital services

Outpatient hospital services are limited to services that are medically necessary and appropriate for the outpatient setting. Under Utah Administrative Code R414-1-12 Utilization Review, utilization management review determines these services' medical necessity and appropriateness.

Reimbursement is limited to credentialed outpatient hospital departments. For information, refer to the Coverage and Reimbursement Code Lookup.

9-13 Outpatient hospital psychiatric services

Outpatient hospital psychiatric services are limited to services provided in an outpatient unit of a general acute care hospital that is licensed and approved for psychiatric care.

9-14 Hyperbaric oxygen therapy

Refer to Utah Administrative Rule R414-2A. Inpatient Hospital Services and Rule R4143A.Outpatient Hospital Services.

9-15 Non-covered services

Certain services are non-covered by Medicaid because medical necessity, appropriateness, and cost-effectiveness cannot be readily determined or justified for

medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

The general exclusions are listed below:

1. Provider preventable conditions (PPC) refer to Utah Administrative Rule R414-2A. Inpatient Hospital Services and Chapter 9-7.
2. Services rendered during a period the client was ineligible for Medicaid.
3. Services medically unnecessary or unreasonable.
4. Services that fail to meet existing standards of professional practice, which are currently professionally unacceptable, or which are investigational or experimental in nature (see note below).
5. Services requiring prior authorization, but for which such authorization was not requested, was not obtained, or was denied.
6. Services, elective in nature, and requested or provided only because of the client's personal preference.
7. Third-party payers are primarily responsible for reimbursing services, e.g., Medicare, private health insurance, and liability insurance. Medicaid may make a partial payment up to the Medicaid maximum if the third party has not reached this limit.
8. Services fraudulently claimed.
9. Services that represent abuse or overuse.
10. Services rejected or disallowed by Medicare when the rejection was based on any of the reasons set forth above.
11. When a procedure or service is not covered for any of the above reasons or because of specific policy exclusion, all related services and supplies, including institutional costs will be excluded from the standard post-operative recovery period.
12. Chemical peeling, dermabrasion, or laser therapy of the face.
13. Tattoo removal.
14. Certain services are excluded as family planning services:
    a) Surgical procedures for the reversal of previous elective sterilization, both male and female.
    b) Infertility studies.
    c) In-vitro fertilization.

d) Artificial insemination.
e) Surrogate motherhood, including all services, tests, and related charges.

15. Surgical procedures that are unproven or experimental are non-covered Medicaid services (see note below).

Note: Experimental, investigational, or unproven services do not include qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the "Consolidated Appropriations Act, 2021."

10 Prior authorization

Providers must verify prior authorization requirements before rendering services. The hospital claim must be submitted with the prior authorization number that was issued to the provider. Facility charges will not be paid when prior authorization is required and there is no valid prior authorization approval on file. For information regarding prior authorization, see Section I: General Information, Chapter 10, Prior authorization. Additional resources and information may be found on the Utah Medicaid Prior Authorization website.

For information on codes requiring prior authorization, manual review, or non-covered status, refer to the Coverage and Reimbursement Code Lookup.

10-1 Retroactive authorization

There are limited circumstances in which a hospital may request authorization after service is rendered. These limitations are described in Section I: General Information, Chapter 10-3, Retroactive authorization.

11 Billing

Refer to Section I: General Information, Chapter 11, Billing Medicaid, for more information about billing instructions.

Medicaid requires UB-04 inpatient and outpatient claims to be billed electronically. The Utah Medicaid agency will return UB-04 claims submitted on a paper form to the provider with a cover letter requesting the claim be submitted electronically.

11-1 Paper claim exceptions

Medicaid accepts paper UB-04 claims in three circumstances only:

1. UB-04 claims billed by out-of-state providers.
2. Dialysis claims.
3. Crossover claims where the Medicare carrier is out of state:
   a) When necessary and appropriate to file a paper claim, refer to the Utah Uniform Billing Instruction Manual.
   b) UB-04 Manual for the Utah Medicaid UB-04 Billing Instructions.

11-2 Electronic billing with AcClaim software

The Utah Health Information Network (UHIN) provides AcClaim software for billing UB-04 claims electronically. Providers who need AcClaim software and to be set up to bill through UHIN may call (801) 466-7705. Providers who need additional assistance may contact Medicaid Information, 801-538-6155, or toll-free 1-800-662-9651, and ask for Medicaid electronic billing support.

The Administrative Simplification Clause supports the requirement to bill electronically through UHIN in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). An advantage of electronic billing for providers is that mistakes, such as placement of the provider number, can be corrected immediately. In addition, because of the reduction in billing errors, claims are processed without delay. Providers can submit electronic claims until noon on Friday for processing that week.

11-3 Crossover claims with EOMB attachment

Medicaid processes crossover claims in two circumstances only:

1. Inpatient claim, Part B only. After Medicare pays the claim, it is processed as a Medicaid claim with the Medicare payment on the claim. Medicaid then pays the Part A (hospital) charges.
2. Out of plan claims such as mammography with the EOMB denial attached.

11-4 Manual adjustments accepted

When submitting a paper UB-04 claim as an adjustment to an original paid or denied claim, write the 17-digit transaction control number (TCN) of the original claim on the paper claim or write PAR (Payment Adjustment Request) on the claim. The claim will be adjusted to correct billing errors or add charges.

11-5 Inpatient hospital claims with third party insurance

Section I: General Information Provider Manual, Chapter 11, Billing third parties, states the general policy for patients who have liable third parties such as private insurance, a health maintenance organization, Medicare Part A and B or B only, or Qualified Medicare Benefits (QMB), in addition to Medicaid.

When a member with third party insurance receives inpatient hospital services, there are two clarifications to the general information. Refer to Section I: General Information Provider Manual, Chapter 11, Billing third parties, for additional information.

11-6 Outpatient and inpatient hospital revenue codes

Medicaid is following the national standard to require CPT codes to be listed with the revenue code. This standard will apply with the exception of the following revenue codes: 0360, 0361, 0451-0452, 0459-0460, and 0469, wherein CPT codes will not be required.

11-7 Reporting and billing covered and non-covered services for acute inpatient hospital claims

Correct coding guidelines encourage providers to include all delivered services on their claim submissions. Therefore, providers should include covered and non-covered services when submitting an acute inpatient hospital claim.

Due to the limitations of Utah's current Medicaid claims processing system, there are instances when an entire claim will deny as a result of a single denied line. For example, a claim is denied when a single line is a non-covered service. This can occur when a claim is submitted for a service requiring prior authorization, but the hospital or other provider did not obtain prior authorization.

To allow payment for covered services, when non-covered services have also been delivered, Medicaid requires acute inpatient hospitals to submit claims that include covered services and exclude non-covered services that would otherwise result in denial of the entire claim. In addition, when a claim is submitted that excludes non-covered services, providers must not include any ICD-10-PCS, CPT, HCPCS, or revenue codes related to the non-covered services.

For example, a member is admitted to an acute care hospital for labor and delivery and elects to have a sterilization procedure performed during the same episode of care. However, the provider does not have prior authorization for the sterilization. In this instance, the sterilization, and the associated services, are non-covered. The facility must exclude the non-covered services from the claim. Note: Providers must be familiar with and adhere to all federal regulations regarding sterilization requirements.

Additionally, if admission to an acute inpatient hospital is primarily to receive services not covered by Medicaid, all services performed for that episode of care are non-covered and will not be reimbursed. This policy applies regardless of whether or not Medicaid would have covered some of the services performed.

12 Coding

Refer to the Section I: General Information Provider Manual, Chapter 12, Coding, for information about coding, including diagnosis, procedure, and revenue codes.

For coverage and reimbursement information for specific procedure, codes see the Coverage and Reimbursement Code Lookup.

13 Reimbursement for inpatient hospital services

1. Reimbursement for inpatient hospital services is covered in the Utah State Plan.
2. Providers must ensure that all submitted diagnoses are appropriate and documented in the patient's medical record.
3. Only covered charges will be included in the calculation of the hospital's reimbursement.
4. Denied or non-covered charges will be excluded.

13-1 Outpatient hospital services

Note: This section does not apply to long-term acute care hospitals, ambulatory surgical centers, or ambulance claims.

A. Effective September 1, 2011, Utah Medicaid began paying outpatient hospital claims like Medicare's Outpatient Prospective Payment System (OPPS) methodology. Hospitals are paid according to their Medicare-designated facility type. Due to differences in clientele, Utah Medicaid may choose to differ in coverage from Medicare's coverage and edits. Coverage is displayed by the outpatient fee schedule posted to the Medicaid website. Please refer to Utah State Plan, attachment 4.19-B, for specifics.

B. Critical Access Hospitals (CAH) are paid 101% of costs for covered procedure codes.

- B.1. Costs are determined using the hospital-specific cost-to-charge ratio (CCR) multiplied by the submitted charges.
- B.2. The Medicare CCR will be used for in-state facilities. The CCR will be obtained quarterly from Noridian.
  - B.2.1.1.1. The Medicare CCR will be used for out-of-state facilities. The CCR will be obtained from the Healthcare Cost Report Information System (HCRIS)
- B.3. Claims will be edited using the Centers for Medicare and Medicaid Service's (CMS) Outpatient Code Editor (OCE). Edits will apply, but reimbursement for CAH facilities is contained within this section.

C. OPPS hospitals are paid on a line-item level based upon the procedure code.

C.1. Claims will be edited using the Centers for Medicare and Medicaid Services (CMS) Outpatient Code Editor (OCE)

C.1.1. Line items with a Medicare status indicator ‘A’ (Paid …under a fee schedule…) will be paid by the applicable Medicare fee schedule. Fee schedules that apply include Medicare’s Lab, DME, DME Penpuf, Physician, and ASP fee schedules (ambulance and ASC fee schedules are not applied for Utah Medicaid). Medicare lab panel methodology applies.

C.1.2. Line items with a Medicare status indicator shown below will only be paid if Medicaid has the code open for outpatient billing. Such claim lines will be paid based on the Medicaid fee schedule rate.

- ‘B’ (Codes not recognized by OPPS)
- ‘E1’ (Items, codes, & services…Not paid by Medicare)
- ‘E2’ (Items, codes, & services…Not paid by Medicare)
- ‘M’ (Items & services not billable to the fiscal intermediary)
- ‘Y’ (Non-Implantable Durable Medical Equipment)

C.1.3. Line items with a Medicare status indicator shown below will not be paid by Medicaid.

- ‘C’ (Inpatient procedures)
  Refer to the Coverage and Reimbursement Lookup Tool for exceptions at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php
- ‘D’ (Discontinued)

C.1.4. Line items with a Medicare status indicator shown below will be paid reasonable cost (charges multiplied by the hospital-specific CCR).

- ‘F’ (Corneal tissue, Hepatitis B vaccines)
- ‘L’ (Influenza, Pneumococcal vaccines)

C.1.5. Line items with a Medicare status indicator shown below will be paid at the passthrough rate. (Pass-through rate means that the provider’s charges reflect the cost of the item only.)

- ‘G’ (Pass-through drugs & biologicals)

- ‘H’ (Pass-through device categories)

C.1.6. Line items with a Medicare status indicator shown below will be paid the APC calculated rate.

- ‘J1’ (Hospital Part B services paid through a comprehensive APC)
- ‘J2’ (Hospital Part B services that may be paid through a comprehensive APC)
- ‘K’ (Non-Pass-Through Drugs…)
- ‘N’ (Items and Services Packaged into APC Rates)
- ‘P’ (Partial Hospitalization)
- ‘Q1’ (STVX-Packaged Codes)
- ‘Q2’ (T-Packaged Codes)
- ‘Q3’ (Codes That May Be Paid Through a Composite APC)
- ‘Q4’ (Conditionally packaged Laboratory tests)
- ‘R’ (Blood & blood products)
- ‘S’ (Significant Procedure, Not Discounted When Multiple)
- ‘T’ (Significant Procedure, Multiple Reduction Applies)
- ‘U’ (Brachytherapy Sources)
- ‘V’ (Clinic or Emergency Department Visit)
- ‘X’ (Ancillary Services)

C.2. Rural Sole Community Hospitals (RSCH)

C.2.1. Receive a 7.1% bonus (or current Medicare rate) for APC-calculated items.

C.2.2. Lab fees are paid at 62% of base rate. This follows Medicare methodology for a 3.3% increase (base is 60%).

C.3. Vaccines & Injectables

C.3.1. Vaccines for children (VFC) payments are reimbursable at Medicaid VFC established rates.

C.3.2. Non-VFC Covered vaccines and injectables are paid through OPPS pricing.

C.3.3. Non-VFC Non-covered vaccines and injectables are not reimbursed, nor are the associated administration charges.

Updates to coverage and pricing will occur quarterly with Medicare's release of OCE and more expensive software. Medicaid will review coverage to match these releases. Due to software release timing, claims may be held for up to 15 days. If additional time is required, claims will be initially processed to make payments and then reprocessed after updates are made in the system.

Pharmaceutical claims lines without a valid NDC will be denied. This includes services billed with revenue codes 450 and 459.

13-2 Inpatient hospital 3-day admission policy

If an admitting hospital furnishes services in an outpatient setting up to three days before an inpatient admission, Medicaid will incorporate the outpatient services into the DRG determination for the inpatient reimbursement. Medicaid defines this as the three-day admission policy.

For example, if a member is admitted to an inpatient hospital on a Wednesday, services performed on the previous Sunday, Monday, or Tuesday would be considered part of the inpatient services.

The 3-day admission policy only applies to acute inpatient hospital admissions.

Preadmission services furnished within the admission window that are determined not clinically related to an inpatient admission are not subject to the 3-day admission DRG payment policy.

14 Long-Term Acute Care (LTAC)

Utah Medicaid policy regarding LTAC preadmission, continued stay, or retroactive review is located in Utah Administrative Code R414-515 Long Term Acute Care.

1. Members must be Medicaid eligible prior to authorization of any LTAC stay.
2. Criteria for a preadmission, continued stay, and retroactive review is determined through an evidence-based review process.

An LTAC request must include:

1. Properly completed Utah Department of Health LTAC document submission cover sheet.
2. A prior authorization request.
3. Current comprehensive documentation to make a preadmission, continued stay, or retroactive determination.

Documentation must include, as applicable:

1. A history and physical.
2. Operative reports.
3. Daily physician progress notes.
4. Consulting physician progress notes.
5. Vital signs.
6. Laboratory test results.
7. Medication administration records.
8. Respiratory therapy notes.
9. Wound care notes.
10. Nutrition notes.
11. Physical, occupational, and speech therapy notes.
12. Any other pertinent information regarding the LTAC request.

14-1 Requirements

1. Payment will be approved for reasonable and medically necessary services and supplies subject to the exclusions and limitations outlined in policy and Utah Administrative Code Title R414-515 Long Term Acute Care.
2. The LTAC must submit a discharge plan with all continued stay reviews.
   a) Failure to properly plan a discharge from the LTAC does not qualify for continued stay in the LTAC.
3. To adjudicate correctly, the billing provider indicator for LTAC in the provider record in PRISM must be a “Y” and claims must be reported using revenue code 0100. This will ensure that the appropriate rate is applied to the claim. All other billing procedures and practices apply to

LTAC claims. These may be found in the General Information: Section I Manual.

4. LTAC providers must utilize value code 80 for covered days and value code 81 for non-covered days on their LTAC claims to ensure proper adjudication.

14-2 Limitations

1. Documentation for preadmission, continued stay, and retroactive review must be submitted in a timely manner as outlined in Administrative Rule R414-515 Long Term Acute Care, or the request shall be denied.
2. An LTAC will not be reimbursed for denied dates of service or for any subsequent dates of service related to that episode of care.
3. The predominant clinical findings will be used to determine the severity of illness criteria for the primary condition.
4. If the member does not admit within 48 hours of the prior authorization approval, a new prior authorization must be submitted.

Rights to the fair hearing process are given to all LTAC denials as outlined in Administrative Rule R414-301. Medicaid General Provisions.

15 Resource table

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

For information regarding:	
Administrative Rules	• Utah Administrative Code Table of Contents • Diabetes Self-Management Training. R414-90. • Dental, Oral and Maxillofacial Surgeons and Orthodontia. R414-49 • Medicaid Policy for Experimental, Investigational or Unproven Medical Practices. R414-1A • Payment for Limited Abortion Services. R414-1B • Physician Services. R414-10 • Transplant Services Standards. R414-10A

	• Podiatric Services. R414-11
Ambulatory surgical centers	• 42CFR Part 416, Ambulatory Surgical Services
Emergency services program for non-citizens	• Section I: General Information • 42 CFR 440.255
General information including: • Billing	• Section I: General Information • Claims
• Fee for service and managed care • Member eligibility • Prior authorization • Provider participation	• Managed Care: Accountable Care Organizations • Utah Medicaid Prior Authorization • Eligibility Requirements. R414-302 • Medicaid General Provisions. R414-301 • Program Benefits and Date of Eligibility. R414-306 • Utah Medicaid Program. R414-1
Hospital services	• §440.10 Inpatient hospital services, other than services in an institution for mental diseases • 42 CFR 447.26 Prohibition on Payment for Provider Preventable Conditions • 42 CFR 482 Conditions of Participation for Hospitals • 42 CFR 440.20 Outpatient Hospital Services and Rural Health Clinic Services • Rule R414-2A. Inpatient Hospital Services • Rule R414-3A. Outpatient Hospital Services • R414-1-12 Utilization Review • Utah Administrative Code. R414-10A. Transplant Services Standards • 42 CFR 441, Subpart F Sterilizations

	• 42 CFR 412, Subpart P Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units
Information including: • Anesthesia fee resources • Coverage and reimbursement resources • National correct coding initiative • Procedure codes with accompanying criteria and limitations	• Office of Healthcare Policy and Authorization (OHPA) • Coverage and Reimbursement Code Lookup • The National Correct Coding Initiative in Medicaid
Information including policy and rule updates: • Medicaid Information Bulletins • Medicaid Provider Manuals Utah State Bulletin	• Utah Medicaid Official Publications • Utah State Bulletin
Laboratory services	• Social Security Act §1833 - Payment of Benefits • PART 493—LABORATORY REQUIREMENTS • Clinical Labs Center • Clinical Laboratory Improvement Amendments • (CLIA) and Medicare Laboratory Services • CMS Clinical Laboratory Improvement Amendments (CLIA) • State Operations Manual • How to Obtain a CLIA Certificate • FDA Clinical Laboratory Improvement Amendments (CLIA) • CDC Clinical Laboratory Improvement Amendments (CLIA)
	• Utah Public Health Laboratory Clinical Laboratory Certification (CLIA) • Medicare Claims Processing Manual Chapter 16 - Laboratory Services

	• Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report • State Laboratories
Medicaid forms including: • Abortion Acknowledgement • Hearing Request • Hospice Prior Authorization Form • Hysterectomy Acknowledgement • PA Request • Sterilization Consent	• Utah Medicaid Forms
Medical Supplies and DME	• Medical Supplies And Durable Medical Equipment Provider Manual • Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70
Modifiers	• Section I: General Information
Patient (Member) Eligibility Lookup Tool	• Eligibility Lookup Tool
Pharmacy	• Drug Criteria Limits • Generic Prescriptions List • ICD-10 Reference Chart Pharmacy • Medicaid Pharmacy Program • OTC Drug List • Pharmacy Provider Manual • Medicaid Policy for Pharmacy Program. R414-60
Prior authorization	• Prior Authorization Form • Utah Medicaid Prior Authorization
Provider portal access	• Provider Portal Access
Provider training	• Utah Medicaid Provider Training
Other	• Baby Your Baby • CDC Vaccines for Children Program

	• Dental, Oral Maxillofacial, And Orthodontia Provider Manual • Hospice Provider Manual • Licensed Nurse Practitioner Provider Manual • Medicaid.gov • Podiatric Services Provider Manual • Behavioral Health Services Provider Manual • RHC-FQHC Provider Manual • Vision Care Services Provider Manual • Women, Infants and Children (WIC)
References including: • Social Security Act	• 42 CFR • Social Security Act 1905(a)
• Code of Federal Regulations • Utah Code Utah State Medicaid Plan	• Social Security Act 1861 (r) • Utah Annotated Code Title 58 • Utah State Medicaid Plan
• Tobacco cessation resources	• Utah Tobacco Quit Line (1-800-QUIT-NOW) • Way to Quit

Utah Medicaid Provider Manual

Housing Related Services and Supports

Division of Integrated Healthcare

Updated November 2024

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1 Overview

The Housing Related Services and Supports (HRSS) program provides tenancy support, community transition, and supportive living services to Medicaid members experiencing homelessness, food insecurity, transportation insecurity, interpersonal violence, and/or trauma. HRSS services are provided under the authority of the Utah Medicaid Reform 1115 Demonstration Waiver. Services are to be delivered in accordance with this manual and the special terms and conditions as set forth by the Centers for Medicare and Medicaid Services (CMS). (See also, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-pcn-appvl-03042022.pdf)

2 Eligibility

HRSS services are available to Medicaid members, ages 19 through 64, who are members of the Targeted Adult Medicaid (TAM) population and meet the needs-based criteria and risk factors criteria outlined in Chapter 3.

Note: TAM eligibility/criteria may have been determined by an entity other than the prospective HRSS provider.

3 Needs-based criteria and risk factors

Providers must attest that members meet at least one needs-based criteria and at least one risk factor below to be eligible for HRSS services.

Needs-based criteria

1. Requires improvement stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a diagnosable substance use disorder, serious mental illness, developmental disability, cognitive impairment or behavioral impairment resulting from dementia, brain injury or other medically based behavior condition/disorder; or
2. Requires assistance with one or more activities of daily living (ADLs), one of which may be body care, verbal queuing, or hands-on assistance.

Risk factors

1. Living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 12 months, or on at least four separate occasions in the last three years;
2. Currently living in supportive housing, but has previously met the definition of chronically homeless defined in Risk Factor #1;
3. Is a victim of domestic violence and living in or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter;
4. Has successfully completed a substance use disorder treatment program while incarcerated in jail or prison, including a tribal jail;
5. Was admitted to (and discharged from) the Utah State Hospital due to an alleged criminal offense;
6. Has been involved in a Drug Court or Mental Health Court, including tribal courts;
7. Receives general assistance from the Utah Department of Workforce Services; and
8. Was civilly committed to (and discharged from) the Utah State Hospital.

4 Authorization of services

All services must be documented in the initial care plan and approved by the Utah Department of Health and Human Services (DHHS) HRSS staff. Providers must submit care plan requests to LTSS_housing@utah.gov. A care plan template is located on the HRSS webpage at: https://medicaid.utah.gov/hrss. Please review the general guidance documents for each service in Chapter 5 of this manual. Chapter 5 provides additional information, requirements, and limitations for these services.

Once the services are approved by DHHS, they may be provided. If the service requires payment upfront, such as an application fee or household items etc., the provider will pay for the service/item and bill Medicaid for reimbursement.

If additional services are needed after the initial care plan approval, an updated care plan will need to be submitted with the required documentation explaining the need for the additional services to LTSS_housing@utah.gov.

5 Benefits

5-1 Tenancy support services

Tenancy support services assist the Medicaid member and includes the following:

1. Tenant screening and housing assessment to identify housing preferences (e.g., housing type, location, living alone or with someone else, roommate identification, type of accommodations needed, etc.), barriers to successful tenancy, identification of housing transition and retention barriers;
2. Development of an individualized housing support plan to address identified barriers and establish goals to address each issue, and identification of providers/services required to meet the established goals;
3. Development of a housing support crisis plan to identify prevention and early intervention services if housing is jeopardized;
4. Participation in planning meetings to assist members with the development of a housing support and crisis plan to address existing or recurring housing retention barriers;
5. Assistance with the housing application process, including application/documentation completion and submission;
6. Assistance with completing reasonable accommodation requests;
7. Assistance with the housing search process;
8. Identification of resources to cover housing expenses (e.g., rental application fees, security deposits, moving costs, furnishings, adaptive aids, environmental modifications, and other one-time expenses);
9. Ensure the living environment is safe and move-in ready;
10. Connect members to education and training on tenant and landlord rights and responsibilities;
11. Provide eviction risk reduction services (e.g., conflict resolution skills, coaching, role-playing, and communication strategies targeted towards resolving disputes with landlords and neighbors);
12. Communicate with landlords and neighbors to reduce the risk of eviction;
13. Address biopsychosocial behaviors that put housing at risk;
14. Provide ongoing support with activities related to household management; and

15. Assistance with the housing voucher/subsidy application and recertification processes.*

* Tenancy support services helps to identify the necessary items a member may require for successfully obtaining housing but should not be used for the purchase of the items or payment of application fees. Community transition services should be utilized for these items.

Members who are also receiving TCM services described above should utilize the Tenancy support services code/billing when working with the member on housing assistance.

5-1.1 Qualified tenancy support service providers

Qualified providers of tenancy support services to eligible members are certified and in good standing as a case manager by the Office of Substance Use and Mental Health or a licensed professional authorized to provide these services. Each case manager is also required to be enrolled in the Medicaid PRISM system as a licensed professional, a servicing only provider or an ordering/referring/prescribing (ORP) provider within 90 days. Providers who are not enrolled within the 90-day timeframe will not be reimbursed for HRSS services. If there are any delays in certification or enrollment, please notify the HRSS team.

5-1.2 Documentation of tenancy support services

The tenancy support service record must be maintained on file in accordance with any federal or state law or state administrative rules and must be made available for state or federal review, upon request.

The following documents must be contained in each member's case file:

1. A written, individualized housing needs assessment which documents the member's need for tenancy support services;
2. A written, individualized tenancy support services plan that identifies the services the member is to receive, who will provide them, and a general description of the tenancy support services activities needed to help the member obtain or maintain these services;
3. A written review of the service plan that summarizes the member's progress toward service plan objectives;

a) Written reviews of the service plan must be conducted every 180 days or more frequently.
b) The service plan review must be completed within the month it is due, or more frequently as required by the member's condition.
c) If changes are required in the written service plan, a revised service plan must also be developed.
d) When constructing periodic review timelines, the provider should also be aware of the member's potential TAM review/termination date.
e) The service plan is not a guarantee of payment. It is the provider's responsibility to verify a member's ongoing eligibility on a periodic basis.

4. Mutual expectations agreement; and
5. Tenant housing services contract.

The tenancy support service provider must develop and maintain sufficient written documentation for each unit of tenancy support services billed.
For each date of service, documentation must include:

1. Date, start and stop time and duration of each service;
2. Setting in which the service was rendered (when via telehealth, the provider setting and notation that the service was provided via telehealth);
3. At the end of the day, the total number of minutes of each tenancy support service based on the rules specified in the billing section below;
4. At a minimum, one note summarizing all of the tenancy support service activities performed during the day, or a separate note summarizing each tenancy support service activity. Notes must document how the activities relate to the tenancy support service plan and must be sufficient to support the number of units billed or reported; and
5. Signature and licensure or credentials of the individual who rendered the tenancy support service.

HCPCS Billing Code: T2024 – Tenancy support service - per 15 minutes

1. When billing these procedure codes, follow the rules specified below for converting the total duration of tenancy support services provided in a day to the specified unit.
2. The number of 15-minute units of service billed or reported cannot exceed 4 units in an hour and cannot exceed in total billings in a day the number of hours the tenancy support service provider worked (e.g., 8-hour workday).

3. If the total duration of tenancy support services activities provided in a day total less than 15 minutes, there must be a minimum of 8 minutes in order to bill one 15-minute unit.
4. If the total duration of tenancy support service activities provided in a day are in excess of 60 minutes, divide the total number of minutes by 15 to determine the number of 15-minute units that can be billed or reported. If there are minutes left over, apply the following rules:
    a) 1-7 minutes equal 0 units; and
    b) 8-15 minutes equals one 15-minute unit.
    c) For example, the tenancy support service provider performed five separate targeted case management activities for the client during the day for a total duration of 70 minutes. When divided by 15, this would result in 5 units of service.
5. A range of dates should not be billed on a single line of a claim (e.g., listing on the claim the 1st through the 30th or 31st as the service date). Each date of service should be billed on a separate line of the claim.

5-2 Community transition services

Community transition services are provided to assist eligible members moving from an institution, a congregate living arrangement, a more restrictive to a less restrictive community setting, members who are homeless, or those lacking safe and secure housing, to secure, establish, and maintain a safe and healthy living environment. Services include:

1. One-time purchase of essential household items and moving expenses required to occupy and use a community domicile, including:
    a) Furniture, window coverings, food preparation items, and bed/bath linens;
    b) Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
    c) Moving expenses;
    d) Necessary home accessibility adaptations;
    e) Activities to assess, arrange and procure necessary resources;
    f) Services needed to establish basic living arrangements in a community setting, including kitchen, bathroom, and cleaning equipment/goods.
2. One-time payment of a security deposit when a member moves into a new residence and a deposit is required for a member to obtain a lease. The

state will impose a maximum of no more than two security deposit payments per member during the five-year demonstration approval period.
3. One-time non-refundable fees to submit rental applications, establish utility and other services (such as pest eradication) that are essential to the operation of the residence.

Services are provided when determined reasonable and necessary, when identified in a member's housing support plan, and when the member is unable to secure funding/items from other sources. Entities that coordinate the purchase of equipment or supplies or that pay deposits or other set-up fees for Medicaid members must be enrolled Medicaid providers that are:

1. Housing authorities;
2. Public or private not-for-profit service organizations;
3. Faith-based organizations;
4. State or local departments and agencies, units of local governments; or
5. Homeless services providers (who provide housing/homeless services to individuals and/or families who are experiencing homelessness or are at risk of becoming homeless).

HCPCS Billing Code: T2038 – 2 episodes per 5-year period per person up to $2,000 per each occurrence.

5-3 Supportive living services

Supportive living services are designed to assist members to retain established housing and coordinate needed services. An entity that provides supportive living services for Medicaid members must be Medicaid enrolled providers.

Coordinated services may include the following, excluding room and board costs:

1. Medical care coordinating medication reminders, health and wellness education, connection to nutritional counseling, home health aides, and personal care services;
2. Mental health services scheduling and coordination of screenings, assessments, counseling, psychiatric services, clubhouses, peer support services, and assertive community treatment teams;
3. Substance use disorder services access to providers of relapse prevention, counseling, intensive outpatient services, medication assisted treatment,

detoxification, residential services, and formal/informal (Alcoholic Anonymous/Narcotics Anonymous) recovery support services;

4. Independent living services including financial management, entitlement assistance, cooking and meal preparation training, and mediation training; and
5. General supportive services including case management, community support, peer support services, crisis intervention, and non-medical transportation.

5-3.1 Qualified supportive living service providers

Qualified providers of supportive living services to eligible members are certified and in good standing as a case manager by the Office of Substance Use and Mental Health or a licensed professional authorized to provide these services. Each case manager is also required to be enrolled in the Medicaid PRISM system as a licensed professional, a servicing only provider or an ordering/referring/prescribing (ORP) provider within 90 days. Providers who are not enrolled within the 90-day timeframe will not be reimbursed for HRSS services. If there are any delays in certification or enrollment, please notify the HRSS team.

5-3.2 Documentation of support living services

The supportive living service record must be maintained on file in accordance with any federal or state law or state administrative rules and must be made available for state or federal review, upon request.

The following documents must be contained in each member's case file:

1. A housing assessment which documents the member's need for supportive living services;
2. A written, individualized supportive living services plan that identifies the services the member is to receive, who will provide them, and a general description of the supportive living services activities needed to help the member obtain or maintain these services; and
3. A written review of the service plan, at a minimum every 180 days, which summarizes the member's progress toward service plan objectives. The service plan review must be completed within the month it is due, or more frequently as required by the member's condition. If changes are required in the written service plan, a revised service plan must also be developed.

The supportive living service provider must develop and maintain sufficient written documentation for each unit of supportive living services billed.
For each date of service, documentation must include:

1. Date, start and stop time and duration of each service;
2. Setting in which the service was rendered (when via telehealth, the provider setting and notation that the service was provided via telehealth);
3. At the end of the day, the total number of minutes of each tenancy support service services based on the rules specified in the billing section below;
4. At a minimum, one note summarizing all of the tenancy support service activities performed during the day, or a separate note summarizing each tenancy support service activity. Notes must document how the activities relate to the tenancy support service plan and must be sufficient to support the number of units billed or reported; and
5. Signature and licensure or credentials of the individual who rendered the tenancy support service.

HCPCS Billing Code: T2017 – Supportive living service - per 15 minutes

1. When billing these procedure codes, follow the rules specified below for converting the total duration of supportive living services provided in a day to the specified unit.
2. The number of 15-minute units of service billed or reported cannot exceed 4 units in an hour and cannot exceed in total billings in a day the number of hours the supportive living service provider worked (e.g., 8-hour workday). Only time worked with the participant may be claimed for reimbursement.
3. If the total duration of supportive living services activities provided in a day total less than 15 minutes, there must be a minimum of 8 minutes in order to bill one 15-minute unit.
4. If the total duration of supportive living service activities provided in a day are in excess of 60 minutes, divide the total number of minutes by 15 to determine the number of 15-minute units that can be billed or reported. If there are minutes left over, apply the following rules:
   a) 1-7 minutes equal 0 units; and
   b) 8-15 minutes equals one 15-minute unit.

c) For example, the supportive living service provider performed five separate targeted case management activities for the client during the day for a total duration of 70 minutes. When divided by 15 this would result in 5 units of service.

5. A range of dates should not be billed on a single line of a claim (e.g., listing on the claim the 1st through the 30th or 31st as the service date). Each date of service should be billed on a separate line of the claim.

Utah Medicaid Provider Manual

Indian Health

Division of Integrated Healthcare

Updated May 2024

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1 General information

This manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as Section I: General Information and the Physician Services provider manuals at https://medicaid.utah.gov/utah-medicaid-official-publications/.

The information in this manual represents available services when medically necessary. Services may be expanded if the proposed services are medically appropriate and are more cost effective than alternative services.

1-1 General policy

The United States Government has an historical and unique legal relationship with and resulting responsibility to American Indian and Alaska Native (AI/AN) individuals. The health care delivery system for AI/AN tribes with this unique government-to-government relationship consists of Indian Health Services (IHS)-owned and operated health care facilities, IHS-owned facilities that are operated by AI/AN tribes or tribal organizations under 638 agreements (contracts, grants, or compacts), and facilities owned and operated by tribes or tribal organizations under such agreements. Medicaid services are available to AI/AN individual who apply and are found eligible under section 1905(b) of the Social Security Act, 42 U.S.C. 1396d. Centers for Medicare and Medicaid Services (CMS) allows 100 % Federal Medical Assistance Percentage (FMAP) for Medicaid services furnished to Medicaid eligible AI/ANs.

The Utah Medicaid State Plan applies to reimbursement for services provided at IHS facilities, Tribal 638 Programs, and Urban Indian facilities. Additionally, unless otherwise stated, all other Utah Medicaid rules apply to IHS, Tribal 638 Programs, and Urban Indian clinics.

1-2 Fee for service or managed care

This manual provides information regarding Medicaid policy and procedures for fee-for-service Medicaid members. This manual is not intended to provide guidance to providers for Medicaid members enrolled in a managed care plan (MCP). A Medicaid member enrolled in an MCP (health, behavioral health or dental plan) must receive

services through that plan with some exceptions called carve-out services, which may be billed directly to Medicaid.

Refer to the provider manual, Section I: General Information, for information regarding MCPs and how to verify if a Medicaid member is enrolled in an MCP. Medicaid members enrolled in MCPs are entitled to the same Medicaid benefits as fee for service members. However, plans may offer more benefits than the Medicaid scope of benefits explained in this section of the provider manual. Contact the Medicaid member services hotline at (844) 238-3091 for further information.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid member enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a member enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a member's enrollment in a managed care plan. However, it is the provider's responsibility to verify eligibility and plan enrollment for a member before providing services. Therefore, if a Medicaid member is enrolled in an MCP, a fee for service claim will not be paid unless the claim is for a carve-out service.

Eligibility and plan enrollment information for each member is available to providers on the Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility.

1-3 Definitions

Definitions of terms used in other Medicaid programs are available in Section I: General Information. Definitions specific to the content of this manual are provided below.

All Inclusive Rate (AIR): It is based on the rates approved by the Office of Management and Budget (OMB). Each year these rates change based on the negotiated rate between HHS, IHS and OMB. See Federal Register. (AIR is also known as encounter rate)

American Indian/Alaska Native (AI/AN) or "Indian": A member of a tribe, band, or other organized group of Indians, including those tribes, bands or groups terminated

since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree or any such member living on, near, or off a reservation.

Behavioral health services: Professional medical services for the treatment of a mental health and/or addiction disorder(s).

CFR: Code of Federal Regulations

CMS: Centers for Medicare and Medicaid Services

DIH: Division of Integrated Healthcare

DWS: Department of Workforce Services

Encounter: A face-to-face contact between a licensed health care professional and an eligible AI/AN Utah Medicaid member for the provision of medically necessary under Title XIX or Title XXI of the Social Security Act covered services through an IHS, Tribal 638 facility, or urban Indian organization.

Encounter rate: See All Inclusive Rate (AIR)

Indian Health Services (IHS) or service: An agency within the Department of Health and Human Services (DHHS), is responsible for providing federal health services to American Indians and Alaska Natives (AI/AN).

I/T/U: The abbreviation for describing the Indian health system, services and programs (Indian Health Service, Tribal 638, and Urban Indian Organization.)

Physician: A Doctor of Medicine or osteopathy legally authorized to practice medicine and surgery or who is a licensed physician employed by the federal Government in an IHS facility or who provides services in an Urban Indian Facility or a 638 Tribal Facility.

Tribal health program or "638" (PL 94-638): an Indian tribe or tribal organization that operates any health program, service, function, activity or facility funded, in whole or part, by the service through, or provided for in, a contract or compact with the service under the Indian Self-Determination and Education Assistance Act (ISDEAA).

Urban Indian Organization (UIO) (PL 94 437, title V): A nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing health activities described in the Indian Health Care Improvement Act (IHCIA).

1-4 Procedure codes

Procedure codes with accompanying criteria and limitations have been removed from the provider manual and are now found on the Medicaid website Coverage and Reimbursement Lookup Tool at:
http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

2 Provider participation requirements

Indian Health Services, Tribal 638 Programs, and Urban Indian Organizations (I/T/Us) are considered eligible for participation in the Utah Medicaid Program. To receive reimbursement, an I/T/U must have a current contract on file with the Utah Department of Health and Human Services, Division of Integrated Healthcare (DIH). DIH recognizes that I/T/Us are the payer of last resort and are not considered creditable health insurance.

2-1 Provider enrollment

Refer to provider manual, Section I: General Information for provider enrollment information.

Indian Health Services, Tribal 638 Programs, and Urban Indian Organizations (I/T/Us) are eligible for participation in the Utah Medicaid program.

Non-institutional provider application requirements

1. Meets all of the credential requirements as listed for each provider type.
2. Completes the Utah Medicaid provider application and signs the Utah Medicaid provider agreement.
3. Receives notice from the Utah Medicaid program that the credentials have been met and the provider agreement accepted.

Note: IHS providers do not require a Utah license, as long as the provider has a valid license in another state.

Professional services requirements (physician, pharmacy, dental, etc.)
Must provide a copy of current professional license, copy from Utah Division of Occupational and Professional Licensing (DOPL) database, or telephone verification from DOPL of professional license from any state. DOPL website: www.dopl.utah.gov.

Hospital services requirements
An IHS hospital must be accredited according to Medicaid requirements.

3 Member eligibility

A Medicaid beneficiary is required to present the Medicaid member card before each service, and every provider must verify each beneficiary's eligibility each time and before services are rendered. For more information regarding verifying eligibility, refer to provider manual, Section I: General Information, Verifying Medicaid eligibility.

For information on how to apply for Medicaid, refer to the provider manual Section I: General Information, Applying for Medicaid, or access the Medicaid website at https://medicaid.utah.gov.

Contacting Medicaid
Medicaid contracts with the Department of Workforce Services (DWS) to process applications from tribal members or representatives for medical services. For tribal member eligibility questions:

1. Contact an I/T/U facility benefits coordinator.
2. Go to www.jobs.utah.gov. Tribal members use the application 'myCase'.
3. Call DWS and speak to a worker:
    a) Call 1-866-435-7414; select option #1; enter the case number. (Once the case has been assigned to the American Indian team, this selection will direct the call to a worker on the AI team.)

4 Program coverage

For additional covered services, refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

4-1 Covered services

Encounters - inpatient and outpatient

Encounters whether inpatient or outpatient, must meet the definition found in Chapter 1-3 Definitions and are limited to covered State Plan services. Services include those identified in the State Plan and Title XIX or Title XXI of the Social Security Act.

5 Non-covered services and limitations

Refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php for additional non-covered services and limitations.

5-1 Non-covered services

The following are excluded from separate coverage, if part of an encounter, and cannot be reimbursed in addition to the encounter. (This list is not all inclusive.)

1. Durable medical equipment or medical supplies not generally provided during the course of a clinic visit (i.e., diabetic supplies)
2. Pharmaceutical or biologicals not generally provided during the clinic visit (i.e., medication samples)
3. Other services that are not defined in the State Plan under Title XIX or Title XXI of the Social Security Act
4. Eyeglasses
5. Emergency ambulance transportation
6. Non-emergency transportation
7. Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices
8. Behavioral health rehabilitative services
9. Hearing aids

10. Behavioral health case management service

I/T/U services not reimbursable under outpatient encounters include:

1. Health or group education classes or activities, including media productions and publications
2. Vaccines covered by the Vaccines for Children (VFC) program
3. Group or sports physicals and medical reports
4. Medication samples or other prescription medications provided to the clinic free of charge
5. Administrative medical examinations and report services
6. Gauze, Band-Aids, or other disposable products used during an office visit

5-2 Limitations

Service limitations governing the provision of all Utah Medicaid services apply. In addition, the following limitations and requirements apply to services provided by I/T/U facilities.

Multiple encounters - outpatients

Medicaid will reimburse for one I/T/U encounter per day, per member; however more than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. Documentation must include unrelated diagnosis codes.

Members seen at a single office visit with multiple problems are reported as a single encounter. Similar services, even when provided by two different I/T/U health care practitioners, are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

1. Well child check and an immunization
2. Preventive dental screen and fluoride varnish application in a single setting
3. Medical encounter with a mental health or addiction diagnosis on the same day as a mental health or addiction encounter
4. Mental health and addiction encounter with similar diagnosis

5. Partial service with one medical provider and partial service from another medical provider

Abortion and sterilization

Federal law governs these services:

1. Abortion procedures are limited to those consistent with the Hyde Amendment restrictions. The amendment allows the use of federal funds for abortions to terminate a pregnancy under two conditions:
    a) A pregnancy resulting from an act of rape or incest, or
    b) The life of the mother would be endangered if the fetus were carried to term.

       (42 CFR 441.203 and Public Law Number 105-78 Section 509 and 510, pertaining to revisions of the Hyde Amendment, 1998).
2. Sterilization procedures are limited to those procedures which meet the requirements of 42 CFR 441 Subpart F.

Refer to Chapter 6-1, Prior authorization, in this Section for PA requirements.

Pharmacy

I/T/U Pharmacy encounters are limited to one per day, per prescriber. If a prescriber issues multiple prescriptions, the reimbursement will be one AIR. If the pharmacy submits a second prescription by a different prescriber on the same day Medicaid will reimburse a second AIR.

Treatment with medication(s) during a clinic visit is included in the encounter rate. The medication or medication sample are included in the encounter rate.

Prescriptions for medications that are to be filled by a pharmacy are not included in the encounter rate and must be billed by a qualified enrolled pharmacy through the pharmacy program.

Dental

I/T/U Dental encounters are limited to one per day, per client; however, multiple encounters may be reimbursable if due to an emergency and/or the same member returns on the same day for a second visit with a different diagnosis.

More than one dental visit with a dental professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. Each service must have distinctly different diagnoses in order to meet the criteria for multiple I/T/U dental encounters.

For example, a member comes to the clinic in the morning for a dental examination, and in the afternoon, the member returns to the office with a broken tooth due to a fall. These are two separate dental encounters and can be billed as two encounters.

Dental claims do not provide diagnosis information therefore the second encounter is denied as a duplicate service. If a second encounter meets the definition above and the claim is denied, contact Medicaid customer service. A customer services agent will review the claim, if approved the claim will be reimbursed through manual override of the claim denial.

Customer service hotline	Telephone number
Salt Lake City area,	801-538-6155
Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, and Nevada toll-free	1-800-662-9651
From other states	1-801-538-6155
From all telephone numbers select option 3, then option 9	

Laboratory procedures

Laboratory procedures performed by an I/T/U outpatient facility (this does not include the independently certified enrolled laboratory) are included in the I/T/U encounter rate.

Behavioral health services

I/T/U behavioral health professional outpatient encounters are limited to one per day. Multiple encounters may be reimbursable if due to an emergency and/or if the same member returns on the same day for a second visit with a different diagnosis. Each service must have distinctly different diagnoses in order to meet the criteria for

multiple I/T/U encounters. Behavioral health services are limited to those services furnished to members at or on behalf of the I/T/U facility.

6 Billing

Refer to the provider manual, Section I: General Information, for detailed billing instructions.

Reimbursement

To receive the All-Inclusive Rate (AIR) reimbursement an I/T/U facility must have a current contract on file with the Utah Department of Health and Human Services, Office of Healthcare Policy and Authorization.

I/T/Us are the payer of last resort and are not considered credible coverage. I/T/Us must meet one of the following:

Directly employ or contract the services of legally credentialed professional staff that are authorized within their scope of practice under state law to provide the services for which claims are submitted to Utah Medicaid.

OR

I/T/U Physicians may meet all requirements for employment by the federal Government as a physician and be employed by the Federal Government in an IHS Facility, Urban Program Facility or affiliated with a 638 Tribal Facility.

IHS and Tribal 638 facilities are reimbursed as shown in this table.

Service/Claim	Reimbursement
Inpatient Services	Inpatient All Inclusive Rate per episode per day
Outpatient Services	Outpatient All Inclusive Rate per episode per day
Inpatient Physician Services	Medicaid fee schedule, plus the rural enhancement (i.e., for physician visits to a member that is inpatient in a hospital)
Pharmacy Services	All Inclusive Rate per episode per day
Dental Services	All Inclusive Rate per episode per day
Crossovers Claims	Utilize the methodology above AIR/fee for service and the Medicare payment to calculate the reimbursement

Urban Indian Organizations are excluded from the above reimbursement types. UIOs are enrolled as Federally Qualified Health Centers and reimbursed accordingly.

6-1 Prior authorization

All Medicaid prior authorization requirements are applicable for these services: orthodontic, physician inpatient, pharmacy, abortion, and sterilization. For prior authorization information, refer to the Medicaid website Coverage and Reimbursement Lookup Tool, http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php or Section I: General Information, Prior authorization at https://medicaid.utah.gov.

1. Medicaid providers must verify whether PA is necessary and comply with applicable requirements. Failure to obtain prior authorization may result in a payment denial.
2. I/T/U outpatient encounters for eligible AI/AN Utah Medicaid members whether medical, dental, or behavioral health, are not subject to prior authorization.
3. Abortion and sterilization procedures are governed by federal law. Refer to Chapter 5-1, Limitations, abortion and sterilization for details.

Receipt of prior authorization for abortion or sterilization services requires compliance with specific criteria and special consents obtainable at https://medicaid.utah.gov/utah-medicaid-forms.

6-2 Timely filing

A claim must be submitted to Medicaid within 365 days from the date of service. The date of service, or “from” date on the claim, begins the count for the 365 days to determine timely filing. For institutional claims that include a span of service dates (i.e., a “from” and “through” date on the claim), the “through” date begins the count for the 365 days to determine timely filing. Any adjustments or corrections must also be received within the 365-day deadline.

Medicare/Medicaid Crossover claims must be submitted within six months from the date of Medicare payment stated on the Medicare Explanation of Medical Benefits (EOMB).

6-3 Medicaid/Medicare crossovers

Medicare claims will "crossover" to Medicaid when an IHS provider is enrolled in the Utah Medicaid program. If a different NPI is used to bill Medicare than to bill Medicaid, contact the Medicaid provider enrollment team.

Do not send a claim if claims are crossing over from Medicare. Claims will pay Medicaid allowed (fee for service or AIR) minus TPL amount. Submit the claim to Medicaid the same as you submitted it to Medicare. For physician inpatient services that were paid line by line by Medicare, submit the claim to Utah Medicaid showing TPL line by line.

7 References

1. 1905(b) of the Social Security Act, 42 U.S.C. 1396d
2. 42 CFR 441 Subpart F
3. 42 CFR 441.203 and
4. Public Law Number 105-78 Section 509 and 510, pertaining to revisions of the Hyde Amendment, 1998

Integrated Healthcare Services

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1 General Information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General Information.

2 Health Plans

Information specific to Managed Care Entities can be found in Section I: General Information, Chapter 2, *Managed Care Entities*.

Refer to Section I: General Information Chapter 1-7, Fee-for-Service and Managed Care for information regarding how to verify if a Medicaid member is enrolled in managed care.

3 Provider Participation and Requirements

To enroll as a Medicaid Home Health Provider refer to Section I: General Information Chapter 3, Provider Participation and Requirements.

4 Record Keeping

Refer to Section I: General Information, Chapter 4, *Record Keeping*.

5 Provider Sanctions

Refer to Section I: General Information, Chapter 5, *Provider Sanctions*.

6 Member Eligibility

It is the responsibility of the provider to verify the member's eligibility prior to every rendered service. For additional information regarding member eligibility refer to Section I: General Information Chapter 6, Member Eligibility.

7 Member Responsibilities

For information on member responsibilities including establishing eligibility and co-payment.

8 Program Coverage

8-1 Definitions

Advanced Care Planning (ACP) a form of integrated healthcare that empowers members to make informed decisions about healthcare preferences and end-of-life care. By facilitating discussions and documenting preferences in advance, healthcare providers can honor members' wishes and ensure care aligns with their values and goals.

Behavioral health care manager (BHCM) - A designated provider with formal education or specialized training in behavioral health (including social work, counseling, nursing, or psychology), working under the oversight and direction of the treating provider.

Behavioral Health Integration (BHI) - a form of integrated healthcare that addresses a member's medical and behavioral health needs, reducing stigma and ensuring holistic care. BHI recognizes the intricate connection between behavioral and physical health.

Chronic Care Management (CCM) – a form of integrated healthcare that focuses on providing continuous, coordinated care for individuals with persistent conditions. By proactively managing a member's health and medical conditions such as diabetes, hypertension, and asthma, providers can establish treatment plans that lead to the prevention of exacerbations and complications, ultimately improving the member's quality of life.

Clinical Staff - are healthcare employees who work under the supervision of a physician or other QHP to perform, or assist in the performance of, a specified professional medical service as allowed by law, regulation, and facility policy. These individuals do not bill the professional service.

Health Behavior Assessments and Interventions (HBAI) a form of integrated healthcare that identifies and addresses the psychological, behavioral, emotional, cognitive, and interpersonal factors critical to the assessment, treatment, or management of specific physical disease-related problems.

Mental health therapist - As defined in the Mental Health Professional Practice Act, Utah Code 58-60-1-102

Nurse practitioner – As defined in the Nurse Practice Act, Utah Code 58-31b.

Physician assistant- As defined in the Physician Assistant Practice Act, Utah Code 58-70a.

Principal Care Management (PCM) - A form of integrated healthcare that delivers care management for members with a single chronic condition or with multiple chronic conditions but focuses on a single high-risk condition.

Psychiatric consultant - A medical provider trained in psychiatry and qualified to prescribe a full range of medications.

Qualified Healthcare Professional (QHP) – An individual who is qualified by education, training, licensure and regulation who performs a professional medical service within their scope of practice and is enrolled with Medicaid as a provider. Medicaid will only reimburse covered services performed by a QHP as indicated in the PRISM Coverage and Reimbursement Code Lookup for their specific provider enrollment type.

Social Determinant of Health (SDOH) - Are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age. These forces and systems include a wide set of forces and systems that shape daily life such as economic policies and systems, development agendas, social norms, social policies, and political systems.

The Collaborative Care Model (CoCM) - A form of integrated healthcare that fosters collaboration between primary care providers, behavioral health specialists, and care managers. This team-based approach ensures that members receive comprehensive support tailored to their distinct circumstances, leading to more effective management of complex health conditions.

Transitional Care Management a form of integrated healthcare that facilitates smooth transitions between different healthcare settings, such as hospitals, nursing facilities, and home care. By coordinating follow-up care and providing support during critical transitions, members experience fewer gaps in care and have a reduced risk of readmission.

Treating provider - A physician or non-physician provider (NPP) who is typically a primary care provider but may be of another specialty.

8-2 Integrated Healthcare and Care Management

Integrated Healthcare is a comprehensive approach designed to prioritize the well-being of individuals by integrating various aspects of healthcare to meet their diverse needs. At its core, integrated healthcare aims to enhance member outcomes, improve access to quality care, and promote cost-effective strategies within the Medicaid population.

Included within the umbrella of integrated healthcare are various approaches to the management of each member's unique medical needs. These strategies include:

- **Chronic Care Management (CCM)** focuses on providing continuous coordinated care for individuals with persistent conditions. By proactively managing a member's health and medical conditions such as diabetes, hypertension, and asthma, providers can establish treatment plans that lead to the prevention of exacerbations and complications, ultimately improving the member's quality of life.
- **Principal Care Management (PCM)** services provide care for a single chronic condition or individuals with multiple chronic conditions but focuses on a single high-risk condition.
- **Behavioral Health Integration (BHI)** recognizes the intricate connection between behavioral and physical health. Through BHI, members have access to integrated services that address both their medical and behavioral health needs, reducing stigma and ensuring holistic care.
- **The Psychiatric Collaborative Care Model (CoCM)** strengthens integrated healthcare and BHI by fostering collaboration between primary care providers, behavioral health specialists, and care managers. This team-based approach ensures that members receive comprehensive support tailored to their distinct circumstances, leading to more effective management of complex health conditions.
- **Health Behavior Assessments and Interventions (HBAI)** identifies and addresses the psychological, behavioral, emotional, cognitive, and interpersonal factors critical to the assessment, treatment, or management of specific physical disease-related problems.
- **Transitional Care Management** plays a vital role in integrated healthcare by facilitating smooth transitions between different healthcare settings, such as hospitals, nursing facilities, and home care. By coordinating follow-up care and providing support during critical transitions, members experience fewer gaps in care and have a reduced risk of readmission.
- **Advanced Care Planning (ACP)** is also integral to integrated healthcare, empowering members to make informed decisions about their healthcare preferences and end-of-life care. By facilitating discussions and documenting preferences in advance, healthcare providers can honor a members' wishes and ensure care aligns with their values and goals.

Integrated healthcare encompasses all components of healthcare, including preventive services, care coordination, member education, and community resources. By prioritizing a member's needs and leveraging a collaborative, multidisciplinary approach, integrated healthcare can enhance the overall health and well-being of Medicaid members.

This manual serves as a resource for understanding how to report (code and bill) time and resources utilized as a part of integrated healthcare. The subsequent chapters of this manual will further outline the Medicaid recognized care models and offer guidance toward best practices for reporting and to help ensure payment for time and care provided to Medicaid members.

Many of these services are eligible to be performed via telehealth when clinically appropriate and the medical needs of the member can be met. Providers are responsible for ensuring that each service meets the Medicaid policy requirements for telehealth services prior to rendering the service. Additional information related to the coverage of telehealth services can be found in Chapter 8-4.2 Telehealth of the Section I: General Information provider manual.

The specific requirements for coverage of services, limitations, non-covered services, prior authorizations, supporting documentation, and reporting are outlined in each chapter based on the care model. Please refer to related chapters for specific policies.

It should be noted that each of these services is timed based and have time thresholds that must be met prior to a provider being able to bill for them. The time and resources of administrative and clerical staff cannot be included as part of the care team reporting requirements and should not be considered when determining time thresholds for billing.

8-3 Chronic Care Management

Chronic Care Management (CCM) is a primary care service that contributes to improved outcomes within healthcare. Medicaid covers CCM services for members with multiple chronic conditions. The elements required as a part of CCM include:

- Structured recording of member health information using electronic health record (EHR).
    - member demographics
    - problems
    - assessment of physical and behavioral health needs
    - medications
    - allergies
- Developing and maintaining comprehensive care plans
    - create, revise, or monitor the member-centered care plan based on physical, mental, cognitive, psychosocial, functional, environmental, and social determinants of health.
- Member education or motivational counseling.
- Manage care transitions between healthcare providers and clinical settings.
    - This includes referrals to other clinicians, follow-up care after an emergency department visit, and discharges from hospitals, skilled nursing facilities, or other health care facilities.
- Coordination of community-based services as needed based on assessment and care plan.
- Coordinating and sharing member health information promptly within and outside of the primary provider's practice.

CCM services provide members with a clear and simplified pathway to access their primary care providers (PCPs) or the clinical staff to address their chronic condition(s). These services offer continuity of care with a designated provider or member of the care team with whom the member may schedule successive routine appointments.

The goal of CCM is to empower members to better manage their health and work towards improved quality of life. By developing a comprehensive care plan, CCM supports member

health goals, presents pathways for ongoing communication and support between visits, and provides the member with resources, community services, and other educational information.

8-3.1 Provider Participation

Providers wanting to furnish CCM services must meet certain criteria to report and bill for this service. This criterion includes:

- The ability to provide continuity of care with the same provider or another member of the care team, with which the member can successfully schedule routine appointments.
- Utilize an EHR capable of exchanging health information with other providers.
- The ability to deliver comprehensive care management, including:
  - Manage care between different specialty providers and settings.
  - Exchange and receive medical records promptly with relevant providers and within federal regulations and guidelines to ensure thorough member care.
  - Offer pathways for members to communicate their care needs through phone, messaging, member portals, emails, or other asynchronous non-face-to-face methods.
    - Providers are responsible for ensuring all forms of communication are compliant with all privacy and security regulatory requirements.
- Obtain and maintain the member’s consent in the medical record. The consent must:
  - Acknowledge that CCM services are available and the member’s willingness to engage in CCM.
  - Indicate that the member may discontinue participation of CCM services at any time.
    - Termination of CCM services is effective at the end of the calendar month in which it was ended (i.e., providers can still report CCM services delivered for that month).
  - Document if the member accepted or declined CCM services.

Members need only provide informed consent for CCM services once, unless they switch to a different CCM provider. Acquiring consent helps to ensure member engagement and prevent duplicate billing by another provider.

8-3.2 Eligible Members

Members eligible for CCM services must have multiple (two or more) chronic conditions expected to last at least 12 months. These chronic conditions may place the member at a significant risk of death, have acute exacerbation or decompensation, or result in a functional decline and a decreased quality of life. Examples of chronic conditions include, but are not limited to:

- Alzheimer’s disease and related dementias (AD/ADRD)
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Behavioral health conditions
- Cancer
- Cardiovascular disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Intellectual and developmental disabilities (IDDs) or developmental delays
- Diabetes
- Hypertension
- Infectious diseases like HIV and AIDS

The services provided under CCM apply to complex and non-complex chronic medical conditions.

8-3.3 Initiating Visit

Prior to initiating CCM services, an initial visit with the provider must occur. This visit is for members that have not participated in CCM before or who have not been seen for one year. An initial visit can occur during a comprehensive face-to-face Evaluation and Management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE). If the practitioner does not discuss CCM and receive member acceptance of CCM services, the provider may not begin billing for CCM services.

8-3.4 Comprehensive Care Plan

A comprehensive care plan is member-centered and based on the member's status of physical, mental, cognitive, psychosocial, functional, and social determinants of health. It should support the care and improvement of the member's identified health issues and focus on managing their chronic conditions and addressing social determinants of health.

Elements of a comprehensive care plan typically include:

- A problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medication management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources, practitioners, and providers
- Periodic review of the care plan with revision as needed

8-3.5 Coding and Billing CCM Services

CCM services are typically billed by the PCP, but some specialty providers may furnish and report these services. CCM services are not within the scope of practice of limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists. CCM providers may, however, refer or consult with these practitioners to coordinate and manage a member's care.

CCM services are not typically face-to-face. CCM services require a minimum of 20 minutes of time spent furnishing the service before it can be billed.

Complex CCM and prolonged E/M services are not reportable in the same calendar month.

If a provider does not perform an initiating visit, they cannot report CCM services.

8-3.5.1 Clinical Staff

Clinical staff are employees who do not individually report their services. Clinical staff includes medical assistants, licensed practical nurses, registered nurses, and others. CCM codes describing clinical staff activities are provided under the overall direction and control of the PCP. Medicaid does not require the provider's physical presence while clinical staff deliver a service.

8-3.5.2 Complex and Non-complex CCM

Complex CCM services require and include moderate to high complexity medical decision-making by the treating provider. These services are directly delivered by the provider

Complex CCM billing requires:

- Two or more chronic conditions, expected to last at least 12 months, that place the member at significant risk of death or significant harm
- At least one of the chronic conditions has a history of ongoing severe exacerbation or decompensation, functional decline, or side effects of treatment, and
- The establishment of a comprehensive care plan or substantially revised.

Non-complex CCM may be provided by clinical staff under the supervision of the provider. For the purposes of CCM, the supervision is done under the providers overall direction and control, which does not require they be directly present while services are being delivered. These services are subject to applicable state law, licensure, and scope of practice parameters.

These services may not require the same level of medical decision making or meet all the requirements to be considered complex.

Non-complex CCM billing requires:

- Two or more chronic conditions expected to last at least 12 months that place the member at significant risk of death, acute exacerbation or decompensation, or functional decline, and
- The comprehensive care plan is already established and does not require ongoing significant changes.

8-3.5.3 Time

Time spent during the initial visit discussing CCM during an E/M, AWV, or IPPE cannot be counted towards the monthly time requirements for reporting CCM services. Providers must not count time and effort towards CCM to support the reporting of other codes. An example of this would be the review of diagnostic results that have a professional component.

Most time spent towards CCM will be non-face-to-face, however, face-to-face time may still count the activity as reportable time.

When counting time spent related to CCM services, the following actions are included in addition to those previously mentioned:

- Management of chronic conditions
- Management of referrals to other providers
- Management of prescriptions
- Ongoing review of member status

Non-complex CCM requires at least 20 minutes of clinical staff or provider time per calendar month spent on non-face-to-face CCM services.

Complex CCM services provided by a PCP require at least 30 minutes of personal time spent in care management activities.

CCM CPT codes are time-based codes and total time spent performing care management services during the calendar month must be documented in the member record. Failure to document time

spent performing CCM and what the activities were related to may result in denial of coverage for reported services, even when those services have been previously reimbursed.

Do not report CCM codes if all elements listed in the code description are not met.

When a provider performs face-to-face E/M visits in the same calendar month as CCM services, the services may be reported separately. The time of the clinical staff on the date the E/M was performed cannot be counted towards the CCM service time.

Time counted toward CCM service codes cannot be applied towards any other billed code.

CCM codes may be reported by the same providers for services furnished during the 30-day Transitional Care Management service period. See the transitional care management chapter for more information.

CCM services cannot be reported during the same service period by the same provider as certain end stage renal disease (ESRD) services. These include CPT codes 90951–90970.

Table 1 – Chronic Care Management Coding Tool

	CPT Code	Performed by		Time Requirements	Coding Note and Limitation
		Provider	Clinical Staff		
Non-Complex CCM	99490	X	X	first 20 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99491 is not billed in the same month. • Limited to 1 unit per month. • Cannot report if less than 20 minutes are utilized.
	99439	X	X	each additional 20 minutes	• Time spent by billing provider is counted when 99491 is not billed in the same month. • Limited to 2 units per month. • Report in conjunction with 99490.
	99487	X	X	first 60-89 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99491 is not billed in the same month. • Limited to 1 unit per month
	99489	X	X	each additional 30 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99491 is not billed in the same month. • Limited to 1 unit per month
Complex CCM	99491	X		first 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Cannot report in same month as non-complex CCM codes. • Limited to 1 unit per month • Cannot report if less than 30 minutes are utilized.
	99437	X		each additional 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Reported in addition to 99491 when time threshold is met. • Cannot be reported without 99491. • Limited to 2 units per month

8-4 Principal Care Management

Principal Care Management (PCM) services are designed to furnish CCM services for members with a single chronic or with multiple chronic conditions but is focused on a single high-risk condition. In either case, the condition must be a high-risk condition. A high-risk condition is a

medical condition places the member at significant risk of hospitalization, nursing home placement, acute exacerbation or decompensation, functional decline, or death

PCM services may be expected to last at least three months or until the member's death. This differs from CCM in that the single high-risk condition must be expected to last at least three months instead of six.

PCM services are reported with separate CPT codes from other CCM services. Other than the distinction of only requiring management of a single chronic condition, PCM services have all the same policy requirements as CCM services.

Table 2 – Principal Care Management Coding Tool

<table>
<tr><th rowspan="2"></th><th rowspan="2">CPT Code</th><th colspan="2">Performed by</th><th>Time Requirements</th><th>Coding Note and Limitation</th></tr>
<tr><th>Provider</th><th>Clinical Staff</th><th></th><th></th></tr>
<tr><td rowspan="2">Non-Complex PCM</td><td>99426</td><td>X</td><td>X</td><td>first 30 minutes</td><td>• Time spent by billing provider can be counted in addition to clinical staff time when 99424 is not billed in the same month.
• Limited to 1 unit per month.
• Cannot report if less than 30 minutes are utilized.
• Cannot be reported in the same month as CCM codes.</td></tr>
<tr><td>99427</td><td>X</td><td>X</td><td>each additional 30 minutes</td><td>• Limited to 2 units per month.
• Report in conjunction with 99426.</td></tr>
<tr><td rowspan="2">Complex PCM</td><td>99424</td><td>X</td><td></td><td>first 30 minutes</td><td>• Clinical staff time cannot be used towards meeting time requirements.
• Cannot report in same month as non-complex PCM codes.
• Limited to 1 unit per month
• Cannot report if less than 30 minutes are utilized.
• Cannot be reported in the same months as CCM codes.</td></tr>
<tr><td>99425</td><td>X</td><td></td><td>each additional 30 minutes</td><td>• Clinical staff time cannot be used towards meeting time requirements.
• Reported in addition to 99424 when time threshold is met.
• Cannot be reported without 99424.
• Limited to 2 units per month</td></tr>
</table>

8-5 Diabetes Prevention

Medicaid encourages providers to screen and refer members to the evidence-based diabetes prevention programs (DPPs) recognized by the Centers for Disease Control and Prevention (CDC) when the member is found to be at risk for the development of type 2 diabetes.

DPP services include behavioral counseling and lifestyle-change programs which are proven effective when delivered to prediabetic members at high risk for developing type 2 diabetes, specifically those with minimal physical activity, obesity, and genetic predisposition. Intensive behavioral counseling includes care management, lifestyle coaching, the facilitation of a peer support group, and the provision of clinically validated educational lessons based on a standardized curriculum focused on nutrition, exercise, stress, and weight management while allowing care plan oversight by a trained provider.

DPP services must be performed by trained lifestyle coaches who have completed a nationally recognized training program. Lifestyle coaches must be available to interact with the participants.

For a member to be considered eligible for coverage of these services, they must meet the following requirements:

- Receive DPP from a CDC-recognized diabetes prevention lifestyle change program
- Must be:
  - 18 years of age or older
  - Overweight – BMI of 25 or higher
  - Not diagnosed with diabetes type 1 or 2
  - Not currently pregnant
- Have at least one of the following:
  - A blood test result in the prediabetes range within the past year (includes any of these tests and results):
    - Hemoglobin A1C: 5.7–6.4%.
    - Fasting plasma glucose: 110–125 mg/dL.
    - 2-hour plasma glucose (after a 75 g glucose load): 140–199 mg/dL.
    - Previously diagnosed with gestational diabetes or high-risk results on prediabetes risk test
    - A score of 5 or higher on the CDC Prediabetes Risk Test

8-6 Diabetes Self-Management

Diabetes self-management training is a covered service when delivered by diabetes self-management programs.

Diabetic self-management training services are limited to an initial ten (10) sessions per year and must be provided through a:

- Nationally recognized *American Diabetes Association* (ADA) certified diabetes educator, or
- An educator certified by the *American Association of Diabetes Educators* (AADE)

Note: This program does not cover self-management training for the sole use of glucose monitoring or nutritional counseling.

For additional policies related to this service, refer to *Utah Administrative Code* R414-90 Diabetes Self-Management Training.

8-7 Behavioral Health Integration

Behavioral Health Integration (BHI) is a type of care management service that integrates behavioral health care services with primary care services, which are often detected and treated in a primary care setting. BHI recognizes there is an intricate connection between behavioral and physical health, because of this, providers may utilize resources to combine mental health and substance use services as a part of the primary healthcare setting. This approach ensures that members receive comprehensive care for both their physical, mental, and emotional well-being in one place.

The BHI care model involves collaboration between healthcare providers and establishes a care team dedicated towards the overall wellbeing of the member. There are two ways to perform BHI:

- General BHI services, and
- Psychiatric collaborative care model (CoCM)

For general BHI, the care team includes the treating provider, clinical staff, and the member. Under the psychiatric collaborative care model (CoCM) the care team consists of a treating provider, behavior health care manager, psychiatric consultant, and the member.

Providers can identify members that may benefit from BHI services by recognizing those individuals with behavioral health conditions that, in the clinical judgment of the provider, warrant further assessment and treatment.

Eligible conditions for BHI services are any behavioral health condition, pre-existing or newly diagnosed that are treated by the provider.

Some examples of conditions that may benefit from BHI are listed below. These conditions serve as examples; however, the list is not comprehensive.

- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Developmental Disorders
- Bipolar Disorder
- Depression and Anxiety Disorders
- Eating Disorders
- Post-Traumatic Stress Disorder (PTSD)
- Substance Use Disorders
- Suicidal Ideation
- Trauma-Related Disorders

8-7.1 Initiating Visit

An initiating visit is required for new members or members not seen within a year prior to the onset of BHI services. This initial visit establishes the member's relationship with the treating provider and allows the provider the opportunity to conduct a baseline assessment prior to initiating BHI services.

8-8 General BHI Services

General BHI services require a member to have a diagnosis of a behavioral health condition. General BHI is used to report time and resources used by a provider and their staff that go beyond the standard office visit.

8-8.1 Provider Participation

Medicaid has outlined the requirements that must be met for providers seeking coverage of general BHI services. These include:

- The member has a diagnosis of a behavioral health condition requiring care management.
- An initial assessment or follow-up monitoring including the use of applicable validated rating scales.
  - The reporting provider must furnish the initial evaluation and management service.
- Behavior health care planning in relation to behavioral or other psychiatric health conditions, including timely revisions for members who are not progressing or whose status changes.
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, or psychiatric consultation.
- Continuity of care with a designated member of the care team.
  - This will primarily be with the clinical staff but can be the treating provider.

The clinician is not required to provide a comprehensive assessment and treatment plan for the behavioral health condition, rather this is the responsibility of the treating provider. The provider is not required to address all chronic care management functions for a member with multiple comorbidities.

8-8.2 Documentation

General BHI is a time-based service. As such, providers and clinical staff are required to document the amount of time spent performing various functions related to the service to receive coverage of the service. Documentation that does not support the time spent performing these functions does not support the reporting of this service for reimbursement.

8-8.3 Eligible Members

The provider may deliver general BHI services to members who have a behavioral health diagnosis.

8-8.4 Coding and Billing General Behavioral Health Integration

Coding of general BHI is recorded using CPT code 99484. This code represents the time spent by clinical staff coordinating a member's behavioral health care plan. For a provider to code for general BHI services they must meet all the requirements outlined within the *General BHI* chapter and the code description. For a full description of CPT code 99484 please see the table listed at the end of this manual.

As a time-based service, providers count the time spent by clinical staff performing BHI related functions. General BHI requires a minimum of 20 minutes spent towards performing functions of the service in a calendar month before it can be considered as reportable. Time spent by the treating provider can be applied towards meeting the time threshold of this service if that time is not counted towards another service.

Billing of general BHI is limited to:

- Meeting the general BHI criteria
- 1 unit per calendar month, and
- Cannot be reported in the same month as Psychiatric collaborative care (CoCM).

The following services are separately reportable on the same day or calendar month as general BHI services:

- Preventive services
- Evaluation and management (E/M)
- Chronic care management (CCM)
- Principal care management (PCM)
- Psychotherapy services
- Transitional care management
- Advanced care planning (ACP)

8-9 Psychiatric Collaborative Care Model

When providers have determined that general BHI services will not meet the behavioral needs of the member, they may determine that psychiatric collaborative care model (CoCM) is an appropriate care management methodology. As a type of BHI, CoCM continues to address

members' behavioral health needs along with physical health needs, however, these needs may require additional resources not provided through general BHI.

Medicaid covers CoCM when all the criteria policies have been met, including those outlined throughout this manual. CoCM services are available to providers to report in order to receive reimbursement for time and resources spent on the management of members with eligible conditions.

Member consent for CoCM services is required in order to be considered for coverage, which can be given in writing or verbally. In either case, providers must document that consent was obtained in the member's medical record. The consent enables the provider to consult with relevant specialists and care team members including the psychiatric consultant.

Psychiatric CoCM typically is provided by a primary care team consisting of a primary care provider and a care manager who works in collaboration with a psychiatric consultant, such as a psychiatrist. Care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of members and to make treatment recommendations.

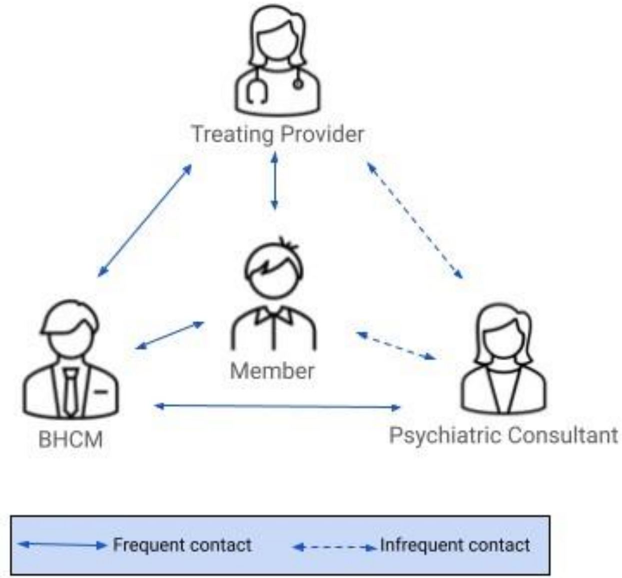
8-9.1 Care Team

The CoCM care team members include:

- Treating provider
- Behavioral health case manager
- Psychiatric consultant
- Member

Collaborative Care Model –

The diagram below demonstrates collaboration between the CoCM care team.



8-9.1.2 Treating Provider

The treating provider has primary oversight of the member's care as they would in any primary care setting. In most instances, the treating provider is a primary care provider (PCP) but may be of another specialty if they have primary oversight of the member's care as previously mentioned. They are responsible for directing the behavioral healthcare manager and other clinical staff. This direction is generally performed under the general supervision of staff through established and well-defined care plans. As part of treating a member using the CoCM model, they are additionally responsible for:

- Ongoing oversight of their member's care, including:
  - prescribing medications
  - providing treatments for both physical and behavioral medical conditions
  - referrals to specialty care when needed
- Establishing comprehensive care plans through collaboration with a psychiatric consultant.
- Maintain communication with the behavioral healthcare manager and psychiatric consultant.

8-9.1.3 Behavioral Healthcare Manager

The behavioral healthcare manager (BHM) is a part of the member's ongoing care and supports the treating provider through various tasks and responsibilities. They are consistently available to meet with the member through scheduled visits whether in person or by means of telehealth. These services include:

- Administering assessment and providing care management services, including:
  - utilizing evidence-based behavioral health rating scales,
  - behavioral healthcare planning that addresses the member's behavioral health condition(s),
  - provider care plan revisions as needed,

  - furnishing brief psychosocial interventions, and
  - continuous collaboration with the treating provider and conferring with the psychiatric consultant.
- Maintaining a continuous relationship with the member,
- Maintaining a collaborative, integrated relationship with the rest of the care team,
- Referring members to appropriate community resources to address social determinants of health and increase access to needed services, and
- Have a clinical license, formal education, or specialized training in behavioral health.
  - Examples include social workers, nurses, and psychologists.

8-9.1.4 Psychiatric Consultant

The psychiatric consultant is an integral part of CoCM services in addition to the BHM. These individuals are medical providers trained in psychiatry and qualified to prescribe the full range of medications to meet the member's medical needs. The psychiatric consultant advises and makes recommendations as needed. Their responsibilities and oversight include:

- assess and diagnose behavioral health disorder(s),
- collaborate in developing treatment strategies including appropriate therapies,
- coordination of medication management,
- medical management of complications associated with treatment,
- referral for direct provision of psychiatric care when clinically indicated,
- take part in regular review of clinical status of members getting BHI services,
- advise ways for resolving issues with treatment adherence and development of medication tolerances,
- adjusts treatment and care plan for members who aren’t progressing, and
- manages adverse interactions between members’ behavioral health and medical treatments.

8-9.2 Provider Participation

Only the treating provider is responsible for being enrolled with Utah Medicaid. While the BH care manager and psychiatric consultant can also be enrolled with Medicaid, it is not necessary that they are for the delivery and coverage of this service.

8-9.3 Reporting – Coding and Billing

Billing of CoCM is reported using time-based codes. These codes represent the time spent by the care team when performing CoCM services during a calendar month.

Reporting of CoCM services is limited to the treating practitioner. The psychiatric consultant and the BH care manager are subsequently paid through whatever remunerable arrangements have been made through the treating providers business model. These are often established through contract or employment agreements; however, Medicaid does not dictate how these arrangements are made.

In instances where a psychiatric consultant or BH care manager are enrolled as Medicaid providers and have delivered additional services beyond those that are considered part of CoCM, these providers may bill for those services separately. Please see the “NOTE” below for additional details.

The following services are separately reportable on the same day or calendar month as CoCM services:

- Preventive services
- Evaluation and management (E/M)
- Chronic care management (CCM)
- Principal care management (PCM)
- Psychotherapy services
- Transitional care management
- Advanced care planning (ACP)

8-9.4 Coding

Providers can use the following when determining code assignment of CoCM services for billing purposes. Documentation in the member's medical record must support services billed to Medicaid.

Initial psychiatric collaborative care management – CPT Code 99492

- Used to report the first month of time spent on CoCM services coordinating an individual's behavioral health care plan.
- This code is based on the amount of time the BH care manager spends doing clinical work, both face-to-face and non-face-to-face with the member.
- Represents first 70 minutes.
    - This code requires a minimum of 36 minutes of documented BH care manager time.
    - The treating practitioner's time can be included in meeting if that time isn't used to support the coding of another service. E.g., evaluation and management visits.
    - The psychiatric consultant's time can be applied towards the time spent on CoCM services.
        - Cannot apply consultation time if reported by another member of the care team.
        - Cannot use the time spent to support the coding of another service.
- Requires BH care manager:
    - outreach to and engagement in treatment of a member directed by the treating provider,
    - initial assessment of the member, including administration of validated rating scales, with the development of an individualized treatment plan,
    - review of treatment plan by the psychiatric consultant with modifications as needed,
    - tracking member care and progress through documentation,
    - participation in weekly caseload consultation with the psychiatric consultant, and
    - providing brief interventions to the member using evidence-based techniques.
- Cannot be billed again until CoCM services have not been provided for at least 6 consecutive months.
- Cannot be billed in the same month as the general BHI code 99484.

Subsequent psychiatric collaborative care management - CPT Code 99493

- This code is used to report subsequent months of time spent on CoCM services coordinating an individual's behavioral health care plan after the initial month of care has been completed.
- This code is based on the amount of time the BH care manager spends doing clinical work, both face-to-face and non-face-to-face with the member.
- Represents first 60 minutes.
    - This code requires a minimum of 31 minutes of documented BH care manager time.
    - The treating practitioner time can be included in meeting this requirement when the time isn't used to support the coding of another service, e.g., evaluation and management visits.
    - The psychiatric consultant's time can be applied towards the time spent on CoCM services.
        - Cannot apply consultation time if reported by another member of the care team.
        - Cannot use time used to support the coding of another service.
- BH care manager requirements:
    - Tracking member care and progress through documentation,
    - Participation in weekly caseload consultation with the psychiatric consultant,
    - Ongoing collaboration with member care team,
    - Review of progress and recommendations for changes in treatment as necessary,
    - Provision of brief interventions using evidence-based techniques,
    - Monitoring of member outcomes using validated rating scales,
    - Relapse prevention planning with members as they achieve remission of symptoms,
    - Establishing treatment goals and preparing for discharge from active treatment.
- Cannot be billed in the same month as the general BHI code 99484.

Initial or subsequent psychiatric collaborative care management - CPT code 99494

- This CPT is used to report time beyond what is covered under CPT codes 99492 and 99493.
- This code represents each additional 30 minutes beyond what the primary code covers.
- Requires a minimum of 16 minutes past the primary codes time.
    - Allowable after 85 minutes for CPT code 99492
    - Allowable after 75 minutes for CPT code 99493
- All other criteria for the applicable primary code apply to this code.
- Providers are limited to reporting this code up to 2 times in a calendar month.
- Documentation must support the reported code requirements.

Initial or subsequent psychiatric collaborative care management – CPT code G2214

- Represents first 30 minutes of CoCM services in a calendar month.
- This code is reportable when CoCM services are discontinued due to either referral to specialized care for ongoing treatment of the behavioral health condition or an inpatient admission.

- Not permitted if billed with other CoCM codes.
- Requires a minimum of 16 minutes of CoCM related service time.
- All other requirements for CPT codes 99492 and 99493 respectively apply to this code.

Table – Quick CoCM Reference

Code	Brief Description	Time Requirement	Limitations and Notes
99492	Initial Psychiatric CoCM	70 minutes	1 unit per month
99493	Subsequent Psychiatric CoCM	60 minutes	1 unit per month
99494	Initial & Subsequent Psychiatric CoCM	30 minutes	2 units per month This is an add on code to 99492 and 99493.
G2214	Initial & Subsequent Psychiatric CoCM	30 minutes	1 unit per month

8-10 Transitional Care Management

Medicaid covers transitional care management services as part of the 30-day period following a member's discharge from an inpatient facility. These services allow the inpatient attending provider to assist the members in their transition back into the community. Transitional care management includes referrals to other clinicians, follow-up after an emergency department visit, and discharges from hospitals, skilled nursing facilities, or other health care facilities. To facilitate the transition of care providers should ensure prompt sharing of medical records, especially with the primary care provider.

Eligible inpatient settings for the reporting of transitional care management services include:

- inpatient acute care hospital,
- inpatient psychiatric hospital,
- inpatient rehabilitation facility,
- long-term care hospital, or
- skilled nursing facility.

When a member discharges from an eligible inpatient setting transitional care management services must be provided during the 30-day period following discharge. As a part of this service, providers must establish face-to-face contact with the member. This requires contacting the member or their caregiver by means of phone, an audio-video virtual visit, or directly in-person within two business days after the member's discharge. If this is not completed within two business days, then the service is non-covered, and reimbursement is prohibited.

This initial action may be performed by the provider or clinical staff. Medicaid recognizes an individual as a clinical staff member when they are supervised by a physician or other qualified health care professional and is allowed by law, regulation, and facility policy to perform or assist in a clinical service but does not individually report that professional service.

When first contacting the member, providers or their staff must be able to manage and reconcile the member's medications. Additionally, they must also address member status and needs beyond scheduling follow-up care.

Transitional care management has multiple requirements and some optional components that can be used in supporting the billing of this service:

- Supporting a member's transition to their place of residence. Examples of the community setting include:
  - Home
  - Domiciliary
  - Nursing facility
  - Assisted living facility
- The provider furnishes transitional care management at the time of post-facility discharge, without a service gap.
  - This is completed within two business days of discharge.
- Moderate or high complexity medical decision making (MDM) is needed to address the members medical needs. The member's medical record must support a diagnosis and severity of illness to justify this level of MDM.

Beyond the established transitional care management requirement, the delivery of face-to-face and non-face-to-face time establishes the medical need for this service. As previously described, the face-to-face criteria needs to be performed within two business days of discharge from a facility.

When providing non-face-to-face transitional care management, providers may support billing this service with time spent in:

- reviewing discharge documentation (for example, discharge summary or continuity-of-care documents),
- reviewing the member's need for or follow up on, diagnostic tests and treatments,
- interacting with other health care professionals who may assume or reassume care of the member's medical care,
- educating the member, family, guardian, or caregiver,
- establishing or re-establishing referrals and arrange needed community resources, and
- aiding with scheduling required community providers and services follow-up

Clinical staff may perform certain non-face-to-face service tasks under the general supervision of the provider, these include:

- communicating with the member,
- coordinating with agencies and community service providers the member uses,
- educating the member or caregiver to support self-management, independent living, and activities of daily living (ADLs),
- assessing and support treatment adherence,
- identifying available community and health resources, and
- helping the member and family access needed care and services

8-10.1 Transitional Care Management Reporting – Coding and Billing

When reporting transitional care management services providers are required to only bill for those services that meet the criteria established throughout this manual and when coding requirements are met for each service reported. There are both time thresholds and limitations regarding the billing of concurrent services provided in conjunction with transitional care management.

Providers may not report transitional care management when the member is under the post-operative global surgery period. The global period payment of a surgery includes the transitional care management services and would be considered double billed under those circumstances.

The member's medical record must reflect and support any reporting of transitional care management. The reporting of transitional care management is limited to the following providers overseeing the discharge of the member:

- Physicians
- Certified nurse-midwives (CNMs)
- Clinical nurse specialists (CNSs)
- Nurse practitioners (NPs)
- Physician assistants (PAs)

Only one provider may report transitional care management services during the 30-day period following the discharge of a member from an eligible inpatient facility. transitional care management may be reported by the same provider that oversees and bills for discharge observation, however, the provider may not perform the transitional care management face-to-face on the same day as the reported discharge management services.

If a member is readmitted during the 30 days after discharge, a provider may report transitional care management services if the criteria have been met.

8-10.1.1 Transitional Care Management Coding

Use the table below to determine which code to report when the criteria for transitional care management have been met.

8-10.1.2 Transitional Care Management Concurrent Billing

Certain other care management services may be reported concurrently with transitional care management services, when medically necessary, and if the time and effort of each are not counted more than once. These services include:

- Monitoring of End-stage renal disease (ESRD)
- Training for home international normalized ratio (INR) monitoring and anticoagulation management
- Collection and interpretation of physiologic data
- Prolonged evaluation and management (E/M) services
- Chronic care management (complex and non-complex)
- Hospice
- Home Health requiring complex and multidisciplinary care modalities

Providers must meet the coding and policy requirements of the above services as applicable prior to reporting.

8-11 Health Behavioral Assessment and Interventions (HBAI)

Health Behavior Assessment and Intervention (HBAI) are covered services for members when used to improve the physical health of the member through psychological assessments and interventions. These services are offered to members with physical illnesses, diagnoses, or symptoms that require psychological interventions designed to ameliorate the specific physical disease-related problems.

HBAI services include the following services used to identify factors important to the prevention, treatment, and management of physical health problems:

- Behavioral
- Cognitive
- Emotional
- Psychological
- Social

8-11.1 Health Behavior Assessment

A health behavior assessment is conducted using health-focused interviews, behavioral observation, and clinical decision-making. Health behavior assessments include evaluating the member's responses to disease, illness or injury, outlook concerning disease prognosis, coping strategies, motivation, and adherence to medical treatment. The assessment is conducted through health-focused clinical interviews, observation, and clinical decision making.

The coverage of a health behavior assessment and reassessment requires a health focused clinical interview, behavioral observations, and clinical decision making.

As part of the health-focused clinical interview the QHP conducts a face-to-face interview with the member while assessing multiple behavioral domains. Collateral interviews are conducted as appropriate. When it precedes a health behavior intervention, the clinical assessment would determine the type(s) of intervention that would best benefit the member.

When performing the health-focused clinical interview the QHP evaluates how the member is responding through direct behavioral observation. These observations will direct the clinical decision-making process and support the medical necessity of the service being provided.

The information gained during the health-focused clinical interview and behavior observations help to conceptualize the QHPs clinical impressions and treatment recommendations.

Health behavior assessment and re-assessment evaluate multiple domains and their degree of impact. These assessments may include the following as they are relevant to the member:

- Academic and vocational histories
- Adjustment to the medical illness or injury
- Coping strategies, member strengths
- Daily activities, level of behavioral activation, and functional impairment
- Health beliefs, perception, and outlook
- Health care decision-making skills
- Mental health and substance use (including tobacco and alcohol use)—current and past
- Mood
- Motivation and self-efficacy beliefs
- Psychological and environmental factors affecting management of the medical condition
- Quality of life
- Relevant medical history
- Sleep, diet, physical activity, and other health risk behaviors
- Social support, family and interpersonal relations
- Treatment adherence and expectations
- Understanding of treatment plan, benefits and risks of procedures

8-11.2 Assessment Medical Necessity Requirements

For Medicaid to cover these health behavioral assessments, the member must meet the following criteria:

- there is an established physical condition, and the purpose of the assessment is not for the diagnosis or treatment of mental illness,
- there are indications that psychological, behavioral, and/or psychosocial factors may be affecting the treatment or medical management of an illness or an injury,
- the member is alert, oriented, and has the capacity to understand and to respond meaningfully during a face-to-face encounter,
- the health behavior evaluation or intervention will contribute to the successful management of the member's activities of daily living (ADLs), and
- the member can be referred from a medical or mental health care provider, or self-referred to seek assistance in addressing the role of psychological and/or behavioral factors affecting an underlying physical health condition.

8-11.3 Re-assessment Requirements

In addition to meeting the criteria stated above, medical necessity for re-assessment must be further established through documentation of one of the following:

- change in the mental or medical status warranting re-evaluation,
- specific concern from the primary medical provider or member of medical team,
- need for re-assessment as part of the standard of care,
- change in providers, or
- at least a 6-month period has elapsed since the last assessment.

8-11.4 Documentation Requirements for Assessments

Health behavior assessment or re-assessment are required to be medically necessary for Medicaid to cover the services. In order to support the medical necessity of services billed the documentation must support the following:

- assess psychological and/or behavioral factors that impact the management of a member's acute or chronic physical health condition (e.g., assessment of stress and its impact on diabetes management),
- assess member's responses to disease, illness or injury, outlook (e.g. health beliefs and attitudes), coping strategies, motivation, and adherence to medical treatment,
- assess behavioral and contextual factors that impact disease management in scenarios that include, but are not limited to:
  - pre-surgical evaluation to identify psychological factors that may potentially affect or complicate the outcome of surgical procedures and/or aftercare (e.g., spinal surgery, bariatric surgery, implantable therapies, organ transplant),
  - assessment of emotional/personality factors impacting physical disease management and ability to comply with and/or benefit from medical interventions, or
  - assessment of psychosocial and/or environmental factors that can impact a member's ability to comply with and/or benefit from medical interventions,
- assess psychological barriers and strengths to aid in treatment planning, including but not limited to:

    - the selection of treatment options when several evidence-based approaches may be indicated,
    - determining treatment prognosis and outcomes, or
    - identifying reasons for poor response to medical treatment,
- assess and monitor psychological factors and impact on medical condition and management over time (repeated assessments), or
- assess health related risk behaviors (e.g., sleep, diet, physical activity, tobacco use) and their impact on the medical condition and management.

8-11.5 Health Behavioral Intervention

Health behavior intervention emphasizes active member and family engagement and involvement. Interventions may be provided individually, to a group of two or more members, and/or to the family, with or without the member present. Interventions include:

- promoting functional improvement,
- minimizing psychological and/or psychosocial barriers to recovery, or
- managing and improving coping methods associated with medical conditions

Health behavior intervention services are considered medically necessary when one or more of the following needs are present:

- manage psychological and behavioral factors that are impacting the management of a member's physical medical condition (e.g., improve stress management to improve diabetes management),
- improve a member's cognitive or emotional responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment,
- improve psychological and/or behavioral factors that impact disease management in scenarios that include but are not limited to:
    - psychological factors affecting or complicating the outcome of surgical procedures and/or aftercare (e.g., spinal surgery, bariatric surgery, implantable therapies).
    - The emotional/personality impacts on physical disease management and/or the ability to comply with and benefit from medical interventions,
- improve a member's adherence to medical treatment and/or health risk-related behaviors,
- improve a member's engagement in self-management and participation in treatment, and
- improve a member's understanding of the medical condition, its treatment, and the psychological, behavioral, emotional, cognitive, or social factors related to the prevention, treatment or management of the medical condition.

These intervention services may be provided to:

- The individual member
- A group of members receiving similar interventions for HBAI
- The member's family or caregiver(s), with or without the member present
    - These intervention services involve face-to-face interaction with the family or caregiver(s) present.

Health behavior intervention includes promotion of functional improvement, minimization of psychological or psychosocial barriers to recovery, and management of and improved coping

with medical conditions. These services emphasize active member/family engagement and involvement.

Evidence-based health behavior interventions address behavioral factors that influence a person's medical condition and consist of various types of treatment interventions, including but not limited to:

- Cognitive restructuring
- Communication skills training
- Coping skills training
- Emotional awareness and management
- Functional and structural family treatment
- Graded activation, behavioral activation, and pacing techniques
- Mindfulness techniques
- Motivational interviewing
- Operant behavior therapy and contingency management
- Problem solving training
- Psychoeducation related to the psychological, behavioral, and/ or psychosocial aspects of the member's illness or presenting problem
- Relaxation techniques and skills training
- Stimulus control

8-11.6 Documentation Supporting Medical Necessity of Interventions

The health behavioral intervention services may be considered reasonable and necessary for the member who meets all of the following criteria:

- The member has an underlying physical illness or injury
- Specific psychological intervention(s) and member outcome goal(s) have been clearly identified and documented
- Psychological intervention is necessary to address:
  - Non-adherence with the medical treatment plan, or
  - The psychological and/or psychosocial factors associated with a newly diagnosed physical illness, or an exacerbation of an established physical illness, when such factors affect:
    - symptom management and expression
    - health-promoting behaviors
    - health-related risk-taking behaviors
    - overall adjustment to medical illness.
- There are indications that psychological, behavioral, and/or psychosocial factors may be affecting the treatment or medical management of an illness or an injury
- The member is alert, oriented and has the capacity to understand and to respond meaningfully during the intervention service

When providing these services to the member's family or caregiver(s) the documentation must additionally support:

- The family representative or caregiver who directly participates in the overall care of the member, and
- The psychological intervention with the member and family is necessary to address psychological or psychosocial factors that affect adherence with the plan of care,

symptom management, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to medical illness.

8-11.7 Provider Participation

Only qualified healthcare professionals may provide HBAI services in accordance with their licensing, training, and scope of practice. Examples of professionals licensed to provide HBAI services include:

- Physicians
- Advanced Practicing Nurse Practitioners (APRN)
- Physician Assistants (PA)
- Psychologist
- Mental Health Therapist

8-11.8 Limitations and Non-Covered HBAI Services

HBAI Services do not include:

- Adaptive behavior services
- E/M services on the same date of service
- Preventive medicine counseling services
- Psychotherapy services

In addition, HBAI is not considered medically necessary when the member:

- Does not have a suspected or established underlying physical illness or injury; or
- There is no indication that psychological and/or psychosocial factors may be significantly affecting the treatment, or medical management of an illness or injury (i.e., screening medical member for psychological problems); or
- Does not have the capacity to understand and to respond meaningfully during the face-to-face encounter for reasons such as, but not limited to:
    - Cognitive status indicates inability to actively participate and benefit from services.
    - Severe dementia that has produced a severe enough cognitive defect for the psychological intervention to be ineffective.
    - Severe or profound intellectual disability.
    - Persistent inability to engage in meaningful interpersonal interactions including inability to respond to cues and directions.
- Updating or educating the family about the member's condition
- Educating individuals who are not direct family members or legally responsible guardians and other members of the treatment team (e.g., health aides, nurses, physical or occupational therapists, home health aides, personal care attendants, and co-workers) about the member's care plan.
- Treatment-planning with staff
- Mediating between family members or providing family psychotherapy
- Education that does not include the psychological, behavioral, and/or psychosocial aspects of the member's illness or presenting problem
- Delivering Medical Nutrition Therapy
- Retraining cognition due to dementia or memory enhancement training
- Provision of support services, not requiring the skills of an individual with health psychology training.
- Provide personal, social, recreational, and general support services, including:
    - Stress management for support staff
    - Replacement for expected nursing home staff functions
    - Recreational services, including dance, play, or art

- Music appreciation
- Craft skill training
- Cooking classes
- Individual or group social activities
- General conversation
- Consciousness raising
- Vocational or religious advice
- General educational activities
- Visits for loneliness relief
- Sensory stimulation
- Games, such as bingo
- Projects, such as shopping outings, even when used to reduce a dysphoric state
- Teaching grooming skills
- Grooming services
- Monitoring activities of daily living
- Teaching the member simple self-care
- Teaching the member to follow simple directives
- Wheeling the member around the facility
- Orienting the member to name, date, and place
- In-vivo exercise programs
- Activities principally for diversion
- Planning for milieu modifications
- Contributions to member care plans
- Maintenance of behavioral logs

8-11.9 Reporting: Coding and Billing Health Behavioral Assessments and Interventions

A provider reporting an Evaluation and Management (E/M) service code cannot report HBAI services on the same day by the same health care professional or another clinician practicing in the same facility under the same specialty.

HBAI services are not used for reporting mental health services provided as part of the treatment of a primary physical health diagnosis.

Do not report health behavior intervention services with psychiatric services on the same date. Instead, report the predominant service performed. It is typical for psychological testing and health behavior assessment, re-assessment, or intervention services to be provided on the same date of service.

Psychological testing performed in addition to a health assessment should be reported separately, based on the type of testing performed.

- HBAI services performed on the same date of service as psychological services should follow NCCI guidelines for reporting these services using an appropriate modifier:
  - Modifier XE for separate encounters on the same DOS; or
  - Modifier 59 for services provided in the same encounter)

Providers reporting HBAI assessments/re-assessments and interventions must maintain clinical documentation that supports the requirements and the medical necessity of the service being delivered. These records are not required as a part of the claim’s submission process; however, they may be requested per the Medicaid post-payment review and claims evaluation processes.

Table -Assessments and Re-assessments

Code	Description	Limitations and Notes
96156	Health behavior assessment, or re-assessment	• Limited to one unit per date of service. • Reassessments can only be billed every six months from either the date of the initial assessment or the previous reassessment.

Table - Interventions

Health Behavioral Intervention Reporting			
	Code	**Description**	**Limitations and Notes**

Individual	96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to being reportable
	96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96158 • Limited to 4 units per date of service o 1 unit requires at least 38 minutes of individual time o 2 units requires at least 53 minutes of individual time o 3 units require at least 68 minutes of individual time o 4 units require at least 83 minutes of individual time
Group	96164	Health behavior intervention, group (2 or more members), face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to reporting
	96165	Health behavior intervention, group (2 or more members), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96164 • Limited to 6 units per date of service o 1 unit requires at least 38 minutes of individual time o 2 units requires at least 53 minutes of individual time o 3 units require at least 68 minutes of individual time o 4 units require at least 83 minutes of individual time o 5 units require at least 98 minutes of individual time o 6 units require at least 113 minutes of individual time
Family or Caregiver, with member present	96167	Health behavior intervention, family (with the member present), face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to reporting
	96168	Health behavior intervention, family (with the member present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96167 • Limited to 6 units per date of service o 1 unit requires at least 38 minutes of individual time o 2 units requires at least 53 minutes of individual time o 3 units require at least 68 minutes of individual time o 4 units require at least 83 minutes of individual time o 5 units require at least 98 minutes of individual time

			○ 6 units require at least 113 minutes of individual time
Family or Caregiver, without member present	96170	Health behavior intervention, family (without the member present), face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to reporting.
	96171	Health behavior intervention, family (without the member present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96170 • Limited to 2 units per date of service ○ 1 unit requires at least 38 minutes of individual time ○ 2 units requires at least 53 minutes of individual time

When coding and billing for interventions providers must report the most appropriate CPT code as supported through clinical documentation. The intervention codes are time-based services and are therefore supported through clinical documentation supporting start and stop times. These are outlined in the following table.

8-12 Advanced Care Planning

Advance care planning (ACP) is a voluntary, face-to-face service between a physician or other QHP and a member, family member, or caregiver to discuss the member's health care wishes if they become unable to make their own medical decisions. The primary goal of ACP is to facilitate people receiving medical care that is consistent with their personal values, goals, and preferences.

Examples of ACP services may include, but are not limited to the following content:

- Introducing and discussing the value and importance of basic ACP,
- Exploring current and past experiences of loved ones who have been seriously ill or have died,
- Exploring goals of care in the event of sudden injury or illness,
- Exploring goals of care when there would be little chance for members to recover or to have the ability to know who they are or who they are with,
- Identifying and/or preparing a healthcare agent,
- Completing or updating an advance directive document, and
- Transferring members' preferences into actionable medical orders.

An advance directive is described as a written document that a member uses to appoint a representative and/or to record his or her wishes as they relate to future medical treatment in the event the member is incapacitated and unable to make decisions on his or her own. Types of written advance directives include, but are not limited to:

- Healthcare proxy
- Durable power of attorney for healthcare
- Living will
- Provider orders for life-sustaining treatment (POLST)

Such formal written documents are not required, but may be included, in the provision and reporting of these services.

8-12.1 Reporting – Coding and Billing

ACP services are time based. No other active management of the member's affairs should be undertaken for the time reported when ACP codes are billed. Brief conversations of just a few minutes (done in the course of an E/M service) related to wishes concerning potential emergent resuscitation do not represent ACP services.

ACP is limited to up to two hours per date of service. Services reported on separate dates of service must include documentation of change in existing ACP or the addition of new written advance directives. Documentation must support the medical necessity of the services as evidenced by the following:

- The content and the medical necessity of the ACP related discussion,
- Voluntary participation in ACP by the member, or in the case of absent decision-making capacity, by the family member or surrogate,
- A change in health status or advance care wishes in order to support repetitive provision of ACP services,
- The scenario for the service: face to face, by phone, as a telehealth service including audio and/or video communication,
- The time spent solely for provision of ACP services, and
- The names of participants involved in the discussion.

ACP codes describe counseling and discussion of advance care directives with the member, family members, or authorized representatives. Such services may or may not include completion of pertinent legal documents.

Table - Coding and Billing for Advanced Care Planning

CPT Code	Description	Limitations and Notes
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the member, family member(s), and/or surrogate.	• Initial 30 minutes • Requires a face-to-face visit.
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	• Each additional 30 minutes • Requires a face-to-face visit.

These codes can be separately reported when performed on the same date of service in conjunction with the following E/M services:

- Office or another outpatient visit
- Initial hospital inpatient or observational care
- Subsequent hospital or observational care
- Discharge day management
- Office or other outpatient consultations for new or established member
- Hospital inpatient or observational care for new or established member
- Emergency department visits
- Initial nursing facility care

- Nursing facility discharge management
- Home or residence visits for new or established member
- Initial comprehensive preventive medicine evaluation
- Transitional care management services

Codes 99497 and 99498 *should not* be reported on the same date of service as the critical care E/M services.

To ensure you are able to report these services for reimbursement please see the PRISM Coverage and Reimbursement Code Lookup Tool.

Reference Tables

Chronic Care Management

	CPT Code	Performed by		Time Requirements	Coding Note and Limitation
		Provider	Clinical Staff		
Non-Complex CCM	99490	X	X	first 20 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99491 is not billed in the same month. • Limited to 1 unit per month. • Cannot report if less than 20 minutes are utilized.
	99439	X	X	each additional 20 minutes	• Time spent by billing provider is counted when 99491 is not billed in the same month. • Limited to 2 units per month. • Report in conjunction with 99490.
	99487	X	X	first 60-89 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99491 is not billed in the same month. • Limited to 1 unit per month
	99489	X	X	each additional 30 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99491 is not billed in the same month. • Limited to 1 unit per month
Complex CCM	99491	X		first 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Cannot report in same month as non-complex CCM codes. • Limited to 1 unit per month • Cannot report if less than 30 minutes are utilized.
	99437	X		each additional 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Reported in addition to 99491 when time threshold is met. • Cannot be reported without 99491. • Limited to 2 units per month

Principal Care Management

	CPT Code	Performed by		Time Requirements	Coding Note and Limitation
		Provider	Clinical Staff		
Non-Complex PCM	99426	X	X	first 30 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99424 is not billed in the same month. • Limited to 1 unit per month. • Cannot report if less than 30 minutes are utilized. • Cannot be reported in the same month as CCM codes.

	99427	X	X	each additional 30 minutes	• Limited to 2 units per month. • Report in conjunction with 99426.
Complex PCM	99424	X		first 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Cannot report in same month as non-complex PCM codes. • Limited to 1 unit per month • Cannot report if less than 30 minutes are utilized. • Cannot be reported in the same months as CCM codes.
	99425	X		each additional 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Reported in addition to 99424 when time threshold is met. • Cannot be reported without 99424. • Limited to 2 units per month

Psychiatric Collaborative Care Model

Code	Brief Description	Time Requirement	Limitations and Notes
99492	Initial Psychiatric CoCM	70 minutes	1 unit per month
99493	Subsequent Psychiatric CoCM	60 minutes	1 unit per month
99494	Initial & Subsequent Psychiatric CoCM	30 minutes	2 units per month This is an add on code to 99492 and 99493.
G2214	Initial & Subsequent Psychiatric CoCM	30 minutes	1 unit per month

Health Behavior Assessments and Interventions

Health Behavioral Assessment Reporting		
Code	**Brief Description**	**Limitations and Notes**
96156	Health behavior assessment, or re-assessment	• Limited to one unit per date of service. • Reassessments can only be billed every six months from either the date of the initial assessment or the previous reassessment.

Health Behavioral Intervention Reporting			
	Code	**Brief Description**	**Limitations and Notes**
Individual	96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to being reportable

	96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96158
			• Limited to 4 units per date of service
			  ○ 1 unit requires at least 38 minutes of individual time
			  ○ 2 units requires at least 53 minutes of individual time
			  ○ 3 units require at least 68 minutes of individual time
			  ○ 4 units require at least 83 minutes of individual time

Group	96164	Health behavior intervention, group (2 or more members), face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to reporting
	96165	Health behavior intervention, group (2 or more members), face-to-face;	• Must be reported as an add on service to 96164 • Limited to 6 units per date of service

		each additional 15 minutes (List separately in addition to code for primary service)	○ 1 unit requires at least 38 minutes of individual time ○ 2 units requires at least 53 minutes of individual time ○ 3 units require at least 68 minutes of individual time ○ 4 units require at least 83 minutes of individual time ○ 5 units require at least 98 minutes of individual time ○ 6 units require at least 113 minutes of individual time
Family or Caregiver, with member present	96167	Health behavior intervention, family (with the member present), face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to reporting
	96168	Health behavior intervention, family (with the member present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96167 • Limited to 6 units per date of service ○ 1 unit requires at least 38 minutes of individual time ○ 2 units requires at least 53 minutes of individual time ○ 3 units require at least 68 minutes of individual time ○ 4 units require at least 83 minutes of individual time ○ 5 units require at least 98 minutes of individual time ○ 6 units require at least 113 minutes of individual time
Family or Caregiver, without member present	96170	Health behavior intervention, family (without the member present), face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to reporting.
	96171	Health behavior intervention, family (without the member present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96170 • Limited to 2 units per date of service ○ 1 unit requires at least 38 minutes of individual time ○ 2 units requires at least 53 minutes of individual time

Transitional Care Management

Complexity of MDM	Code	Description
Moderate	99495	Transitional care management services with communication with the patient or caregiver within 2 business days of discharge, at least moderate level of medical decision making during the service period, Face-to-face visit, within 14 calendar days of discharge.
High	99496	Transitional care management services with communication with the patient or caregiver within 2 business days of discharge. High level of medical decision making during the service period, Face-to-face visit, within 7 calendar days of discharge.

Advanced Care Planning

CPT Code	Description	Limitations and Notes
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the member, family member(s), and/or surrogate.	• Initial 30 minutes • Requires a face-to-face visit.
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	• Each additional 30 minutes • Requires a face-to-face visit.

Utah Medicaid Provider Manual

Long Term Care Services in Nursing Facilities

Division of Integrated Healthcare

Updated April 2018

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1 Long term care program for Medicaid clients residing in a nursing facility

This manual provides information on coverage of Long Term Care (LTC) for Medicaid clients in Nursing Facilities (NFs) and Intermediate Care Facilities for Persons with Intellectual Disabilities (ICFs/ID). For information regarding other Medicaid requirements and policies, refer to SECTION 1 of this Medicaid provider manual.

Nursing facility services are mandated under the Medicaid program. ICF/ID services are optional services.

Institutions primarily for the care and treatment of mental disease (IMDs) are not reimbursable for persons over age 21 and under age 65.

1-1 List of contacts

For more information on a specific policy or procedure, please contact the responsible agency as indicated below:

Customer Service and Provider Manual Distribution
Office of Medicaid Operations
(801) 538-6155 Toll-free: 1-800-662-9651

Medicaid Financial Eligibility
Office of Eligibility Policy
(801) 538-6494

Resident Assessment
Office of Long Term Services and Supports
(801) 538-6155 Toll-free: 1-800-662-9651

Preadmission Screening and Resident Review (PASRR)
Department of Health and Human Services
Division of Integrated Healthcare
(801) 538-3918

Facility Licensing

Office of Health Facility Licensing and Certification
(801) 273-2994

Nurse Aide Training and Competency Evaluation Program
Office of Managed Health Care
(801) 538-6636

Reimbursement
Office of Reimbursement and Audit
(801) 538-6096

1-2 Hospice and home-based long term care

Other long term care programs in the Utah Medicaid program are the Home and Community-Based Services Waiver Programs, Hospice Care, Personal Care Services, and Home Health Services.

Contact Medicaid information to obtain information regarding these programs, or view the provider manuals at: https://medicaid.utah.gov.

1-3 Appropriate placement

The cost of care in a nursing facility must be less than the cost of care for alternative, non-institutional services for the Department to approve nursing facility coverage for an applicant. The Department may not consider the availability of Medicaid reimbursement for alternative services as a factor in determining the relative costs of alternative services. Unless the cost of care through alternative, non-institutional services is higher than the cost of care in a nursing facility, the Department will deny nursing facility coverage for an applicant whose health, rehabilitative, and social needs may reasonably be met through alternative non-institutional services.

Reference: R414-502-3 of the Utah Administrative Code (UAC).

2 Definitions

ACT

The Federal Social Security Act.

Ancillary charges
Any charges made by a medical provider, not included as part of nursing facility coverage.

Applicant
Any person who requests assistance under the medical programs available through the Division.

Certified program
A nursing facility program with Medicaid certification.

Code of Federal Regulations (CFR)
The publication by the Office of the Federal Register, specifically Title 42, used to govern the administration of the Medicaid program.

Crossover payments
When a client is eligible for both Medicare and Medicaid, claims are first sent to Medicare. After the Medicare payment is made, Medicaid is then sent the remaining bill. Payment depends on services covered and the amount paid by Medicare.

Department
The Department of Health and Human Services.

Director
The director of the Division of Integrated Healthcare within the Department of Health and Human Services.

Division
The Division of Integrated Healthcare within the Department of Health and Human Services.

Executive Director
The executive director of the Department of Health and Human Services.

Family

The monthly amount a Medicaid recipient must pay from his own funds toward the cost of nursing facility care.

Medicaid certification

The right to Medicaid reimbursement as a provider of a nursing facility program shown by a valid federal Centers for Medicare and Medicaid Services (CMS) Form 1539 (7-84).

Medicaid rate

The patient reimbursement rate paid to a nursing facility for an individual eligible for the Utah Medicaid program.

Medical assistance program or Medicaid program

The state program for medical assistance for persons who are eligible under the State Plan adopted pursuant to Title XIX of the Federal Social Security Act, as implemented by Title 26, Chapter 18, UCA.

Medical or hospital assistance

Services furnished or payments made to or on behalf of recipients eligible for the Utah Medicaid Program.

Nursing facility

Any Medicaid participating NF, SNF, ICF, ICF/ID, or a combination thereof, as defined in 42 USC 1396r (a) (1988), 42 CFR 440.150 and 442.12 (1993), and UCA 26-21-2(15).

Nursing facility program

The personnel, licenses, services, contracts, and all other requirements that must be present for a nursing facility to be eligible for Medicaid certification as detailed in 42 CFR 442.1 through .119, 483.1 through .480, and 488.1 through .64 (1993), which are adopted and incorporated by reference.

Physical facility

The building(s) or other physical structure(s) where a nursing facility "program" is operated.

Private pay rate
The rate an individual not eligible for Medicaid would pay for long term care in the facility.

Resident
An individual eligible for the Utah Medicaid Program who resides in a nursing facility.

Service area
The boundaries of the distinct geographical area served by a type of certified program, the Department to determine the exact area, based on fostering price competition and maintaining economy and efficiency in the Medicaid program.

Utah Administrative Code (UAC)
The compilation of rules promulgated by state agencies under delegation of authority from the Utah Legislature.

Utah Code Annotate (UCA)
The compilation of legal statutes enacted by the Utah Legislature.

3 Provider enrollment

3-1 Medicare skilled nursing facility certification

All skilled nursing facilities must be certified for Medicare participation as a condition of Medicaid certification. Authority: R414-27 of the Utah Administrative Code (UAC).

3-2 Certification of new nursing facilities

Medicaid limits reimbursement of nursing facility programs to programs certified as of January 13, 1989. In addition:

1. The Department shall not process initial applications for Medicaid certification or execute initial provider agreements with nursing facility programs, except as authorized by Chapters 3 - 21 or 3 - 22.

2. The Department shall not reinstate Medicaid certification for a previously certified provider whose Medicaid certification expires, or is terminated by action of the federal or state government, except as authorized by Chapters 3 - 21 or 3 - 22
3. The Department shall not execute a Medicaid provider agreement with a certified program that moves its nursing facility program to a new physical facility, except as authorized by Chapters 3 - 21 or 3 - 22.

Authority for this subsection is found in Sections 26-18-2.3, 26-1-5, 26-1-30(2)(a), (b), and (w) and 26-18-3 of the Utah Code Annotated (UCA) , and R414-7A of the Utah Administrative Code (UAC).

The purpose of this subsection is to control the supply of Medicaid nursing facility programs. The oversupply of nursing facility programs in the state has adversely affected the Utah Medicaid program and the health of the people within the state. This subsection continues the prohibition against certification of new nursing facility programs that has been in place since January 13, 1989. This subsection clarifies that prohibition and sets up policy to deal with the possible future need for additional Medicaid nursing facility programs in a service area. The July 1990 Report of the Governor's Task Force on Long Term Care recommended continuation of this prohibition. The task force concluded that "Market entry into the nursing facility industry should be regulated to allow supply to come more in line with demand". This subsection also supports the policy of the Department to direct new resources into community based alternatives.

3-3 Authorization to renew, assign, or transfer Medicaid certification

1. The Department may renew Medicaid certification of a certified program without any lapse in service to Medicaid recipients, if its nursing facility program was certified by the Department at the same physical facility.

2. The Department may certify a new nursing facility program if a certified program transfers all of its rights to Medicaid certification to the new nursing facility program and the new program meets all of the following conditions:

a) The new nursing facility program operates at the same physical facility as the previous certified program.
b) The new nursing facility program complies with 42 CFR 442.14 (1993).
c) The new nursing facility program receives Medicaid certification within one year of the date the previously certified program ceased to provide medical assistance to a Medicaid recipient.

3. The Department may certify a previously certified program that moves to a new physical facility and meets all of the following conditions:

   a) On the last day that the certified program provided medical assistance to a Medicaid recipient in the original physical facility, it meets all applicable requirements to be a certified program.
   b) The new physical facility is in the same service area.
   c) The time between which the certified program ceases to operate in the original physical facility and begins to operate in the new physical facility does not exceed three years.
   d) The provider operating the certified program gives written assurances satisfactory to the executive director or his designee that:
      i. no third party has a legitimate claim to operate a certified program at the previous physical facility;
      ii. the certified program agrees to defend and indemnify the Department against any claims made by third parties who may assert a right to operate a certified program at the previous physical facility; and
      iii. if a third party is found, by a final agency action of the Department after exhaustion of all administrative and judicial appeal rights, to be entitled to operate a certified program at the original physical facility, the certified program shall voluntarily comply with item D of this subsection (3 21).
4. Upon a finding being made as set forth in item C. 4. C. of this subsection (3 - 21), the certified program shall immediately surrender its Medicaid certification, cease billing Medicaid for all services to Medicaid recipients, and arrange for the orderly discharge of Medicaid recipients to a facility

satisfactory to the Department. If the third party found to be entitled to operate a certified program at the original physical facility requests Medicaid certification, and the previously certified program has surrendered its Medicaid certification, the Department shall treat the request as a transfer of all its rights under item B of this subsection (3 - 21).

3-4 Certification of additional nursing facility programs

The Department may certify additional nursing facility programs if the executive director or his designee determines that there is insufficient capacity at certified programs in a service area to meet the public need.

1. The Department may certify an additional nursing facility program only when the following conditions are met:

   a) After 30-day notice to the Department of Human Services of the Department's finding that there is insufficient capacity at certified programs in a service area to meet the public need, the Department of Human Services cannot demonstrate that community-based services can meet the public need; and

   b) After the close of the 30-day notice to the Department of Human Services and a separate 30-day notice to all certified programs operating in the service area, the certified programs operating in the service area cannot demonstrate that they have tangible plans to add additional capacity to their nursing facility programs to meet the public need.

2. If community-based services and existing certified programs operating in the service area cannot demonstrate that they can meet the public need, the Department may select an additional nursing facility program through a request-for-proposal process.

   a) Each proposal must include sufficient information to allow the Department to evaluate and rank it among all proposals according to the criteria in item 2 below, as well as other information that the Department solicits in its request-for-proposals. The Department shall reject all proposals that

offer to operate for a reimbursement rate higher than that paid to similar certified programs.

b) The Department shall evaluate and select from among the proposals based on maintaining price competition, economy, and efficiency in the Medicaid program; the ability of the proposed nursing facility program to deliver quality care; and how quickly the proposed nursing facility program can begin to operate.

3. If a nursing facility program that the Department selected under the request-for-proposal process fails to undertake the necessary steps to become Medicaid certified or fails to begin to provide medical assistance to Medicaid recipients as represented in its proposal, the Department may reject that nursing facility program, and either select the next ranked nursing facility program or solicit new proposals without again complying with the requirements of item A in this subsection (3 - 22).

4. If, after certifying an additional nursing facility program, the executive director or his designee determines that there is sufficient capacity at certified programs in a service area to meet the public need, the limitations set out in items A, B and C in this subsection (3 - 22) control the certification of nursing facility programs.

3-5 Provider contract

1. With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:
   a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
   b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
   c) For providers of ICF/ID services, the requirements of participation in 42 CFR Part 483, subpart I are also met.

2. The Provider contract is appendix A.

4 Requirements for nursing facilities

4-1 Nurse aide training and competency evaluation program

Any individual working in a nursing facility as a nurse aide for more than four months on a full-time basis must have successfully completed a nurse aide training and competency evaluation program or competency evaluation program approved by the state. The Omnibus Budget Reconciliation Acts of 1987, 1989, and 1990 prohibits facilities from employing a nurse aide for more than four months on a full-time basis who has not successfully completed a nurse aide training and/or competency evaluation program approved by the state. The text of the Nursing aide training and competency evaluation program provider manual is Appendix B.

4-2 Free choice of providers

1. Except as provided in paragraph B, the Medicaid agency assures that a recipient eligible for Medicaid may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

2. Paragraph A does not apply to services furnished to a recipient:

    a) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph 3, or
    b) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph 3, or
    c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in Section 1915(b)(1) of the Social Security Act, a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the recipient may receive emergency services or services under Section 1905(a)(4)(c).

4-3 Leave of absence

Definition: Any day during which the resident is absent from a facility for therapeutic or rehabilitative purposes and does not return by midnight of the same day.

1. Reimbursement for a nursing facility resident temporarily admitted to hospital

   A nursing facility certified under Title XIX will not receive payment for any day or days for which a bed is held while a resident is temporarily in a hospital. The facility will receive payment for the day of admission to the facility, but not for the day of discharge to the hospital.

2. Reimbursement for temporary leave of absence for reasons other than admission to hospital

   a) Nursing facility
      i. Payment for therapeutic or rehabilitative leave of absence shall be limited to 12 days per calendar year for each resident of a nursing facility.
      ii. Payment for additional leave of absence days may be authorized only with prior approval from the Division of Integrated Healthcare. The facility's request for prior approval must be accompanied by appropriate and adequate documentation and must include approval of the additional leave days by the resident's attending physician and/or the interdisciplinary team as appropriate to meet and support the resident's plan of care.

   b) Intermediate care facility for people with intellectual disabilities
      i. Payment for therapeutic or rehabilitative leave of absence shall be limited to 25 days per calendar quarter for each resident of an intermediate care facility for people with intellectual disabilities.
      ii. Payment for additional leave of absence days may be authorized only with prior approval from the Division of Integrated Healthcare. The facility's request for prior approval must be accompanied by appropriate and adequate documentation and must include approval of the additional leave days by client's

attending physician and/or the interdisciplinary team as appropriate to meet and support the resident's plan of care.

c) Any therapeutic or rehabilitative leave of absence must be pursuant to a written order by the resident's attending physician, appropriately and adequately documented in the progress notes of the resident's chart and identified as rehabilitative leave by the physician and/or the interdisciplinary team as meeting and supporting the resident's plan of care.

d) All leave of absence days must be reported on the monthly billing form.

4-4 Notice of financial rights and covered services

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid of the following:

1. The items and services that are included in nursing facility services under the Medicaid State Plan and for which the resident may not be charged;

2. Other items and services the facility offers for which the resident may be charged and the amount of charges for those services.

The facility must inform each resident when changes are made to the items and services specified above.

The Medicaid flat rate reimbursement shall cover the services specified in Appendix G, Utah State Plan, Attachment 4.19D, Section 400.

4-5 Resident personal funds

Medicaid clients are permitted to retain a fixed monthly amount for personal needs. For most individuals the amount is $45 a month. For individuals receiving a VA Aid and attendance payment, the amount is $90. This monthly allowance is reserved strictly for a resident to use as wished for personal reasons and is protected as a resident right in accordance with Section 1919(F)(7) of the Social Security Act and 42 CFR 483.10.

4-6 Protection of resident personal funds

1. The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

2. Upon written authorization of a resident, the facility must hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as follows:

   a) The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and that credits all interest earned on resident's funds to that account. In pooled accounts there must be a separate accounting for each resident's share.

   b) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest bearing account, or petty cash fund.

3. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

   a) The accounting system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

   b) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

4. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less that the SSI resource limit for one person and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

5. Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final

accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

6. If the facility sells or leases the business, it must:

    a) Provide the buyer or lessee with a written statement of all of the residents' monies and properties being transferred;

    b) Obtain a signed receipt from the new owner or lessee before the sale or lease is final; and

    c) Provide each resident's legal guardian, representative payee, or other person the resident authorized to manage his personal funds; a written accounting of all funds held by the facility before any transfer of ownership. The new owner or lessee shall assume full liability for all residents' personal needs accounts.

7. The facility must notify the Social Security Administration office to have a representative payee appointed for residents who do not have a legal guardian, representative payee, or other authorized individual to manage their personal needs funds.

8. The facility must serve as a temporary representative payee for the resident until the representative payee is appointed.

9. The facility must give any benefits to the resident either personally or through the resident's personal need fund unless there is a written authorization from the resident or legal guardian to do otherwise. This includes resident entitlements from Social Security Supplemental Income, government and private pensions, Veterans Administration, and other similar entitlement programs.

10. The facility must allow the resident to access his funds for at least one hour during business hours.

11. Upon request, the facility must return funds to the resident from an outside interest-bearing account within one business day.

12. The facility may deposit the resident's Social Security check into the facility's bank account if the resident's personal needs allowance portion of the resident's check is transferred to the resident's account on the same day.

4-7 Limitations on charges to resident personal funds

The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid and not requested by the resident. The facility may not require a resident to request any item or service as a condition of admission or continued stay.

When the resident requests a non-covered item or service for which a charge will be made, the facility must inform the resident that there will be a charge and the amount of the charge. There must be an agreement in writing between the facility and the resident regarding the service and the amount to be paid by the resident prior to the resident receiving the non-covered service. Without written agreement, the facility may not bill the resident. Refer also to SECTION 1, General Information, Chapter 6 - 8, Billing patients, and 6 - 9, Exceptions to billing patients.

1. During the course of a covered Medicaid stay, the facility may not charge a resident for routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to the following:

   a) Hair hygiene supplies;

   b) Comb and brush;

   c) Bath soap;

   d) Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection;

   e) Razor;

   f) Shaving cream;

   g) Toothbrush;

   h) Toothpaste;

   i) Denture adhesive;

   j) Denture cleanser;

   k) Dental floss;

l) Moisturizing lotion;

m) Tissues;

n) Cotton balls;

o) Cotton swabs;

p) Deodorant;

q) Incontinence care and supplies

r) Sanitary napkins and related supplies;

s) Towels and washcloths;

t) Hospital gowns;

u) Over the counter drugs;

v) Hair and nail hygiene services;

w) Bathing;

x) Basic personal laundry.

2. With written agreement, categories of items and services that the facility may charge to residents' funds if they are requested and if payment is not made by Medicaid, include:

   a) Telephone;

   b) Television/radio for personal use;

   c) Personal comfort items, including smoking materials, notions and novelties, and confections;

   d) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid;

   e) Personal clothing;

f) Personal reading matter;

g) Gifts purchased on behalf of a resident;

h) Flowers and plants;

i) Social events and entertainment offered outside the scope of the activities program required by 42 CFR 483.15;

j) Non-covered special care services such as privately hired nurses or aides;

k) Private room, except when therapeutically required (for example, isolation for infection control);

l) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by 42 CFR 483.35.

4-8 Privacy act notification statement

Each facility is required to provide a Privacy Act Notification Statement to each new resident at the time of admission. The statement explains the release of certain data about each resident to the Office of Medicare/Medicaid Program Certification and Resident Assessment for data collection and analysis. The required statement follows this chapter of the manual.

Privacy Act Notification Statement

The Centers for Medicare and Medicaid Services (CMS) is authorized to collect these data by Sections 1819(f), 1919(f), 1819(b)(3)(A), and 1864 of the Social Security Act. The purpose of this data collection is to aid in the administration of the survey and certification of Medicare/Medicaid long term care facilities and to study the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1516. Information from this system may be disclosed, under specific circumstances, to: (1) a congressional office from the record of an individual in response to an inquiry from the congressional made at the request of that individual; (2) the Bureau of Census; (3) the Department of Justice; (4) an individual or organization for a research, evaluation, or epidemiological project relating to the prevention of disease of disability, or the restoration of health; (5) contractors working for CMS to carry out Medicare/Medicaid functions, collating or analyzing data, or to detect fraud or abuse; (6) an agency of a State government for purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State; (7) another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds or to detect fraud or abuse; (8) Peer Review Organizations to perform Title XI or Title XVIII functions, (9) another entity that makes payment for or oversees administration of health care services for preventing fraud or abuse under specific conditions.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

Collection of the Social Security Number is voluntary; however, failure to provide this information may result in the loss of Medicare benefits provided by the nursing

home. The Social Security Number will be used to verify the association of information to the appropriate individual.

4-9 Family income

This chapter provides instructions regarding the amount of family income to be collected by nursing facilities and the submission of family income to the appropriate state agency. There are six subsections in this chapter.

1. Determination of family income
2. Collection of family income
3. Reporting changes in family income
4. Special situations
5. Remitting income to the Office of Recovery Services
6. Definitions

4-9.1 Determination of family income

The Medicaid eligibility worker determines the amount of income the Medicaid client must pay to the facility in order to be eligible for Medicaid. This amount is called family income. When there are questions or information concerning Medicaid patients that may affect the amount of family income, Medicaid eligibility, or the collection of family income, please contact the local Medicaid worker.

It is important to be aware that Medicaid policy states that the eligibility worker must calculate family income based on the gross entitlement amount of the client's income. Sometimes the entitlement amount differs from the amount actually received by the client. In determining family income, the eligibility worker cannot allow a deduction from the entitlement amount for any amounts withheld because of a previous overpayment or court-ordered support payment.

The deduction allowed from the gross entitlement amount varies according to the client's marital status and the length of time the client is expected to stay in the facility.

1. For married clients and long term stay (more than six months) clients, the following deductions apply:
   a) A personal needs allowance of $45.
   b) The $90 VA payment.
   c) Medical insurance premium and income to be sent to the spouse at home.

2. An unmarried client is not expected to contribute as much countable income to the facility if a medical doctor expects the client to stay in the facility for six months or less. The following deductions apply:
   a) Basic maintenance needs allowance. (As of March 1999, the allowance is $382.)
   b) The cost of medical insurance.

4-9.2 Collection of family income

The facility is responsible for collecting the family income amount from the client. This amount is the portion of the cost of care the client must pay to the facility. Since this amount is owed to the facility by the client, a state agency cannot be involved in the collection process.

4-9.3 Reporting changes in family income

The facility, the client, or the client's representative is responsible to report to the Medicaid eligibility worker all changes that may affect the client's contribution to the cost of care within 10 days of the date of the change. This includes, but is not limited to, the amount of income received, medical premiums paid, length of stay, and marital status.

4-9.3.1 Income changes

If a change in income results in an increase in the client's contribution to the cost of care, do not collect the increase. Notify Medicaid eligibility immediately and they will determine what the increased contribution to the cost of care will be and when you should begin to collect it. The change will usually be effective for the next month.

If the client receives a one-time lump sum payment, do not collect it and do not send it to the Office of Recovery Services (ORS). Collect only the

usual amount of family income and contact the Medicaid eligibility worker.

If you have questions concerning the collection of family income as explained in this subsection, please contact the Medicaid eligibility worker.

4-9.4 Special situations concerning family income

This subsection addresses collection of family income in the following circumstances:

1. Income between the private pay and Medicaid rates
2. Income above the private pay rate
3. Medicare and Medicaid crossover payments
4. Death of recipient, and family income is greater than the product of the daily Medicaid rate multiplied by the countable days of institutionalization
5. Recipient is discharged, and the family income changes for the month of discharge
6. Short term hospitalization
7. Long term hospitalization

The policy references the form **Sending Family Income to ORS** (Office of Recovery Services). This form is included with this manual and follows this chapter.

If you have questions concerning the collection of family income as explained in this subsection, please contact the Medicaid eligibility worker, or you may call Medicaid Information and ask for the supervisor for Nursing Home Medicaid eligibility workers.

4-9.4.1 Income between the private pay and Medicaid rates

When the family income is more than the Medicaid rate but less than the facility's monthly private pay rate, please take three actions:

1. Collect the family income.
2. Keep enough of the family income to cover the Medicaid rate.

3. Submit the remaining income to Recovery Services with the form **Sending Family Income to ORS**. Mark 1 on the form to indicate the income is between the private pay and Medicaid rate.

4-9.4.2 Income above the private pay rate

If the family income is more than the facility's monthly private pay rate, take two actions:

1. Collect from the resident enough income to cover the family income.

2. Contact the Medicaid eligibility worker. He or she will confer with you to determine if it is in the resident's best interest to seek Medicaid coverage for ancillary services. Please assist the worker in establishing the anticipated cost of ancillary charges and the resident's cost for long term care at the Medicaid rate.

   a) Resident eligible for coverage of ancillary charges.
      i. The Medicaid worker determines the amount of family income owed to the State. (The resident is allowed to keep more than the standard personal needs allowance.)
      ii. The resident must remit the correct amount of income to the Medicaid office before he or she is actually eligible for Medicaid for that month.
      iii. The Medicaid worker will notify you when the resident is eligible for Medicaid to cover ancillary charges only. Once the resident pays the monthly amount owed to the State, Medicaid will cover medical costs other than the nursing facility rate.

   b) Resident NOT eligible for coverage of ancillary charges.
      i. If the resident is no longer eligible for Medicaid, the Medicaid case is closed.
      ii. If the resident does not pay the monthly amount owed to the State, the Medicaid case is closed.
      iii. When the resident is not eligible for Medicaid, the facility may charge the private pay

4-9.4.3 Medicare and Medicaid crossover payments

When Medicare and Medicaid crossover payments cover part of the Medicaid rate and family income covers the remainder of the rate, take two actions:

1. Collect the entire amount of family income amount.
2. Keep enough of the family income amount to cover the remainder of the Medicaid rate.

Submit all remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark line 2 of the form to identify the refund as one which results from Medicare/Medicaid coverage.

When Medicare and Medicaid crossover payments cover all of the Medicaid rate, take these actions:

1. Collect the entire amount of family income.
2. Submit all family income to Recovery Services with the form **Sending Family Income to ORS**.
3. Mark 2 on the form to identify the refund as one which results from Medicare/Medicaid coverage.

4-9.4.4 Death of recipient, and family income is greater than the product of the daily Medicaid rate multiplied by the countable days of institutionalization

When the recipient dies, and the family income amount is greater than the per diem rate for the total days billed, follow these instructions:

1. Collect the entire amount of family income. Please explain to the responsible party that:
   a) There may be bills for medical care other than the nursing facility charge, and all family income must be applied toward payment of these medical costs.
   b) The responsible party may request a refund by contacting the Medicaid eligibility worker. The refund amount will be the family income minus

the costs of all medical care, including the nursing facility charge. Refer to subsection F of this chapter, Refunds of Income Sent to ORS.

c) Of the family income collected, the facility is entitled to keep the product of the per diem rate multiplied by total days billed.

d) Send the remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 3 on the form to identify the payment as one resulting from death or discharge of the recipient.

2. If the responsible party refuses to pay the entire amount owed, contact the Medicaid worker and report the amount you have collected. If you have collected more than the Medicaid rate, follow the directions in item A above.

4-9.4.5 Recipient is discharged and the family income changes for the month of discharge

If the client is single or has a spouse who is also a resident of a medical institution, the client may be entitled to keep a larger portion of family income for the month of discharge. The Medicaid agency requests that the facility assist in refunding to the client as soon as possible the difference between the original family income collected and the correct amount. The client needs this money to live on during the month of discharge.

1. The facility can help in two ways:

a) Notify Medicaid. You can help by expeditiously notifying the Medicaid worker that the client has left the facility. The Medicaid worker will compute a new family income amount, which may be less than the original amount collected.

b) Make refund.

After the worker tells you the correct family amount, please refund the difference between the original amount collected and the correct amount to the client. Make this refund as soon as possible.

There are two exceptions to the refund process:

i. If refunding income to the client creates a hardship for your facility for any reason, let the Medicaid worker know. The worker can request the refund from the Division of Integrated Healthcare. The Division will correct your nursing facility payroll as necessary.

ii. Any refunds computed for the month of discharge after the month following the month of discharge will be handled through the Division's internal procedures.

2. Family income collected exceeds nursing facility bill

In some cases, after all adjustments are made, the amount collected by the facility will still exceed the amount owed to the facility. If so, take two actions:

a) Of the family income collected, keep the product of the per diem rate multiplied by total days billed.

b) Send the remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 3 on the form to identify the payment as one resulting from the discharge of the client.

4-9.4.6 Short term hospitalization

Short term hospitalization is any month during which the recipient is a resident of a LTC facility, is discharged to a hospital, and then returns or is expected to return to the facility by the end of the next month. The facility should take three actions:

1. Collect the family income.

2. Of the family income collected, the facility is entitled to keep the product of the per diem rate multiplied by the total days billed.

3. Send the remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 4 on the form to identify the payment as one resulting from short term hospitalization.

4-9.4.7 Long term hospitalization

Any hospitalization which does not meet the short term definition is long term. In long term hospitalizations, take four actions:

1. Notify the Medicaid worker that the client is in the hospital for a long term stay.

2. Collect the family income amount for the month the client is discharged to the hospital.

3. Calculate and keep the cost of care, which is the product of the per diem rate multiplied by the total days billed.

4. Send the remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 5 on the form to identify the payment as one resulting from long term hospitalization.

Family income for subsequent months of hospitalization

Generally, the Medicaid office will collect family income for months after the initial month the client is in the hospital. However, collection can be negotiated between the Medicaid office and the facility. For example, when the facility is the payee for the client, and it is expected that the client will return to the facility, it may be simpler for the facility to continue collecting the family income. During these months, send any family income collected to the local Medicaid office with the form Sending Family Income to ORS. Mark 5 on the form to identify the payment as one resulting from long term hospitalization.

4-9.5 Remitting income to the Office of Recovery Services

When sending family income to Recovery Services, **make checks payable to ‘Office of Recovery Services’**. Send the check to the following:

ATTN: Team 85
Department of Health and Human Services
Office of Recovery Services, Medicaid Section
P.O. Box 45025
Salt Lake City, Utah 84145-5025

Attach a copy of the form **Sending Family Income to ORS** to the check. This form appears on the next page. Place an X on the appropriate line to inform ORS of the reason for the refund.

4-9.6 Refunds of income sent to ORS

If the client or family asks for a refund of any family income that has been or should be sent to ORS, instruct them to contact the local Medicaid worker. The only exception to this is found in subsection D - 4 of this chapter (Death of recipient, and family income is greater than the product of the daily Medicaid rate multiplied by the countable days of institutionalization).

UTAH MEDICAID PROGRAM

NURSING HOME PROGRAM

SENDING FAMILY INCOME TO OFFICE OF RECOVERY SERVICES (ORS)

When it is appropriate to submit income to ORS, make checks payable to ORS and send to:

Attention: Team 85
Department of Human Services
Office of Recovery Services, Medicaid Section
P.O. Box 45025
Salt Lake City, Utah 84145-5025

Attach this form to the refund check and identify the reason for the refund by placing an X in the appropriate space.

1. **Income Between the Private Pay and Medicaid Rate**
2. **Medicare and Medicaid Cross-Over Payments**
3. **Recipient Dies or is Discharged and the Family Income is Greater than the Product of the Daily Medicaid Rate Multiplied by the Countable Days of Institutionalization.**
4. **Short Term Hospitalization**
5. **Long Term Hospitalization**

4-10 Nursing facility refunds to Medicaid clients who paid the private pay rate

When a nursing facility resident is or becomes eligible for Medicaid, the resident's financial liability is limited to the monthly client contribution to cost of care required by Medicaid. The client contribution, also called the family income amount, is determined by the Medicaid eligibility worker. The family income amount is stated in the Medicaid notice of eligibility. See also Chapter 4 - 7, Family income.

If the resident has paid or been billed at the private pay rate for the month and then becomes eligible for Medicaid for the same month, the facility may owe the client a refund. The facility must refund to the client the difference between the amount paid and the family income amount. The facility may bill Medicaid for any cost of care not covered by the family income amount.

The facility must refund any excess income paid because it is required to accept the Medicaid reimbursement amount as payment in full. The Medicaid reimbursement is the client's contribution to cost of care *plus* the remainder of the Medicaid per diem payment. Residents eligible for Medicaid must not be billed in excess of the required contribution to cost of care.

5 Preadmission screening and continued stay review

R414-501 of the Utah Administrative Code (UAC) defines the preadmission and continued stay review process.

Please refer to http://www.rules.utah.gov/publicat/code/r414/r414-501.htm for the most current information relating to this rule.

5-1 Preadmission/continued stay inpatient care transmittal (form 10A)

The Preadmission/Continued Stay Inpatient Care Transmittal (commonly known as Form 10A) is the document used in the nursing preadmission and continued stay approval process. Form 10A contains data elements that will be entered into the computer system and generate the approved level of care. Errors in the completion of Form 10A will result in delay and/or nonpayment of services approved for

payment. Form 10A and instructions are included with this manual as Appendix E.

5-2 Patient/resident release of information

The Patient/Resident Release of Information form is for authorization from the resident, or the responsible party and/or next of kin. The release permits the Resident Assessment Section to review the medical and psycho-social information necessary and to assess care and service needs relating to the proposed placement in the nursing facility or ICF/ID specified in the Form 10A. A copy of this form is on the next page of this manual.

Department of Health and Human Services	Patient Name ______________________
Division of Integrated Healthcare	I D # ______________________
Office of Facility Review	Facility Name ______________________
Patient Release of Information	NPI #______________________

PATIENT / RESIDENT Release of Information:

I hereby authorize the release to PATIENT ASSESSMENT SECTION, information relative to my medical and social status for the purpose of assessing my care/service needs in relationship to the proposed placement in the nursing care facility specified in this document.

If placement in a nursing care facility is not recommended at this time, I also authorize the release by PATIENT ASSESSMENT SECTION to other State agencies of pertinent information from my file for the purpose of developing implementing and appropriate alternative placement to meet my medical/social care and service needs.

SIGNATURE____

Patient/Resident Date

SIGNATURE____

Next of Kin and/or responsible party Date
(if applicable)

5-3 Nursing facility levels of care

R414-502 of the Utah Administrative Code (UAC) defines the levels of care provided in nursing facilities.

Please refer to http://www.rules.utah.gov/publicat/code/r414/r414-502.htm for the most current information relating to this rule.

5-4 Preadmission screening and annual resident review

R414-503 of the Utah Administrative Code (UAC) implements requirements for the preadmission screening and annual review of nursing facility residents with serious mental illness or for people with intellectual disabilities.

Please refer to http://www.rules.utah.gov/publicat/code/r414/r414-503.htm for the most current information relating to this rule.

5-5 Preadmission screening and annual resident review identification screen

The Preadmission Screening and Annual Resident Review Identification Screen which follows is the document to be used in the Level I screening process.

STATE OF UTAH
Preadmission Screening and Resident Review
Identification Screening
(Level I – ID Screen)

INSTRUCTIONS FOR FILLING OUT ID SCREEN

1. ID SCREEN MUST BE COMPLETED PRIOR TO ADMISSION TO MEDICARE/MEDICAID CERTIFIED NURSING HOME, REGARDLESS OF THE PAYMENT SOURCE.
2. PAGES 4 AND 5 MUST BE READ, AND QUESTIONS ANSWERED *BEFORE* **SECTIONS A** AND **B** ON *PAGE 3* ARE COMPLETED.
3. FILL OUT PAGE 3 THROUGH 5 COMPLETELY, KEEP THIS FORM WITH THE PATIENT'S MEDICAL RECORDS.

IF A PREADMISSION/CONTINUED STAY INPATIENT CARE TRANSMITTAL (10A) FORM IS SENT TO THE RESIDENT ASSESSMENT SECTION FOR MEDICAID REIMBURSEMENT, PLEASE COPY PAGES 3, 4, AND 5, SEND WITH TRANSMITTAL TO:

UTAH DEPARTMENT OF HEALTH RESIDENT ASSESSMENT SECTION 288 NORTH 1460 WEST P.O. BOX 142905 SALT LAKE CITY, UT 84114-2905

IF YOU HAVE QUESTIONS, PLEASE CALL RESIDENT ASSESSMENT DEPT at (801) 538-6158, OR TOLL FREE 1-800-662-4157.

THE LOCAL PASRR OFFICES FOR SMI ASSESSMENTS ARE:

1. Salt Lake, Summit, and Tooele counties: 801-567-3663
2. Box Elder, Cache, Rich, Morgan, and Weber counties: 801-625-3840
3. Wasatch and Utah counties: 801-373-7394
4. Davis County: 801-773-7060
5. Washington County: 435-634-5600
6. Iron County: 435-586-8226
7. Kane, Garfield and Beaver counties: 435-676-8176
8. Carbon, Daggett, Duchesne, Emery, Grand, Juab, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne counties: 435-6546465.

STATE DIVISION OF MENTAL HEALTH/PASRR SECTION 801-538-9857

STATE DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES/PASRR SECTION FOR PEOPLE WITH INTELLECTUAL DISABILITIES OR DEVELOPMENTAL DISABILITY ASSESSMENTS 801-538-4209

THE LEVEL-1 ID SCREEN WILL BE BASED ON FEDERAL MINIMUM CRITERIA REQUIRED UNDER SECTION 1929(b)(3)(f) OF THE SOCIAL SECURITY ACT AND MUST, AT A MINIMUM, INCLUDE AN EVALUATION OF THE FOLLOWING CRITERIA TO DETERMINE IF THE APPLICANT/RESIDENT HAS A POSSIBLE SERIOUS MENTAL ILLNESS AND/OR INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITY.

Revised 10/12

NOTICE OF REFERRAL FOR
PREADMISSION SCREENING RESIDENT REVIEW (PASRR)
LEVEL – II EVALUATION

NAME: ____

SOCIAL SECURITY NUMBER: _______: _________ : _________

This is to inform you and your legal representative that you have received a positive PASRR Level-I identification screen (ID Screen) for the licensed health care professional signing this notice.

A positive Level-I ID Screen indicates you have a diagnosis of mental illness or intellectual disability/developmental disability. This requires a referral for a Level-II evaluation.

When the PASRR Level-I Screen is positive, a PASRR Level-II evaluation must be done prior to admission to a Medicaid certified nursing facility, regardless of the source of payment.

You will be contacted by a representative from either the Division of Mental Health or the Division of Services for People with Disabilities, to arrange for the PASRR Level-II evaluation.

If you have questions regarding this notice, please contact the Level-I ID Screen evaluator.

____

Signature: Level-I ID Screen Evaluator & Phone Number

____

Date

cc: Legal Representative

PREADMISSION SCREENING RESIDENT REVIEW
IDENTIFICATION (ID) SCREENING
DOCUMENT NUMBER
- - - - - - - - - - - - - -

Screening Date: _______ / _________ / _________
MM DD YY

Name: _______________________________ Soc. Sec. No.: _____ - ___ - ____

DOB: : _____ / _____ / _____Medicaid #:_________ Medicare #:___________
MM DD YY

Facility: ______________________________ Admission Date: ____ - ___ - ___
MM DD YY

Residence: ____
Address City State Zip

Placement prior to Request for Nursing Facility: ___________________________

Nursing Facility Payment Source: __________________________________

- -

THIS SECCTION TO BE FILLED OUT BY A LICENSED HEALTH PROFESSIONAL: I certify that the above information is true and correct to the best of my knowledge and is adequately documented in the applicant/resident case record.

- -

____

PLEASE PRINT NAME AND TITLE OF PROFESSINOAL

_______________________________ ___________________ ______ / ____ / ____

Signature Title MM DD YY

SECTION A: Current Medical Diagnosis (with ICD-10-CM coding)

1. (_____ - _____)____________________ 4. (_____ - _____)____________________

2. (_____ - _____)____________________ 5. (_____ - _____)____________________

3. (_____ - _____)____________________ 6. (_____ - _____)____________________

SECTION B: Psychiatric Diagnosis (with ICD-10-CM Coding)

1. (_____ - _____)____________________ 2. (_____ - _____)____________________

***THE APPLICANT HAS BOTH A SMI AND MR/DD DIAGNOSIS: YES ( ) NO ( )**

Instructions on page 5 indicate Intellectual Disability/Developmental Disability YES ( ) NO ( )

REFFERED BY PASRR LEVEL-II DATE: ______ / ____ / ____

MM DD YY

NAME OF PERSON AND AGENCY CONTACTED: __________________________________

PASRR EXEMTPION/HOSPITAL TRANSFER ONLY: DISCHARGE M.D. HAS CERTIFIED IN WRITING; THE NURSING FACILITY STAY IS ANTICIPATED TO BE LESS THAN 30 DAYS. YES ( ) NO ( )

LEVEL I REVISION DUE TO: ____________________________**DATE:**______ / ____ / ____

MM DD YY

SIGNATURE: ____

*Call both Mental Health & MR/DD PASRR Programs

SERIOUS MENTAL ILLNESS
CATEGORIES AND CRITERIA

Schizophrenia and Other Psychotic Disorders
Depression or Bipolar Disorders
Delusional Disorder
Panic or Other Server Anxiety Disorders
Somatization Disorders
Borderline Personality Disorder

THE APPLICANT/RESIDIENT REQUIRES A REFERRAL FOR A PASRR LEVEL-II ASSESSMENT WHEN:

1. THERE IS A CURRENT SMI DIAGNOSIS OR WITHIN THE PAST YEAR, THERE HAVE BEEN SYMPTOMS OF A SERIOUS MENTAL ILLNESS THAT FALL INTO THE ABOVE CATEGORIES, **AND IF ANY** OF THE QUESTIONS BELOW ARE MARKED YES.

2. THIS SMI DIAGNOSIS PREDATES THE ONSET OF ANY ORGANIC MENTAL DISORDER (I.E., CVA, DEMENTIA, MENTAL DISORDER DUE TO A GENERAL MEDICAL CONDITION, ETC.)

   YES________ NO________

3. THIS PERSON IS CURRENTLY RECEIVING, OR IN THE PAST YEAR HAS BEEN PRESCRIBED AN ANTIPSYCHOTIC, ANTIDEPRESSANT OR ANTIANXIETY MEDICATION FOR A SMI.

   YES________ NO________

COMMENTS: ____

____

____

____

____

____

PERSON WITH INTELLECTUAL DISABILITES
DEVELOPMENTAL DISABILITY
CRITERIA

REFER FOR A PASRR LEVEL-II ASSESSMENT IF ANY OF THE FOLLOWING ARE MARKED YES.

THE RESIDENT APPLICANT HAS A DIAGNOSIS OF PERSON WITH INTELLECTUAL DISABILITIES

YES (   ) NO (   )

IF YES, LIST DIAGNOSIS: ____

__________________________________ **OR**

THE RESIDENT/APPLICANT HAS A DIAGNOSIS OF A RELATED CONDITION; I.E., CEREBRAL PALSY, TRAUMATIC BRAIN INJURY, EPILEPSY/SEIZURES, OR AUTISM, (THIS IS NOT AN ALL- INCLUSIVE LIST), OR DEVELOPMENTAL DELAYS, WHICH INCLUDES A HISTORY OF FUNCTIONAL LIMITATIONS RELATED TO THAT CONDITION WHICH:

C. OCCURRED PRIOR TO HIS/HER 22ND BIRTHDAY YES ( ) No ( )
D. IS LIKELY TO CONTINUE THROUGHOUT HIS/HER LIFE YES ( ) No ( )
E. HAS RESULTED IN SIGNIFICANT FUNCTIONAL DEFICITS YES ( ) No ( )

COMMENTS: ____

____

____

____

____

____

____

____

6 Program certification and resident assessment

6-1 Program survey and certification

Requirements related to program survey and certification are contained in state operations manual transmittals 273, 274 and 277. Copies of these transmittals can be obtained from the Office of Medicare/Medicaid Program Certification and Resident Assessment.

6-2 Alternative remedies for nursing facilities

R414-7C of the Utah Administrative Code (UAC) provides for the imposition of alternative remedies as the result of on-site inspection findings.

Please refer to http://www.rules.utah.gov/publicat/code/r414/r414-07c.htm for the most current information relating to this rule.

6-3 Minimum Data Set (MDS)

All certified Medicare or Medicaid nursing facilities must complete, record, encode and transmit the Minimum Data Set (MDS) for all residents in the facility, regardless of age, diagnosis, length of stay or payment category. MDS requirements do not apply in the following situations:

1. Unless otherwise required by the state, licensed-only nursing facilities that do not participate in either Medicare or Medicaid.

2. Unless otherwise mandated by the state, individuals residing in non-certified units of nursing facilities.

7 Billing and reimbursement

7-1 LTC turnaround document (TAD) replaced by 837 I

Utah Medicaid has replaced the proprietary TAD with the HIPAA compliant 837 Institutional (837I) electronic transmission.

The Utah Medicaid LTC Companion Guide for the 837I can be found here. (For more details about electronic billing see the "EDI with UHIN and Utah Medicaid" article in the January 2006 Medicaid Information Bulletin).

Ancillary services include any services rendered by a medical provider that are not included as part of the nursing facility daily rate. These services must be provided by and billed by the ancillary service provider. The ancillary service provider must be an enrolled Medicaid provider for the services rendered in order to seek reimbursement. Medicaid coverage and criteria are applicable to all ancillary services. See also: Utah State Plan, Attachment 4.19-D; Section 430, Non-Routine Services.

8 Payment rates and cost profiling

8-1 Nursing facility reimbursement

The Utah State Plan, Attachment 4.19-D, provides details concerning nursing facility reimbursement. For details visit the website at http://health.utah.gov/medicaid/stplan/longtermcare.htm.

Utah Medicaid Provider Manual

Medical Supplies and Durable Medical Equipment

Division of Integrated Healthcare

Updated January 2024

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1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, noting the specific link that is not working and the page number where the link is.

For general information regarding Utah Medicaid, refer to Utah Medicaid Provider Manual, Section I: General Information.

1-1 Medical supplies and durable medical equipment (DME) services

This manual is designed to be used in conjunction with Section I: General Information and other sections and attachments. Refer to the Utah Medicaid website at https://medicaid.utah.gov for additional resources.

Not all medical supplies and DME are mentioned within this manual. However, the Coverage and Reimbursement Code Lookup contains information about coverage status and limitations for specific items listed by Healthcare Common Procedure Code (HCPCS).

Information in this manual represents services available when medically necessary. For information regarding medical necessity, refer to Section I: General Information Chapter 8-1 Medical necessity.

For information specific to EPSDT eligible members, refer to the EPSDT Services Manual.

2 Health plans

For more information about Managed Care Entities (MCEs), refer to Section I: General Information, Chapter 2, Health plans.

Refer to Section I: General Information Chapter 1-7, Fee for service and managed care, for managed care entities (MCEs), and verify if a Medicaid member is enrolled in an MCE.

3 Provider participation and requirements

To enroll as a Medicaid provider for medical supplies and DME, refer to Section I: General Information Chapter 3, Provider participation and requirements.

4 Record keeping

Refer to Section I: General Information, Chapter 4, Record keeping.

5 Provider sanctions

Refer to Section I: General Information, Chapter 5, Provider sanctions.

6 Member eligibility

Refer to Section I: General Information, Chapter 6, Member eligibility, for information about verifying a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member responsibilities

For information on member responsibilities, including establishing eligibility and co-payment requirements, refer to Section I: General Information, Chapter 7, Member responsibilities.

8 Programs and coverage

8-1 Definitions

The following definitions are specific to the content of this manual.

Definitions of terms used in multiple Medicaid programs are in Section I: General Information, Chapter 1-9, Definitions and Utah Administrative Code R414-1.

Carve-out services: Services not included in the Medicaid contract with an MCE are carve-out services and paid through fee for service. Example: Apnea monitors are a carve-out service

Customized manual wheelchair: A wheelchair that has been measured, fitted, or adapted in consideration of the member's body size, disability, period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs that are intended for individual member's use following instructions from the member's physician

Durable medical equipment or equipment: Items that are primarily and customarily used to serve a medical purpose and are not generally beneficial to an individual in the absence of a disability, illness, or injury, can withstand repeated use, and can be reusable or removable

Enteral nutrition (EN): EN is the provision of nutritional requirements through a tube into the gastrointestinal (GI) tract and administered by syringe, gravity, or pump

Maintenance: Servicing of equipment that, based on the manufacturer's recommendations, needs to be performed by a provider

Manual wheelchair: A wheelchair that can be self-propelled or pushed by another individual and is not a power wheelchair

Medical supplies or supplies: Items that are consumable, disposable, or cannot withstand repeated use by more than one individual that is required to address an individual medical disability, illness, or injury

National drug code (NDC): Unique product identifier used in the United States for drugs intended for human use

Optimally configured manual wheelchair: A manual wheelchair with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories

Orthotic device: An orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body

Physician: Defined in sections 1861(r)(1) and 1861(aa)(5) of the Social Security Act and acting within their scope of practice

Power wheelchair: A wheelchair propelled utilizing an electric motor rather than manual power

Prosthetic device: Replacement, corrective or supportive devices prescribed by a physician to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunctions (including promotion of adaptive functioning), or support a weak or deformed part of the body

Repair: To fix or mend and put the equipment back in good condition after damage or wear

Replacement: To change an existing piece of equipment with an identical or nearly identical item

Total parenteral nutrition (TPN): Nutritional support given by means, such as intravenously (IV), other than through the GI tract

Warranty: A guarantee to the purchaser or owner of equipment promising to repair or replace, if necessary, within a specified period

8-2 Requirements for obtaining medical supplies or DME

Orders for equipment or supplies require:

1. documentation supporting medical necessity maintained in the member's medical records
   a) submission of documentation for PA
2. a physician's order including the following information:
3. member's name
4. date of the order
5. the start date, if the start date is different from the date of the order
6. diagnosis
7. a detailed description of equipment or supplies

8. duration of use
9. for items used periodically, the written order must include dosage and duration frequency of use
10. number of refills
11. refills expire 12 months from the date of initial signature
12. quantity to be dispensed
13. route of administration
14. a physician's signature following Section I: General Information Chapter 4-6, Signature requirements

Medical supplies filled monthly may be refilled between days 25 and 30 to ensure that the member has the needed product for subsequent usage.

8-3 Face-to-face requirements

Under 42 CFR 440.70, providers must comply with the face-to-face requirements related to equipment and supplies. Therefore, providers must be aware of the equipment and supplies required for a face-to-face evaluation as mandated by the Center for Medicare and Medicaid Services (CMS). See the CMS Face-to-Face Encounter Requirement for Certain Durable Medical Equipment for details.

For the initiation of equipment and supplies requiring a face-to-face evaluation, the evaluation must be related to the primary reason the member needs the item. In addition, it must occur no more than six months before services start.

Documentation must support that the face-to-face encounter is related to the primary reason the member requires medically necessary equipment or supplies and occurred within the timeframes needed before services start.

In addition, documentation must indicate:

1. the evaluating physician
2. the date of the face-to-face
3. if the evaluation was conducted via telehealth

Medicaid will deny equipment or supplies coverage unless the physician documents a face-to-face encounter with the member consistent with the requirements outlined in this manual, Utah Administrative Code R414-1-30, and 42 CFR 440.70.

All other criteria, in addition to the face-to-face requirement, for equipment and supplies, must be met to qualify for coverage.

8-4 Quantity limits

Providers can find information regarding quantity limits in Section I: General Information, Chapter 9-3.5, Quantity limits. In addition, specific HCPCS code quantity limits for equipment and supplies are found using the Coverage and Reimbursement Code Lookup.

8-5 Long-term care facilities – medical supply and DME coverage

For details on covered equipment and supplies for members residing in a long-term care facility, refer to the Utah State Plan, Attachment 4.19-D 430 Non-Routine Services.

8-5.1 Nursing facility reimbursement

For details, refer to Medicaid's Long-Term Care Resources.

8-5.2 Equipment and supplies within the per diem rate

For this manual, equipment, supplies, and services for members residing in long-term care facilities covered in the per diem rate include, but are not limited to, the following:

1. Routine personal hygiene items and services as required to meet the needs of the member:

basins	denture cleaner	soaps
bedpans	deodorant	tissues
brush	disinfecting soaps	toothbrush
comb	hair hygiene supplies	toothpaste
cotton balls	moisturizing lotion	towels
cotton swabs	sanitary napkins	washcloths
dental floss	razor	water pitchers

denture adhesive
shaving cream

2. Items stocked at nursing stations or on the floor in gross supply:

adhesive bandages
alcohol wipes
applicators
catheters
colostomy bags
compression stockings
cotton balls
CPAP/Bi-PAP supplies
gauze
hospital gowns
incontinence supplies
irrigation supplies
IV equipment
ostomy supplies
oxygen masks
oxygen tubing
routine dressings
suppositories
syringes
tape
tongue depressors

3. Items used by individual patients which are reusable and expected to be available such as:

bed rails
canes
crutches
ice bags
traction equipment
standard beds
walkers
wheelchairs

4. Special dietary supplements for tube feeding or oral feeding except those indicated as ancillary services.
5. Specialized cleaning agents when indicated to treat unique skin problems or to fight infection.

8-5.3 Equipment and supplies reportable as ancillary services

Ancillary equipment, supplies, and services reportable outside of the per diem coverage are:

1. Oxygen
2. Enteral or parenteral nutrition meeting the criteria found in Chapter 8-9 Nutrition general
3. Prosthetic devices to include:
   a) Artificial legs
   b) Artificial arms
   c) Artificial eyes

   d) Special braces
4. Equipment approved by Medicaid for individual members. This equipment is currently limited to:
   a) Air or water flotation beds
   b) Mattresses or overlays for the treatment of decubitus ulcers
   c) Power wheelchairs
   d) CPAP/Bi-PAP machine
   e) Customized wheelchairs meeting the criteria outlined in the Utah Medicaid definition
   f) Negative pressure wound therapy equipment and supplies

8-6 Purchases and rentals

DME may be available for purchase, capped rental, or continuous rental. Items identified as capped rental or continuous rental must be reported with a correct modifier. Failure to use the correct modifier will result in denial of the submitted claim.

8-6.1 Purchased equipment

DME purchased under the Medicaid program must be new, unused equipment. The DME provider must retain invoices in the member's record documenting the equipment is new.

Refurbished, rebuilt, or used equipment is not covered for purchase by Medicaid unless specifically authorized in writing by Medicaid.

8-6.2 Capped rental

Certain DME is reimbursable as a capped rental. After 12 consecutive months, Medicaid considers the equipment to be paid in full and owned by the member.

If there is an interruption of 60 consecutive days or more during the capped rental period, and the equipment is returned to the provider. In that case, a new 12-month rental period will begin if reordered at a later date.

Providers must submit claims for capped rental DME with an LL modifier on the claim.

8-6.3 Continuous rental

Providers may furnish limited specialized equipment to the member on a permanent rental basis as indicated in the coverage policy.

The continuous rental rate includes maintenance and backup equipment if needed.

Providers must submit claims for continuous rental DME with an RR modifier.

8-7 Incontinence products

Incontinence products are covered for traditional Medicaid members with documentation supporting medical necessity.

The following quantity limits apply to any combination of the covered incontinence supply codes for a one-month supply. If the member's need exceeds these limits, PA is required.

1. members on traditional Medicaid programs - 156 per 30-day period
2. members on a waiver program do not have a quantity limit

Incontinence supplies are not covered for normal infant use.

8-8 Urinary catheters

Refer to the Coverage and Reimbursement Code Lookup for specific coverage information by HCPCS code.

A coude tip catheter is considered medically necessary for male or female members only when the member cannot use a straight tip catheter.

8-9 Nutritional services

Medical foods, enteral formula, and parenteral formula are covered services when medically necessary. When reporting or requesting medical foods or enteral formula, providers must ensure the appropriate HCPCS code is used and is listed as covered in the Coverage and Reimbursement Code Lookup. Medicaid uses the Pricing, Data Analysis and Coding (PDAC) to ensure the appropriate HCPCS code is requested for each product.

As a primary payor to the Utah Women, Infants and Children (WIC) Program, Medicaid covers medically necessary nutritional services. When nutritional services are non-covered, providers are encouraged to direct members to WIC when the member meets the criteria for receiving WIC benefits. Members younger than five years of age or pregnant are eligible for the WIC program.

Medical foods and enteral formulas require prior authorization for members 21 years old and older. Quantity limits control the associated supplies and equipment.

Requests for enteral formula and medical foods must include the following documentation:

1. A physician's order includes:
   a) Diagnosis(es)
   b) Product name
   c) Total daily prescribed intake amount (e.g., ml, gram, etc.)
   d) Daily frequency of ingestion
   e) Duration or period the product is to be used (e.g., days, weeks, months, etc.)
   f) Height and weight of the member
      i. History regarding significant changes should be included.
2. Documentation supporting medical necessity
   a) If less expensive nutritional products are available, documentation to justify the costlier product.

8-9.1 Donor human milk

Medicaid coverage for human donor milk applies to members residing in a home setting. The provider must be a donor human milk bank certified by the Human Milk Bank Association of North America and enrolled as a Utah Medicaid provider.

The member must meet the following criteria:

1. Member is Medicaid eligible and age birth through 11 months
2. The requesting prescriber is the infant's treating practitioner
3. Completed feeding trial
4. The requesting prescriber has addressed with the parent or guardian the benefits and risks of using donated milk. Refer to the FDA for additional information on the Use of Donor Human Milk

5. The prescriber has given the parent or guardian information concerning donor screening, pasteurization, milk storage, and transport of the donated milk
6. An informed consent signed and dated by the parent or guardian, outlining the risks and benefits using banked donor human milk
   a) Prior authorization obtained
7. The request must be resubmitted every 180 days
8. To request a PA, the infant's treating physician will submit:
   a) Request for Prior Authorization Form
   b) Donor Human Milk Request Form
   c) Documentation supporting the finding that donated human breast milk is medically necessary for the intended recipient and why the mother cannot supply the breast milk

8-9.2 Total nutrition by enteral tube

Total nutrition by enteral tube is covered when a member receives 90% or more of their daily nutritional requirements via an enteral tube. Members weaning from total enteral tube feedings are covered for three months and then transition to the supplemental nutrition policy.

Enteral formula is non-covered for members under one year of age. An exception to this policy is found under Chapter 8-9.4, Inborn errors of metabolism.

8-9.3 EPSDT oral and supplemental enteral nutrition:

The policy for EPSDT eligible members requiring oral nutrition or supplemental enteral nutrition requires the member to have one of the following medical conditions:

1. Acquired Immune Deficiency Syndrome (AIDS),
2. Malnutrition/malabsorption because of a stated primary diagnosed disease and being in a wasting state
   a) Have a Weight for Length (WFL) <=5th percentile for three years of age or under
   b) Body Mass Index (BMI) <=5th percentile (ages 4-17)

    c) BMI <=18.5 percentile (ages 18-20)
    d) BMI <=25 percentile with an unintentional weight loss of five percent in one month, seven and a half percent in three months, or 10 percent in six months
3. Metabolic disorders requiring a specialized nutrition product
4. Cancer
    a) Receiving chemotherapy or radiation therapy
    b) Up to 3 months following completion of chemotherapy or radiation therapy
5. Chronic renal failure
6. Decubitus pressure ulcers
    a) Stage three or greater
    b) Stage two with documentation that member is malnourished
7. Maintenance patients with an increase of less than 10 BMI percentile points or an increase of less than 2 BMI in the past year

Medical foods or enteral formulas are not covered as calorie packing options or used to treat failure to thrive, inadequate growth, or weight gain.

Oral or supplemental enteral nutrition is non-covered for adults 21 years of age or older except for members with inborn errors of metabolism. Refer to Chapter 8-9.4, Inborn errors of metabolism, for additional information.

8-9.4 Inborn errors of metabolism

Enteral formula and medical foods for the treatment of inborn errors of metabolism are covered services. Both services are covered for members under one year of age. Reporting of these services is limited to the following:

1. Members 21 years or older should report the following code regardless of delivery method.
    a) B4157 - Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
2. EPSDT members receiving enteral formula or medical foods for the

treatment of inborn errors of metabolism are reported with the following:

a) B4162 - Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
b) S9435- Medical foods for inborn errors of metabolism.

Specific medical food coverage information is found in the Coverage and Reimbursement Code Lookup.

8-9.5 Nutritional products and residents of long-term care facilities

When criteria are met, parenteral solutions and total enteral therapy administered through a tube are covered for members residing in long-term care facilities.

Covered supplies include:

1. Parenteral solutions
2. A monthly parenteral nutrition administration kit which includes all catheters, pump filters, tubing, connectors, and syringes relating to the parenteral infusions
3. Enteral solution for total enteral therapy given by tube and includes all supplies

8-9.6 Parenteral therapy

Specific coverage information is found in the Coverage and Reimbursement Code Lookup.

8-9.7 Coverage limitations for nutritional products

Oral nutritional supplements for adults are not a Medicaid benefit except for members with inborn errors of metabolism.

Enteral formula is not covered for members under one year of age, as most enteral products are breast milk substitutes.

8-10 Prosthetic and orthotic devices

Providers can find code coverage for prosthetic and orthotic devices on the Medicaid Coverage and Reimbursement Code Lookup.

8-11 Speech generating devices (SGD) and augmentative alternative communication devices (AAC)

Medicaid covers SGD and AAC. Coverage of this equipment is determined using evidence-based criteria.

Further information regarding code coverage for SGDs and AACs can be found on the Medicaid Coverage and Reimbursement Code Lookup.

8-12 Oxygen and respiratory related equipment

The oxygen benefit comes in four forms:

1. Oxygen concentrator with backup oxygen supply
2. Stationary gaseous oxygen system
3. Portable gaseous oxygen
4. Liquid oxygen

8-12.1 Oxygen concentrator and backup oxygen supply

Oxygen concentrators, and backup oxygen supply, are provided exclusively through a contract with Alpine Home Medical Equipment (1-888-988-2469) for fee for service members and members who have voluntarily enrolled in an MCE in a non-mandatory county. See Section I: General Information for county-specific information.

8-12.2 Stationary gaseous oxygen system

Gaseous oxygen systems require PA and may be delivered by any willing Medicaid DME provider. Coverage of a stationary gaseous oxygen system is limited to the following circumstances:

1. Electrical power to run an oxygen concentrator is not available, or
2. When other equipment necessary for the member requires a saturation percentage higher than the capacity of an oxygen concentrator, or

3. When the member requires a flow rate higher or lower than the capacity of an oxygen concentrator.

8-12.3 Portable gaseous oxygen

Portable gaseous oxygen systems and contents must be medically necessary and require orders for delivery by any willing Medicaid DME provider. Portable oxygen systems and contents do not require PA.

Portable oxygen systems and contents are not covered for members requiring oxygen only intermittently or part-time.

8-12.4 Liquid oxygen systems

Liquid oxygen systems or contents require PA and may be furnished by any willing Medicaid DME provider. Content is included and not separately reimbursed in stationary systems. A liquid oxygen system or contents may be approved only when:

1. Multiple pieces of equipment are used by the member in a series, such as compressors or ventilators, or
2. Gaseous oxygen systems will not provide the liter flow per minute or the percent of concentration required by the member.

See Chapter 11-2 Billing for claim submission of liquid oxygen.

8-12.5 Ventilators

Information regarding code coverage for ventilators can be found on the Medicaid Coverage and Reimbursement Code Lookup.

8-13 Monitoring equipment

8-13.1 Blood glucose monitors

Blood glucose monitors are available to Medicaid members through the pharmacy benefit. Members can obtain blood glucose monitors from the manufacturers of preferred test strips from a pharmacy. For additional information, refer to the Pharmacy Manual.

Blood glucose monitors available through DME services are limited to those with special features (e.g., voice synthesizers) and must be medically necessary for an individual member. These are approved on a case-by-case basis and require PA.

8-14 Wheelchairs

8-14.1 General information

When requesting a wheelchair:

1. Providers are required to demonstrate medical necessity per Utah Administrative Code R414-1-2(18) and the Utah Medicaid Provider Manual, Section I: General Information Chapter 8 Medical necessity.
2. Wheelchairs, accessories, attachments, components, and options require PA or have a quantity limit.
   a) PA requests are evaluated using evidence-based criteria.
   b) PA requests will not be approved when a member owns an appropriate wheelchair that meets medical necessity.
3. Maintain documentation of physician orders within the DME provider's member record.

Wheelchairs are limited to one every five years and are not replaceable until the member's current wheelchair no longer meets medical necessity.

The member owns wheelchairs purchased by Medicaid.

The provider cannot submit claims to Medicaid until the wheelchair and all related items have been received and signed for by the member or their authorized representative.

In addition to criteria outlined within Chapter 3-5 Wheelchairs, wheelchair requests are considered using evidence-based criteria.

8-14.2 Wheelchair evaluation forms

When requesting a wheelchair, DME providers must:

1. complete and submit the required wheelchair evaluation forms
2. submit the applicable form(s) with the PA request
3. maintain the original wheelchair evaluation forms within the DME provider member record

Wheelchair Initial Evaluation Form

1. required as part of the wheelchair PA request
2. completed before requesting a wheelchair
3. performed by a physician, licensed physical therapist, or licensed occupational therapist

Wheelchair Final Evaluation Form

1. required for claims related to power wheelchairs, ultra-lightweight wheelchairs, and manual wheelchairs equipped with tilt in space
   a) when a claim is submitted without a properly executed Wheelchair Final Evaluation Form, the entire claim will be denied
   b) for claims submission, the provider must fax this form to 801-536-0481
2. completion of the form must be within ten business days from the date of delivery
3. forms that contain a checkbox marked as "NO" or an unanswered question will be denied as incomplete
4. a caregiver is permitted to sign the form when the member is incapable of signing for themselves due to medical-related reasons
   a) a caregiver is any person working or living with the member in their place of residence while assisting with ADLs or MRADLs in addition to ongoing care
   b) a caregiver is not:
      i. an evaluating therapist
      ii. an evaluating or ordering provider
      iii. an ATP
      iv. a vendor delivering the equipment
      v. any person whose signature is used elsewhere on the form

Wheelchair Training Checklist (Power Wheelchair)

1. required as part of the power wheelchair PA request
2. performed by a physician, licensed physical therapist, or licensed occupational therapist

The wheelchair evaluation forms are located at Utah Medicaid Forms.

Reporting evaluations

Licensed physical and occupational therapists should report evaluations with the following CPT codes:

1. 97535 - Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes, or
2. 97542 - Wheelchair management (e.g., assessment, fitting, training), each 15 minutes

The wheelchair evaluations include completion of Wheelchair Initial Evaluation Form, Wheelchair Final Evaluation Form, and Wheelchair Training Checklist (Power Wheelchair) Form.

8-14.3 Manual wheelchair

Manual wheelchairs require the member:

1. has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair, or
2. has a caregiver who is available, willing, and able to assist with the wheelchair

Wheelchairs identified with HCPCS codes E1161 and K0005 must be provided by a supplier who employs a RESNA-certified Assistive Technology Professional (ATP) and has direct, in-person involvement in the wheelchair selection for the member.

8-14.4 Power wheelchairs

Power wheelchairs must be provided by a supplier who employs a RESNA-certified Assistive Technology Professional (ATP) and who has direct, in-person involvement in the wheelchair selection for the member.

1. Power wheelchair coverage requires the member does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair, and
   a) has the mental and physical capabilities to operate the power wheelchair safely, or
   b) The member is unable to use the power wheelchair safely and has a caregiver who is unable to propel an optimally configured manual wheelchair adequately but is available, willing, and able to operate the power wheelchair safely, and
   c) weighs less than or equal to the weight capacity of the power wheelchair and greater than or equal to 95% of the weight capacity of the next lower weight class power wheelchair, and
   d) use of a power wheelchair will significantly improve the member's ability to participate in MRADLs
   e) for members with severe cognitive or physical impairments, participation in MRADLs may require the assistance of a caregiver.

8-14.5 Accessories, attachments, components, and options

Listed accessories, attachments, components, and options require meeting the following criteria.

1. Nonstandard seat frame dimensions
   a) a nonstandard seat width or depth outside of standard wheelchair seating description requires the member's physical dimensions to justify the need
2. Wheels and tires for manual wheelchairs
   a) a gear reduction drive wheel requires the member has been self-propelling in a manual wheelchair for at least one year
3. Power tilt and or recline seating systems

a) a power seating system tilt only, recline only, or combination tilt and recline with or without power elevating leg rests require the member meets all the coverage criteria for a power wheelchair described in Chapter 8-14.4 Power wheelchairs, and:
   i. is unable to perform a functional weight shift, or
   ii. utilizes intermittent catheterization for bladder management and is unable to transfer from the wheelchair to bed independently, or
   iii. the power seating system is needed to manage increased tone or spasticity

4. Power wheelchair drive control systems
   a) an attendant control may be covered when:
      i. in place of a member-operated drive control system if the member meets coverage criteria for a wheelchair, and
      ii. is unable to operate an optimally configured manual or power wheelchair, and
      iii. the caregiver, who is unable to operate an optimally configured manual wheelchair, can safely operate a power wheelchair
5. Transit systems
   a) when a member utilizes personal or public transportation for their transit needs, coverage of this equipment is considered medically necessary
   b) transit systems are not covered for members residing in long-term care facilities or for members who utilize Medicaid non-emergency medical transportation broker as their primary source of transportation
6. Miscellaneous accessories
   a) anti-rollback devices require the member to self-propels and use wheelchair ramps
   b) safety belt/pelvic strap requires the member to have weak upper body muscles, upper body instability, or muscle spasticity, which requires the use of this item for proper positioning
   c) manual fully reclining back option requires the member to have one or more of the following conditions:
      i. is at high risk for the development of a pressure ulcer and is unable to perform a functional weight shift, or

ii. utilizes intermittent catheterization for bladder management and is unable to transfer from the wheelchair to the bed independently

Criteria for equipment identified using an HCPCS code with the terms miscellaneous or not otherwise specified can be found in Chapter 12-3 Healthcare Common Procedure Coding System (HCPCS) Miscellaneous Codes

Table A

Coverage of equipment in Column I (base equipment) includes items in Column II (add-on equipment). Equipment in Column II that is medically necessary must be provided to the member at the time of initial issue of equipment found in Column I. For equipment not identified within the table, use the standard process for requesting wheelchair-related items.

Column I	Column II
Manual Wheelchair E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007	E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2224, E2225, E2226, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072, K0077
Power Wheelchair Group 2 K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018, K0019, K0037, K0040, K0041, K0042, K0043, K0044,

	K0045, K0046, K0047, K0051, K0052, K0077, K0098
Power Wheelchair Groups 3 & 5 K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0858, K0860, K0861,	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017
K0862, K0863, K0864, K0890, K0891	K0018, K0019, K0037, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0077, K0098
Adjustable height, detachable armrest, complete assembly E0973	K0017, K0018, K0019
Tray E0950	E1028
Foot box, any type, includes attachment and mounting hardware, E0954	E1028
Elevating, complete assembly E0990	E0995, K0042, K0043, K0044, K0045, K0046, K0047
Power tilt and/or recline seating systems E1002, E1003, E1004, E1005, E1006, E1007, E1008	E0973, K0015, K0017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
Leg elevating systems E1009, E1010, E1012	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047, K0052, K0053, K0195
Sip and puff E2325	E1028

Residual limb support system E1020	E1028
Leg strap, H style K0039	K0038
Footrest, complete assembly, replacement only K0045	K0043, K0044
Elevating leg rest, lower extension tube, replacement only K0046	K0043
Elevating leg rest, upper hanger bracket, replacement only K0047	K0044
Elevating footrests, articulating (telescoping) K0053	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047
Rear wheel assembly, complete, with solid tire, spokes or molded, replacement only K0069	E2220, E2224
Rear wheel assembly, complete, with pneumatic tire, spokes or molded, replacement only K0070	E2211, E2212, E2224
Front caster assembly, complete, with pneumatic tire, replacement only K0071	E2214, E2215, E2225, E2226
Front caster assembly, complete, with semi-pneumatic tire, replacement only K0072	E2219, E2225, E2226

Front caster assembly, complete, with solid tire, replacement only K0077	E2221, E2222, E2225, E2226

8-14.6 Members residing in long-term care facilities

Wheelchairs are part of the per diem rate for members residing in long-term care facilities when the equipment provided is identified with HCPCS codes K0001-K0004, K0006, and K0007.

Manual wheelchairs that meet the Medicaid definition of a customized manual wheelchair may be reported outside the per diem rate.

For further details regarding wheelchair coverage for members residing in long-term care facilities, refer to the Utah State Plan, Attachment 4.19-D Section 400 Routine Services.

8-15 Equipment service requirements

8-15.1 General equipment service requirements information

Maintenance, repairs, and replacements are services for medically necessary equipment and are covered benefits when criteria for services are met. Reimbursement of services may not include payment for parts and labor covered under warranty.

Requirements for all services include:

1. A physician order
2. Prior authorization
3. Equipment is a Medicaid-covered benefit
4. The member owns equipment
5. The member is using equipment

8-15.2 Maintenance

Maintenance is a covered service.

Routine periodic servicing, such as testing, cleaning, regulating, and checking the member's equipment, is not covered.

Upon receiving equipment, the member should be given an operating manual that describes the servicing an owner may perform to maintain the equipment properly. It is expected that a member or caregiver will perform this maintenance.

When requesting PA for maintenance, providers must use the MS modifier with the equipment's designated HCPCS code. Maintenance claims cannot be submitted until six months after the capped rental period and can only be submitted once every six months after that.

Maintenance includes the technician time and supplies used to keep the equipment operating correctly.

8-15.3 Repairs

Repairs are covered when required to make equipment operable and will not exceed the cost of replacement.

The equipment warranty must be expired before Medicaid will cover repairs.

Documentation of repairs must be maintained in the member's record.

Medical necessity for repairs to equipment is established if Medicaid covered the item.

When Medicaid did not initially cover equipment, repair requests must be submitted with a treating physician's statement that the equipment being repaired continues to be medically necessary, and the repair itself is medically necessary.

Coding for repairs

The following tables contain the allowed units of service per each item repaired. When coding for repairs submit documentation indicating each item to be repaired, e.g., right and left armrest. Units of service include basic

troubleshooting, problem diagnosis, testing, cleaning, screws, nuts, and bolts. One unit of service equals 15 minutes.

Power/Manual Wheelchair

Equipment	Allowed Unit(s) of Service
Armrest/arm pad	1 (any type, per armrest/pad)
Arm trough, with or without hand support	1 (per arm trough)
Positioning belt/safety belt/pelvic strap	1 (any type, per belt)
Safety vest	1
Ratchet assembly	1

Manual Wheelchair Only

Equipment	Allowed Unit(s) of Service
Anti-tipping device	1
Hand rim	1 (any type/per hand rim)
Push activated power assist	1
One arm drive attachment	1
Adapter for amputee	1 (any type/ per adapter)
Solid seat insert	1
Wheel lock brake extension (handle)	1 (per handle)
Wheel lock assembly, complete, each	1 (any type, per assembly)
Wheel braking system and lock, complete, manual, disc brakes	1 (any type, per brake)
Anti-rollback device, each	1 (any type, per device)

Power Wheelchair Only

Equipment	Allowed Unit(s) of Service
Joystick (programming not covered)	1

Harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware	2
Electronic connection between wheelchair controller, power seating system motors (any number of motors), includes all related electronics, including fixed hardware	2 (any type, per connection)
Power controllers or actuators	2 (any type)
Power w/c accessory, electronic interface to operate speech generating device using control interface	2
Charger	1
Drive wheel motors (single/pair)/gearbox and combos	2 single/ 3 pair
Drive belt	2

Leg and Footrests

Equipment	Allowed Unit(s) of Service
Elevating leg rest, complete assembly	1 (any type, per leg rest)
Calf rest/pad	1 (any type, per pad)
Leg rest parts	1 (any type, per leg rest)
Cam release assembly, footrest or leg rests	1

Headrest

Equipment	Allowed Unit(s) of Service
Replace headrest assembly	1 (any type, includes removal of previous)
Replace headrest pad	1 (any type)
Headrest extension	1 (any type)

Miscellaneous

Equipment	Allowed Unit(s) of Service

Wheelchair tray	1
Heel loop/holder	1
Toe loop/holder	1
Foot box, any type, includes attachment and mounting hardware	1 (any type/ per foot)
Lateral trunk or hip support	1 (any type, including fixed mounting hardware, per side)
Lateral thigh or knee support, any type, including fixed mounting hardware	1 (any type, per side)
Medial thigh support	1 (any type, including fixed mounting hardware/per side)
Shoulder harness/straps or chest straps, including	1 (any type, includes mounting hardware)
Narrowing device	1 (any type)
Shock absorber manual/power	1 (any type, per side)
Residual limb support system for	1 (any type, per side)
Manual swing-away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory	2
Ventilator tray fixed or gimbaled	2

Seating Systems

Equipment	Allowed Unit(s) of Service
Power seating system, tilt only	2
Power seating system, recline only, without shear reduction	2
Power seating system, recline only, with mechanical shear reduction	2
Power seating system, recline only, with power shear reduction	2

Power seating system, combo tilt and recline without shear reduction	3
Power seating system, combo tilt and recline, with mechanical shear reduction	3
Power seating system, combo tilt and recline with power shear reduction	3
Addition to power seating system, mechanically linked leg elevation system including pushrod and leg rest	1 (per side)
Manual w/c nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches	2
Manual wheelchair nonstandard seat frame width, 24-27 inches	2
Manual wheelchair nonstandard seat frame depth, 20 to less than 22 inches	2
Manual wheelchair nonstandard seat frame depth, 22 to 25 inches	2
Manual wheelchair solid seat support base (replaces sling seat)	2 (includes any type mounting hardware)
Back, planar or contoured, for pediatric size wheelchair	2 (including fixed attaching hardware)
Seat, planar or contoured, for pediatric size wheelchair	2 (including fixed attaching hardware)
Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features	2
Power wheelchair accessory, nonstandard seat frame widths, depths	2
Cushions, positioning, seat	2 (any type)
Cushions, positioning, backs	2 (any type)

Seat height <17" or equal to or greater than 21" for a high strength, lightweight, or ultra-lightweight wheelchair	2
Semi-recline back and fully recline	2

Oxygen

Equipment	Allowed Unit(s) of Service
CPAP/Bi-PAP (blower assembly)	2

Hospital Beds

Equipment	Allowed Unit(s) of Service
Head/foot board	2
Pendent	2

Lifts

Equipment	Allowed Unit(s) of Service
Hydraulic pump	2

Repairs require using the appropriate code with the number of units required:

1. K0739 - Repair or non-routine service for DME other than oxygen requiring the skill of a technician, labor component, per 15 minutes
2. K0740 - Repair or non-routine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes

Note: For hearing aid repairs, refer to the Speech-Language Pathology and Audiology Services Provider Manual and the EPSDT Services Manual.

8-15.4 Replacements

Equipment may be replaced if medically necessary or the item is lost, stolen, or damaged beyond repair.

Documentation supporting the need for the replacement of equipment will be maintained in the supplier's member record.

When submitting a claim for replacement, providers must use the appropriate modifier.

1. RA - Replacement of a DME item, due to loss, irreparable damage or when item has been stolen
2. RB – Replacement of a DME item as part of a repair

8-15.5 Warranties

1. A provider must notify a member of warranty coverage and honor all warranties.
2. A provider must not charge the member or the Medicaid program for services covered under warranty.
3. Record of the warranty must be retained in the member's record with the DME provider.

8-15.6 Medical device recalls

In the event of a medical device recall, the DME provider shall coordinate with the member and the manufacturer to return the defective DME and replace the item as needed. If the medical device is a continuous rental item, the device should be replaced with a suitable device that will meet the medical needs of the member.

If the medical device has been purchased, either as a one-time purchase or after a 12-month capped rental period, the DME provider is responsible for the following actions:

1. Register the device for repair or replacement
2. Furnish a replacement device during the period required for the manufacturer to repair or replace the device; and
3. Replace the equipment at no charge to the Medicaid program or member if the equipment doesn't last for the entire 5-year reasonable useful lifetime.

9 Non-covered services

Some specific non-covered DME are listed below. The list is not all inclusive.

1. Equipment permanently attached or mounted to a building or a vehicle, including ramps, lifts, and bathroom rails.
2. Sacro-lumbar or dorsal lumbar corset type supplies are not considered prosthetic devices or special appliances.

10 Prior authorization

Prior authorization (PA) is required for certain equipment and supplies. Information regarding PA can be found in Section I: General Information, Chapter 10, Prior authorization.

10-1 Medicare and prior authorization

Except for paid Medicare crossover claims, the PA requirement for Medicaid applies to all equipment and supplies subject to PA regardless of third-party liability coverage or eligibility.

Refer to Section I: General Information, Chapter 11-5.1 Medicare crossover claims for further details.

10-2 Retroactive authorization

Refer Section I: General Information, Chapter 10-3, Retroactive authorization.

10-3 Transition of care

When equipment or supplies are prior authorized for purchase and ordered for a member, and the member is then enrolled in another plan (MCE or fee for service) before receiving the equipment, the plan that prior authorized the item is responsible for adjudicating the claim.

11 Billing

Refer to Section I: General Information, Chapter 11 Billing Medicaid.

11-1 Returned medical supplies or DME

If a member returns equipment or supplies purchased with a Medicaid card, a cash refund must not be given to the member. The provider must refund the reimbursement to Medicaid or call the Office of Medicaid Operations, Medicaid claims team and request the claim be reversed.

11-2 Billing for liquid oxygen

Liquid oxygen is reported monthly in 10-pound increments. (One 10-pound increment equals 1 unit). Report a stationary liquid oxygen system with HCPCS code E0439RR, which includes the first 10 pounds. If more than 10 pounds of liquid oxygen is used per month, report with code E0442 in additional 10-pound increments.

Note: For a member residing in a long-term care facility, all oxygen and oxygen-related equipment (except for services covered under the oxygen concentrator contract) must be submitted through the appropriate DME provider who is responsible to obtain appropriate PA.

12 Coding

12-1 Repairs

See Chapter 8-15.3 Repairs Coding for repairs of this document for information related to coding for repairs.

12-2 Wheelchair evaluations

See Chapter 8-14.2 Wheelchair evaluation forms reporting evaluations of this manual for information related to coding wheelchair related evaluations.

12-3 Healthcare Common Procedure Coding System (HCPCS) miscellaneous codes

For the purposes of this manual, HCPCS codes using the terms miscellaneous or not otherwise specified are considered miscellaneous codes.

Equipment or supplies not described by a specific HCPCS code may be submitted using a miscellaneous code.

Equipment or supplies submitted with a miscellaneous code require PA.

PA requests for miscellaneous equipment or supplies is contingent upon documentation supporting the provider's actual acquisition cost, a picture of the equipment or supply, and medical necessity.

12-4 Modifiers

When ordering an item requiring PA that could be used bilaterally, append the applicable modifier(s) to the PA request and claim. Refer to the Coverage and Reimbursement Code Lookup. Below are examples of how to report modifiers for bilateral and unilateral use.

Example 1 - Bilateral use

Code L8420: Prosthetic sock, multiple ply, below knee, each. Allowed 24 per year, per side without PA.

Ordered: L8420 x 12 for bilateral use.

Report on one claim using two lines with the applicable modifier:

	Unit(s)	Code	Modifier 1	Modifier 2
Correct	6	L8420	RT	
Correct	6	L8420	LT	

Incorrect	12	L8420	RT	LT

Example 2 - Unilateral use

Code L8420: Prosthetic sock, multiple ply, below knee, each. Allowed 24 per year, per side without PA.

Ordered: L8420 x 12 to use on the left side.

Report on one claim using two lines with the applicable modifier:

	Unit(s)	Code	Modifier 1	Modifier 2
Correct	12	L8420	LT	

Incorrect	12	L8420		

13 Resource table

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

For information regarding:	
Administrative Rules	Utah Administrative Code Table of Contents Rule R414-1. Utah Medicaid Program. Utah Administrative Rule R414-70 Medical Supplies, Durable Medical Equipment, and Prosthetic Devices.
General information including: Billing fee for service and managed care Member eligibility Prior authorization Provider participation	Section I: General Information Claims Managed Care: Accountable Care Organizations Utah Medicaid Prior Authorization Administrative Rules Eligibility Requirements. R414-302. Medicaid General Provisions. R414-301 Program Benefits and Date of Eligibility. R414-306. Utah Medicaid Program. R414-1.
Information including: Coverage and reimbursement resources National correct coding initiative Procedure codes with accompanying criteria and limitations	Office of Coverage and Reimbursement Policy Coverage and Reimbursement Code Lookup The National Correct Coding Initiative in Medicaid
Information including policy and rule updates: Medicaid Information Bulletins (Issued bimonthly),	Utah Medicaid Official Publications Utah State Bulletin

Medicaid Provider Manuals, Utah State Bulletin (Issued on the 1st and 15th of each month)	
Medicaid forms including: PA Request Utah Medicaid Initial Wheelchair Evaluation Form Utah Medicaid Final Wheelchair Evaluation Form Utah Medicaid Power Wheelchair Training Checklist	Utah Medicaid Forms
Medical supplies and DME	Medical Supplies and Durable Medical Equipment Provider Manual Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70.
Patient (Member) Eligibility Lookup Tool	Eligibility Lookup Tool
Prior authorization	Prior Authorization Form Utah Medicaid Prior Authorization
Provider portal access	Provider Portal Access
Provider training	Utah Medicaid Provider Training
References including: Social Security Act Code of Federal Regulations Utah Code	42 CFR 440.50 42 CFR 440.120(C) 42 CFR 441.15 42 CFR 414 subpart D and subpart F

	Social Security Act 1905(a) Social Security Act 1861 (r) Utah Annotated Code Title 58

Utah Medicaid Provider Manual

Personal Care Services

Division of Integrated Healthcare

Updated November 2024

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Introduction

The information in this manual represents personal care services available for members when medically necessary. Services may be more limited or expanded if medically appropriate, and more cost-effective services are available. This manual is designed to be used in conjunction with Section I: General Information and other provider manuals. Refer to the Utah Medicaid website at https://medicaid.utah.gov for additional resources.

This manual has two parts:

1. Personal Care Services (PCS), and
2. Employment-Related Personal Assistance Services (EPAS)

PART 1 – TRADITIONAL PERSONAL CARE SERVICES

1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, noting the specific link that is not working and the page number for the link.

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General information.

1-1 Personal care services

The purpose of PCS is to provide supportive care to members in their place of residence, maximize independence, and prevent premature or inappropriate institutionalization. Supportive care offers a range of assistance services that enable persons with disabilities (cognitive or physical) and acute or chronic conditions to perform tasks associated with activities of daily living (ADLs) or instrumental activities of daily living (IADL).

PCS assists ADLs, IADLs, or other tasks that do not require direct intervention or supervision of a licensed healthcare professional. PCS assistance may be in the form

of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by themselves. These tasks may include, but are not limited to, those health care services which an unlicensed individual may perform without delegation by a healthcare provider per Utah Code Section 58-1-307.1 and Utah Admin. Code Subsection R156-31b-701a (1).

Agency staff must administer PCS as ordered by a physician and stated in the established care plan.

1-2 HCBS waiver personal care services

For PCS coverage under the Home and Community-Based Services (HCBS) waivers, see the Medicaid Home and Community-Based Waiver Services Manual for the specific waiver information.

2 Health plans

For more information about Managed Care Entities (MCE), refer to Section I: General Information, Chapter 2, Health plans.

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information, Chapter 2-1.2, Prepaid mental health plans, and the Rehabilitative Mental Health and Substance Use Disorder Services provider manual.

A list of ACOs and PMHPs with which Medicaid has a contract to provide health care services is found on the Medicaid website Managed Care: Accountable Care Organizations.

3 Provider participation and requirements

Refer to Section I: General Information, Chapter 3, Provider participation and requirements.

3-1 Electronic visit verification requirement

Electronic visit verification (EVV) requirements, defined in section 12006 of the 21st Century Cures Act, apply to all PCS provided under the Utah Medicaid State Plan or a 1915 (c) Home and Community-Based Waiver.

The Division of Integrated Healthcare collects and monitors EVV records from PCS providers.

Providers may select their own EVV service provider and must make records available to Medicaid for review. All systems must be compliant with the 21st Century Cures Act requirements, including:

1. Type of service performed;
2. Individual receiving the service;
3. Date of the service;
4. Location of service delivery;
5. Individual providing the service;
6. Time the service begins and ends; and
7. The date of creation of the electronic record.

For more information regarding EVV requirements, refer to Section I: General Information Chapter 11-9, Electronic visit verification requirements for home health and personal care services, and Utah Administrative Code R414.

4 Record keeping

Refer to Section I: General Information, Chapter 4, Record keeping.

5 Provider sanctions

Refer to Section I: General Information, Chapter 5, Provider sanctions.

6 Member eligibility

Refer to Section I: General Information, Chapter 6, Member eligibility, for information about verifying a member's eligibility, third party liability, ancillary providers, and

member identity protection requirements. Medicaid members not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

The provider's responsibility is to verify the member's eligibility before rendering services. For additional eligibility information, refer to Chapter 6, Member eligibility.

6-1 Personal care service eligibility requirements

PCS is available to members who meet the following conditions:

1. The member is non-bedbound.
2. The member is unable to independently perform two or more of the following personal care tasks:
    a) Self-administration of medications due to memory lapse.
    b) Toileting.
    c) Bathing or showering.
    d) Skincare.
    e) Ambulation.
    f) Personal grooming.
    g) Nutritional requirements, including meal planning, preparation, cleanup, and motivation to eat.
3. The member needs personal care to:
    a) Maintain the capacity to function, delay disease progression, prevent regression and complications, or
    b) Receive assistance while recovering from an acute condition.

7 Member responsibilities

For information on member responsibilities, including establishing eligibility and copayment requirements, refer to Section I: General Information, Chapter 7, Member responsibilities.

8 Programs and coverage

PCS are covered services provided by a home health agency or a personal care agency, as defined in Chapter 8-1, Definitions, and provided following Utah Medicaid policy.

8-1 Definitions

Definitions of terms used in other Medicaid programs are available in the Utah Medicaid provider manual, Section I: General Information. In addition, definitions specific to the content of this manual are provided below.

Agency: incorporates personal care agency and home health agency.

Custodial care services: Custodial care primarily assists ADLs, such as bathing, dressing, eating, and maintaining personal hygiene and safety.

Certified nurse aide (CNA): As stated in Utah Administrative Code Rule R432-45: A "Certified nurse aide" means any person who completes a nurse aide training and competency evaluation program (NATCEP) and passes the state certification examination. CNAs are required to practice within the parameter of their training and certifications.

EVV: Electronic visit verification

Home health aide (HHA): an individual who meets federal and State of Utah requirements of a home health aide, including those outlined in 42 CFR 484.80 and 440.70, Utah Administrative Code R414-14 and R432-700 (22)(23), and R432-725.

Home health agency: A public or private organization licensed by the Bureau of Health Facility Licensure and Certification under Utah Code Annotated, Title 26, Chapter 21 and is certified through the Centers for Medicare and Medicaid Services (CMS).

Institution: Institutions are residential facilities that assume total care of the admitted individuals.

Licensed health care professional: a professional licensed under Title 58, Occupational and Professional Licensing (Utah Code Annotated) by the Utah Department of Commerce who has the education and experience to assess and evaluate the member's health care needs.

Personal care aide: an individual who meets federal and State of Utah requirements for personal care aide services, including 42 CFR 440.167, 484.80(i) Administrative Code 414-38, 432-700-23 and R432-725-14.

Personal care agency: A care agency that consists of two or more individuals providing PCS on a visiting basis and is licensed under Utah Administration Code R432-725.

Personal care assessment: An assessment performed by a registered nurse on the initial visit or at the time of recertification that assesses:

1. The functional level of the member;
2. The adaptability of the member's place of residence to provide personal care services;
3. The capability of the member to participate in their care; and
4. To identify family support systems; or
5. Identify individuals who are willing to assume the appropriate level of responsibility to care for the member when they cannot care for themselves.

Personal care services: PCS provides supportive care to members in their place of residence, maximize independence, and prevent premature or inappropriate institutionalization. Supportive care offers a range of assistance services that enable persons with disabilities and acute or chronic conditions to accomplish tasks associated with ADLs and IADLs.

8-2 Personal care coverage requirements

8-2.1 Program access

Members must meet the following requirements to receive PCS:

1. A physician must prescribe the necessary PCS.
2. Only an agency may provide PCS.
3. Only a qualified personal care aide, a CNA, an HHA, a licensed practical nurse (LPN), or a registered nurse (RN) (performing only personal care level tasks) may provide PCS.
4. An RN must supervise the provision of PCS.
5. PCS is covered in a member's residence, not an institutional setting.
6. An RN must complete an initial personal care assessment to determine:
    a) The member's level of function;
    b) The adaptability of the member's place of residence to provide personal care services;
    c) The capability of the member to participate in their care; and
    d) To identify family support systems; or
    e) To identify individuals who are willing to assume the appropriate level of responsibility to care for the member when they cannot care for themselves.
7. An RN must complete a personal care assessment at recertification or sooner if warranted by a change in the member's condition.

8-2.2 Plan of care

Agencies must deliver PCS according to a written plan of care developed by agency staff, in consultation with the physician and their orders. The plan of care must include the following:

1. Diagnosis(es) supporting the medical need for PCS
2. Patient status:
    a) Mental and cognitive status
    b) Functional limitations
3. Service need:
    a) Frequency/duration of service
    b) Personal care tasks required
    c) Equipment required (if applicable)
    d) Medications
4. Discharge planning or referral
5. Other identified appropriate services

6. Identification of support systems

The parent/guardian is the primary caregiver for a minor child and is obligated to provide age-appropriate custodial care for a minor child with disabilities as they would for a developing child without disabilities.

The care plan must be signed by an RN and included in the agency's permanent record for the member. Changes to the care plan must be made in writing and signed by an RN or the person receiving the physician's orders. Verbal orders must be documented in writing on or before the following care plan review.

The certification period for each plan of care is 60 days. An RN must perform a new nursing assessment, and the agency must review and revise the plan of care as medically appropriate to fit the member's needs every 60 days. The care plan should always include consecutive dates from the previous plan unless there has been a break in service.

Agency professional staff must promptly alert the physician of any changes in the patient's condition that suggest a need to alter the care plan.

8-2.3 Supervision by a registered nurse

The RN must make a supervisory visit to the member's residence at least once every 60 days to ensure adequate care is provided according to the written plan of care. The visit may be made when the aide is present to observe and assist or when the aide is absent to assess relationships and determine whether goals are being met.

8-2.4 Record keeping

Agencies must maintain accurate and complete records per Utah Administrative Code R432-725-13 and Section I: General Information, Chapter 4-2, Record keeping and disclosure.

9 Non-covered services and limitations

The following represent limitations and non-covered services under PCS:

1. Nursing assessments are limited to one every 60 days.
    a) Nurses may perform assessments three (3) days before or two (2) days after the 60-day mark.
    b) Assessments conducted outside of this window require prior authorization.
2. Personal care aide services are limited to 60 hours per month.
3. Agencies may not furnish PCS for a member on the same day home health services or capitated home health services are delivered.
4. Services furnished by personal care aides are restricted to those outlined under the Division of Occupational and Professional Licensing (DOPL) Tasks an Unlicensed Individual May Perform Without Delegation.
5. PCS is non-covered if the member's needs exceed the level of care allowable for agencies as determined by policy.
6. An agency must refer a member to a licensed health care professional or an appropriate service provider who can safely meet the level of care required if the member's needs exceed that which is allowable under PCS.
7. PCS should not be confused with services that would more appropriately be provided by persons who provide chore services in the home. Examples of chore services that are not PCS include:
    a) Cleaning of floors and furniture in areas not occupied by the member.
    b) Laundry, other than that which is incidental to the care of the member.
    c) Care related to the member's pet(s).

10 Prior authorization

Personal care services reported under HCPCS code T1019 require prior authorization (PA). Failure to obtain PA will result in the denial of payment by Medicaid.

Further PA information is available in the Section I: General Information provider manual, Chapter 10-3, Prior authorization. Code-specific coverage and PA

requirements are provided on the PRISM Coverage and Reimbursement Code Lookup.

To request PA, the personal care agency must submit the physician's written order requesting care, the plan of care resulting from those orders, and a request for PA form for all home health services beyond the initial visit, including therapies. Approval must be received before additional services are given. The level of service, skilled, supportive, or maintenance, is established and approved based on the PA request.

Prior authorization is not required for the initial comprehensive nursing assessment, or the nursing assessment required for recertification. Providers must perform a recertification assessment every 60 days with reimbursement limited to one every 60 days.

The location of the member must be documented in the request for personal care services (i.e., own home, group home, assisted living center).

Medicaid does not provide retroactive authorization except in certain circumstances detailed on the Section I: General Information provider manual, Chapter 10-3, Retroactive authorization.

When the nursing assessment indicates a Medicaid member may qualify for personal care services, complete the PA request through PRISM with supporting medical documentation that demonstrates the need for the service within 10 business days of the nursing assessment. Documentation must be submitted at the time of the request, or the request will be returned. PA forms can be found on the Utah Medicaid Website Forms section.

11 Billing

Refer to Section I: General Information, Chapter 11, Billing Medicaid, for general information about billing instructions.

12 Coding

Refer to the Section I: General Information, Chapter 12, Coding, for information about coding, including diagnosis, procedure, and revenue codes.

For coverage and reimbursement information for specific procedure codes, see the Coverage and Reimbursement Code Lookup. Generally, the fees represented on the Coverage and Reimbursement Code Lookup are only for fee for service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.).

12-1 Personal care service reportable codes

The following represents the typical service codes reported for PCS.

T1001 Initial and subsequent nurse assessments to establish a plan of care.

1. Agencies must perform an initial nurse assessment by an RN to assess the member's needs and functional level and establish the plan of care.
2. Reassessments must be performed every 60 days.

T1019 Personal care aide

1. Agency reporting of services with T1019 represents up to one hour per unit reported.

T1021 Home health aide, per visit

1. See the Utah Medicaid Provider Manual: Home Health Services and the Coverage and Reimbursement Lookup Tool for policy requirements related to code T1021.

12-2 Utilization modifiers

Medicaid provides enhancements to the reimbursement rate when travel distances to offer service are extensive. The enhancement is available only in rural counties where round-trip travel distances from the provider's base of operations are more than 50 miles. In addition, the member must reside in the same or an adjacent rural county as the provider.

Rural counties are counties other than Weber, Davis, Salt Lake, and Utah. Report the applicable service code with modifier "TN" to receive the rural home health travel enhancement.

For additional coverage information, refer to the Coverage and Reimbursement Code Lookup.

Refer to the Utah Medicaid provider manual, Section I: General Information, for detailed billing instructions.

PART 2 – EMPLOYMENT-RELATED PERSONAL ASSISTANT SERVICES

1 General information

1-1 General policy

Employment-related personal assistant services (EPAS) is an optional Utah Medicaid program authorized by Section 1905(a)(24) of the Social Security Act. Part 2 of the Personal Care Manual and addresses State Plan covered EPAS. For information related to traditional PCS, see Part 1 of this manual.

The manual is designed to be used in conjunction with other sections of the Utah Medicaid provider manual, such as Section I: General Information and the Physician Services provider manuals.

EPAS provides services to Medicaid participants with disabilities who work and need personal assistance in order to successfully maintain their employment. EPAS may be delivered by a personal care agency licensed to provide PCS or through the self-administered services (SAS) delivery option. The SAS delivery option allows the Medicaid participant to employ and directly supervise the EPAS employee who meets provider qualifications established by the Medicaid Agency. Medicaid participants who choose to receive EPAS through the SAS delivery option must utilize a financial management service agency to ensure that the necessary employer-related duties and tasks, including managing the EPAS employee's payroll, are properly completed.

1-2 Fee for service or managed care

EPAS services are only available on a fee for service basis. EPAS is a carve-out service and is not available through MCE's.

1-3 Acronyms and definitions

Activities of daily living (ADLs)

Basic self-care tasks that people tend to do every day without needing assistance. ADLs include eating, toileting, dressing, grooming, maintaining continence, bathing, walking and transferring (such as moving from bed to wheelchair).

Assessor

A licensed clinical social worker or a registered nurse who conducts the required EPAS functional assessment(s) of the Medicaid participants.

OLTSS

Office of Long Term Services and Supports.

Disability

As defined by established disability criteria according to the Social Security Administration or the Medical Review Board.

DSPD

Division of Services for People with Disabilities.

DWS

Division of Workforce Services.

EPAS

Employment-related Personal Assistant Services.

EPAS specialist

Individual employed by the State Medicaid Agency who provides overall program management and oversight of the EPAS program.

FMS

Financial management services is the service provided in support of self-administered services that ensures the necessary employer related duties and tasks, including managing the EPAS employee's payroll, are properly completed.

HCPCS

Healthcare Common Procedure Coding System.

Instrumental activities of daily living (IADLs)

These activities are not necessary for fundamental functioning but allow the individual to live independently in a community. IADLs include meal preparation, ordinary housework and basic home maintenance, managing finances, managing medications, phone use or other communication devices, shopping, and transportation (driving or handling public transit).

LOC

Level of care.

MDS-HC

Minimum data set for home care. The standard comprehensive assessment instrument used in the EPAS program.

PA

Personal assistant.

SAS

A self-administered service is a service delivery option that allows the Medicaid participants to employ and directly supervise the EPAS employee who meets provider qualifications established by the Medicaid Agency. Under this service delivery method, the Medicaid participant is responsible for hiring, training, supervising, setting work schedule, and carrying out disciplinary actions. Medicaid participants who choose to receive EPAS through the SAS delivery option must utilize a financial management services provider to ensure that the necessary employer

related duties and tasks, including managing the EPAS employee's payroll, are properly completed.

SC

Service coordinator.

2 Provider participation requirements

Refer to provider manual, Section I: General Information, for general provider enrollment information.

Any willing provider that meets the qualifications defined below may enroll at any time to provide EPAS services. To enroll as an EPAS provider contact the EPAS specialist. The EPAS specialist will facilitate completion and submission of the required Medicaid provider application. The provider is only authorized to provide the EPAS services specified and approved in their Medicaid provider agreement.

2-1 Service coordinator enrollment

Service coordinator agencies are responsible for the ongoing management of the EPAS participant's case.

Management of the case includes verification of employment, verifying and assisting the participant to maintain Medicaid eligibility, assisting the participant with training the EPAS personal assistant(s), creating and implementing care plans, and scheduling and coordinating with the EPAS assessor to complete periodic reassessments. Service coordinator provider qualifications include:

1. Possess a bachelor’s degree, preferably in human services or related field, or can substitute a year of equivalent work providing services to the target population for each year of the required education.
2. Possess a valid state or federal photo identification.
3. Have an applicable business license.
4. Pass a Utah criminal history and background check.

5. Have general liability/professional liability insurance.
6. Attend the mandatory EPAS service coordinator training provided by State Medicaid Agency staff and demonstrate required competencies for service coordination, protocols and procedures.
7. Complete the Utah Medicaid provider application.
8. Complete attachment A (located in the online PRISM enrollment system).
9. Complete and agree to provider responsibilities in attachment B (located in the online PRISM enrollment system).

2-2 Financial management services agency enrollment

If an EPAS participant chooses a non-agency individual to provide their PCS, a financial management services agency must be used to assist the EPAS participant in payroll and employer related taxes. Fiscal agencies are responsible for processing paychecks and issuing them in a timely manner. Financial management services provider qualifications include:

1. Possess a business license.
2. Pass a Utah criminal history and background check.
3. Possess a valid state or federal photo identification.
4. Complete the Utah Medicaid provider application.
5. Complete attachment A (located in the online PRISM enrollment system).

2-3 Assessor enrollment

EPAS assessors are responsible to conduct EPAS assessments to determine participants' program eligibility and to evaluate needs for care plan development. The minimum data set- home care (MDS-HC) assessment tool is the required assessment tool. EPAS assessor provider qualifications include:

1. Must be a licensed clinical social worker (LCSW) or a registered nurse (RN).
2. Pass a Utah criminal history and background check.
3. Possess a valid state or federal photo identification.

4. Attend the mandatory EPAS assessor training provided by state Medicaid agency staff and demonstrate required competencies for completing assessments, protocol and procedures.
5. Complete the Utah Medicaid provider application.
6. Complete attachment A (located in the online PRISM enrollment system).

2-4 Personal care agency enrollment

EPAS may be delivered by a personal care agency licensed to provide PCS or through the self-administered services (SAS) delivery option. The SAS delivery option allows Medicaid participants to employ and directly supervise the EPAS employee who meets provider qualifications established by the Medicaid Agency. EPAS PCS include physical assistance and cognitive cuing to direct self-performance of necessary activities. Medicaid participants who choose to receive EPAS through the SAS delivery option must utilize a financial management services provider to ensure that the necessary employer related duties and tasks, including managing the EPAS employee's payroll, are properly completed.

PCS may be delivered by an agency licensed to provide PCS outside of a 24-hour supervised living setting, in accordance with Utah Code Annotated, Title 26, Chapter 21.

Personal care agency provider qualifications:

Personal care agencies must be licensed in the State of Utah in accordance with UAC R432-725 Personal Care Agency Rule.

SAS provider qualifications:

1. Must be at least 16 years of age.
2. Possess a valid state driver's license.
3. Possess automobile liability insurance if providing transportation services.
4. May not be the spouse of the EPAS participant.
5. May not be the parent of an EPAS participant under the age of 18.

6. Receive training on how to deliver EPAS services according to the authorized care plan by the EPAS participant and/or representative upon every care plan renewal.

3 Participant eligibility

3-1 Eligibility for EPAS services

To be eligible for the EPAS program the Medicaid participant must:

1. Meet the SSI definition of disability.
2. Be gainfully employed in an integrated community setting making at least minimum wage.
   a) An integrated community setting is defined as a workplace or environment where there are persons with and without disabilities employed within the same company.
   b) Gainful employment is defined as an employment situation where the employee receives consistent work and payment of at least minimum wage from an employer.
3. Be employed and working for an employer at a minimum of 40 hours per month, or
   a) Enrollment onto the EPAS program is determined on a case-by-case basis. If the applicant is unable to work 40 hours per month due to company restrictions, location, or other circumstances, despite the applicant's capacities to work 40 hours per month, the applicant may submit rationale to petition to be enrolled onto the EPAS program.
4. Be self-employed and able to demonstrate substantial income and specific work activity each month.
5. Need a personal assistant in order to remain employed.

The participant is not eligible if:

1. The participant is employed by the institutional setting in which they reside.
2. The participant is enrolled in a 1915(c) Home and Community-Based Waiver Program where PCS are provided as a component of covered waiver services.

General eligibility

A Medicaid participant is required to present the Medicaid identification card before each service, and every provider must verify each participant's eligibility each time before services are rendered. For more information regarding verifying eligibility, refer to provider manual, Section I: General Information, Verifying Medicaid eligibility, the eligibility lookup tool located at https://medicaid.utah.gov/eligibility, or call Medicaid Customer Service (801) 538-6155.

3-2 EPAS participant's freedom of choice of service providers

At the time of initial care plan development and any time a change is made to the participant's care plan, the service coordinator or EPAS specialist will present the participant with a freedom of choice consent form.

The freedom of choice consent form allows the participant to declare their choice of available services and providers within their county of residence. The service coordinator and EPAS assessor must maintain a signed copy of this form in the participant's case records.

4 Program coverage

4-1 Covered services

4-1.1 Personal assistant services

Personal assistants may only provide assistance with ADLs or IADLs in support of assisting the EPAS participant to maintain employment. Services are not available for other household participants living with the Medicaid participant. Duplicate services at different times of the day from different providers are permitted; however, duplicate services at the same time of day are not allowed. Any instance where an individual requires two PAs at the same time of day to perform multiple tasks requires justification and prior authorization from the SMA.

1. ADLs include the following services:

   a) Mobility in bed

   b) Transferring

c) Locomotion in and outside of home

d) Dressing

e) Eating

f) Toileting (excludes assistance with enemas, suppositories, catheters and ostomy care or insertion of feminine hygiene products)

g) Personal hygiene

h) Bathing

2. IADLs include the following services:

   a) Meal preparation

   b) Ordinary housework

   c) Laundry

   d) Managing finances (includes assistance with simple budgeting, paying bills, and maintaining Medicaid eligibility spend downs or Medicaid work incentive requirements)

   e) Medications reminders and cueing (In compliance with the Utah Nurse Practice Act, personal assistants may administer medications, including the application of prescription ointments or creams).

   f) Shopping to include purchase of items such as groceries, personal hygiene products, prescription medications, uniforms or work clothing. Shopping for clothing will be authorized on an occasional and limited basis with the intent of assuring that the participant is dressed appropriately for work as per the authorized care plan.

   g) Transportation: payment is rendered according to the time spent traveling from one destination to another. (EPAS does not provide medical transportation nor allow compensation for mileage, gas or time when the participant is not in the vehicle with their personal assistant). Authorized uses of travel include:

      i. Accompanying the individual to and from public transportation for work.

1 Time is authorized for when the personal assistant is with the participant.

ii. Transporting the participant to and from work.

iii. Time is authorized for when the personal assistant is with the participant in the vehicle.

Transporting the individual to go shopping for items described in Item 6 above.

iv. Self-employed participants who require specific products in order to maintain their business may be allotted time for purchasing these products as per the authorized care plan.

v. Transporting the individual to and from the pharmacy to pick up or drop off prescription medication orders.

vi. Transporting the individual to and from the bank/financial institution to fulfill services described above in item 4.

4-1.2 EPAS assessment services

A licensed clinical social worker (LCSW) or a registered nurse (RN) who has received initial and annual training by the State Medicaid Agency must conduct an EPAS assessment utilizing the Department's required assessment tool, the MDS-HC assessment instrument.

The MDS-HC assessment is a standardized, minimal assessment and screening tool designed for clinical use. The MDS-HC assessment form consists of items and definitions that should be used as a guide to structure a clinical and social assessment in planning for community-based care and services.

The assessment process requires communication with the person and primary caregiver/family member (if available), observation of the person in the home environment, and review of secondary documents when available. Where possible, the person is the primary source of information. EPAS requires that whenever possible, the MDS-HC assessment should be performed during a face to face visit within the individual's home. In special circumstances, the EPAS specialist may pre-approve the completion of the assessment in another setting or over the phone.

Items on the MDS-HC assessment form flow in a logical sequence and can be completed in the order in which they appear. However, the assessor is not bound by this sequence. Items may be reviewed in any order that works for the assessor and the participant.

To determine EPAS eligibility, a score will be derived from the completed assessment based on the nine critical areas of the assessment.

The EPAS assessor will utilize the MDS-HC criteria scoring form to determine if the applicant meets the minimum eligibility criteria for the program. The individual must score > 0 on five or more of the nine criteria listed on the scoring form. Instruction and training on the use of the scoring form will be included in the EPAS assessor's mandatory training.

4-1.3 Service coordination services

As part of the care planning process, the service coordinator is responsible to review the results of the MDSHC assessment and the MDS-HC criteria scoring form. The service coordinator is responsible for developing a written individualized care plan.

The plan must include:

1. The name, date of birth, and Medicaid ID of the individual.
2. Employment data.
3. Care plan type selection of initial, annual, or change in information.
4. Billing or HCPCS codes for service coordination, financial management services agency, and personal attendant services.
5. Name of chosen service providers.
6. The recommended amount and frequency of services. Explained in both weekly and monthly hours.
7. The care plan’s beginning and end date of services.
8. Other employment or community supports being utilized by the individual.
9. The basis for the need of ADL or IADL assistance, including MDS-HC impairment score data.

10. Signatures from the participant or representative, service coordinator, and State Medicaid Agency.

4-1.4 Annual assessment and care plan process

All assessments for active EPAS participants are valid for a period of 12 months. Care plans must be developed within 30 calendar days of each new assessment; therefore, care plans must be completed annually as well. The process of conducting the annual assessment process consists of the following activities:

1. The service coordinator and EPAS assessor are responsible to coordinate and regulate appointments in a timely manner for all annual EPAS reviews. The EPAS assessor or service coordinator will initiate the need for a new assessment.
2. The EPAS assessor and service coordinator must verify the Medicaid eligibility of the participant before providing any services.
3. The assessor must complete the annual reassessment in the same calendar month as the previous assessment.
   a) It is possible to complete several assessments within a one-year time frame due to possible changes in health status or circumstances of the EPAS participant. Each time a new assessment is completed a new care plan must also be developed.
4. The service coordinator has 30 calendar days from the date of the completed assessment to develop an annual renewal care plan. The care plan must be turned into the EPAS specialist 10 days prior to the begin date of the new care plan.
   a) For example: If a participant's new care plan begin date was Jan 1, the service coordinator must have the new care plan turned into the EPAS specialist 10 days prior, on Dec 21, in order to give the EPAS specialist time to review and approve the care plan prior to its begin date. Please note that although an initial care plan may begin any day of the month, an annual care plan must begin at the first of the month. Example: a participant's initial care plan was authorized to begin Jan 13, 2015; however, upon developing the participant's

annual care plan, the care plan must start on the first of the month or Jan 1, 2016.

5. Once the care plan, MDS-HC, and all other initial paperwork are turned into the EPAS specialist, the EPAS specialist will review the care plan and assessment for validity and justification of hours allotted to the participant. The approved care plan is the authorization for the EPAS assessor, service coordinator, and PCS. Financial management service agencies will receive a separate authorization/ budget for each EPAS participant.

4-2 Non-covered services

1. Medical transportation, including transportation to doctor appointments or other medically related services.
2. Work training including job coaching, job training, or reasonable accommodations that an employer is required to provide under the Americans with Disabilities Act).
3. Participants who are self-employed may not use their personal assistant(s) as an employee in their business.
4. Cleaning EPAS participant's vehicle, running miscellaneous errands, or providing any other services not listed under covered services.
5. Taking care of EPAS participant's personal pets or animals.
6. Watching, or tending to EPAS participant's children or relatives.

5 Billing

Refer to the provider manual, Section I: General Information, for detailed billing instructions.

5-1 Billing and rate codes

HCPCS	Description	Provider type	Unit	Rate (unit/hour)
T1028	Home assessment, determination of PT's needs	68	Per encounter	Rate can be found on Coverage and Reimbursement

				Look-Up Tool*
S5125	Self-directed service attendant care	54	15 min = 1 unit	Self-directed service attendant care is 61% of the maximal allowable rate (MAR) for traditional attendant care*
S5125	Traditional attendant care services	54	15 min = 1 unit	Rate can be found on Coverage and Reimbursement Look-Up Tool*
S5125 TU	Self-directed service attendant care (overtime)	54/68	15 min = 1 unit	Modifies base payment to 150% of submitted charge
T2040	Financial management services, self-directed	68	1 unit allowed per month, per member	Rate can be found on Coverage and Reimbursement Look-Up Tool*
T2024	Service coordination, service assessment/plan of care development	68	15 min =1 unit	Rate can be found on Coverage and Reimbursement Look-Up Tool*

* Utah HCPCS rates are found on Medicaid's Coverage and Reimbursement Look-Up Tool: https://medicaid.utah.gov/coverage-and-reimbursement

5-2 Application requirements and prior authorization of EPAS services

The application process and performance of the initial assessment consist of the following activities:

1. An applicant submits their application into the EPAS specialist. The EPAS specialist reviews the application to determine if the applicant meets basic program eligibility. If the EPAS specialist determines that the applicant meets basic program eligibility, the specialist will send the applicant an EPAS program packet that includes the freedom of choice consent form. Once the applicant completes and submits the paperwork to the EPAS specialist, a referral from the EPAS specialist to the chosen EPAS assessor and service coordinator is made.
2. The EPAS assessor and service coordinator must first verify the Medicaid eligibility of the participant before providing any services and work together to assure appointments are set up with the participant in a timely matter.
3. The EPAS assessor has 30 calendar days from the date of referral from the EPAS specialist to complete the initial assessment and give it to the participant's service coordinator and EPAS specialist. The service coordinator has 30 calendar days from the date the initial assessment was completed to develop the participant's care plan and submit it to the EPAS specialist.
4. Once the care plan, MDS-HC, and all other initial paperwork are turned into the EPAS specialist, the EPAS specialist will review the care plan and assessment for validity and justification of hours allotted to the participant. The approved care plan is the authorization for the EPAS assessor, service coordinator, and PCS. Financial management service agencies will receive a separate authorization/ budget for each EPAS participant.

All EPAS authorizations will contain the following information:

1. The HCPCS billing code.
2. The amount and frequency of the service ordered.
3. The start and end date of the services.
4. EPAS specialist signature and date.

6 Suspension of EPAS services

6-1 Holds and suspensions

When the participant is not meeting the program requirements on a temporary basis, the EPAS specialist may place an EPAS participant's case on hold. Reasons for placing a participant's case on hold may include:

1. The participant is hospitalized or admitted to a nursing facility and is unable to remain working. If the participant remains in the hospital or nursing facility longer than 60 days without continuing employment, the participant will be disenrolled from the program.
    a) The participant is unable to be contacted.
        i. If the participant is unable to be contacted by the service coordinator for more than 30 days their case will be reviewed for possible disenrollment.
    b) The participant is on vacation.
        i. If the participant is on vacation for more than 30 days their case will be reviewed for possible disenrollment.
2. The participant goes on maternity leave.
    a) If the participant is receiving personal time or annual pay while away on maternity leave, services may continue uninterrupted. However, if the participant is not receiving income from their place of employment during maternity leave, services will be suspended until they return to work.
3. The participant did not pay their Medicaid work incentive (MWI) premium or spend down for the month.
    a) If the participant does not pay their premium or spend down, their services will be on hold until the outstanding amount is paid. If the participant's case is closed by the Division of Workforce Services (DWS) for outstanding premium or spenddown amounts the participant will be disenrolled.
4. The participant does not meet the minimum of 40 work hours per month criteria or fails to submit monthly employment information.
    a) If a participant's illness or sickness makes them absent from work longer than two work weeks, the participant's case will be placed

on hold until they have returned to work and are able to continue performing the 40-hour minimum per month. An absence longer than 60 days will be reviewed for possible disenrollment.

b) If the participant is consistently not meeting the 40-hour minimum work hour criteria, their case will be reviewed for possible disenrollment. Each situation will be evaluated on a case by case basis by the EPAS specialist.
c) If the participant has personal, sick, or annual time in which they may still receive income when they are not working, their services may continue uninterrupted.
d) Self-employed participants who fail to submit their monthly income financial statements, ledgers, work activity logs, or federal tax returns for 60 days or more will be reviewed for possible disenrollment. All work hours must be accounted for in relation to the participant's business. If an activity does not have the potential to produce a new consumer or revenue, it is not considered to be work related.
e) Participants who are employed by others and fail to submit at least one earning statement per month to their chosen service coordinator, for 60 days or more, will be reviewed for possible disenrollment.

6-2 Disenrollment, termination, and reenrollment of EPAS services

6-2.1 Disenrollment

Participation in the EPAS program is voluntary. Participants may disenroll from the program at any time. The EPAS specialist will conduct periodic reviews of cases that have been placed on hold to determine if program termination is warranted. The EPAS specialist will review cases that are non-routine in nature and involve circumstances that are specific to the participant involved. In addition, the EPAS specialist will consider cases for termination when any of the following circumstances exist.

1. The participant no longer meets Medicaid program eligibility requirements and was determined to be ineligible for Medicaid by DWS (e.g., moved out of state,

participant did not submit Medicaid review documentation, outstanding premium or spenddowns, etc.)

2. The participant's employment has been terminated for any reason (quit, fired, laid off).
3. The participant has 30 days from their last day of work to regain employment before they will be disenrolled from the program. If the participant is working with vocational rehabilitation or similar job coaching company, the participant will have 60 days to regain employment before the case is terminated.
4. Self-employed participants who are unable to sustain business operations or receive income after a period of 12 months.
5. Participant is noncompliant with the authorized care plan and/or program policies and regulations.
6. Participant has not utilized EPAS services for 60 days or more (i.e., did not hire a personal assistant).
7. Fraud and/or misuse of Medicaid funds.

The service coordinator or EPAS specialist may initiate disenrollment. The EPAS specialist will review all recommended disenrollments that are submitted by the service coordinator. Should the disenrollment request be approved, Medicaid will provide the participant with a notice of decision. The notice will include the reason for termination, last date of service, information on how to contact the EPAS specialist, and information on how the participant may exercise their right to an appeal if they disagree with the decision. Upon final termination, including the final determination of any appeals, the EPAS specialist will send written notice to the participant's provider agencies with a date of termination.

6-2.2 Reenrollment

If the participant is disenrolled from the EPAS program for more than 90 days, the participant must complete a new application and complete the enrollment process as if they were a new applicant.

If the participant is disenrolled from the EPAS program for less than 90 days, the applicant's case will be reviewed to assure that participant has not had a significant

change in health conditions. If there is a significant change in condition, a new MDS-HC must be completed by the EPAS assessor. If there have been no significant changes in health conditions, the last MDS-HC assessment completed will be considered valid and the service coordinator will be required to submit the following documents to the EPAS specialist:

1. A care plan with new begin and end dates.
2. A new participant information form.
3. A new freedom of choice selection form.
4. A new SAS employer/employee agreements.

The EPAS specialist will then create authorizations of service for the participant.

6-3 Retroactively opening cases or making payments

The EPAS specialist will only open or authorize claims to be paid out 90 days retroactively consistent with the eligibility date as determined by the Division of Workforce Services (DWS). The participant's case may be open retroactively in the following circumstance:

1. The participant was determined ineligible for Medicaid, for any reason, but remained working and continued to meet EPAS eligibility criteria (i.e., working 40 hours per month), and was retroactively opened by DWS to a status of Medicaid eligible. EPAS services may be retroactive consistent with the eligibility date as determined by the Division of Workforce Services (DWS).

7 Provider reimbursement

7-1 Service coordinating agency, financial management services agency, EPAS assessor, and personal care agency reimbursement

1. A unique provider number is issued for each provider. When submitting claims for reimbursement, the provider must use their unique provider identification number, and the proper provider type number (68-Personal Services Agent or 54-Licensed Home Health Service, Category 21-PCS) associated with EPAS. Claims containing a provider number that is not associated with the proper program will be denied.

2. Provider agencies will be reimbursed according to the specified reimbursement rate(s) found on the Coverage and Reimbursement Look-Up Tool at https://medicaid.utah.gov/coverage-and-reimbursement.

3. Provider agencies may only claim Medicaid reimbursements for services that are ordered by the EPAS specialist and for which the provider has a current service authorization form. Service authorizations are valid for a maximum of 12 months and must be reissued annually. The EPAS specialist will supply the provider with a service authorization that contains the following information:

    1. The HCPCS billing code.
    2. The amount and frequency of the service ordered.
    3. The start and end date of the services.
    4. EPAS specialist signature and date.

    Claims must be consistent with the amount, frequency and dates authorized by the EPAS specialist in order to be paid. Any services provided that exceed the amount or frequency authorized or for which there is not current service authorization form are not eligible for payment and will be denied. Any claims inaccurately paid will be recovered.

4. Financial management services reimbursement
    Reimbursement for self-administered services includes reimbursement for all mandatory employer payroll taxes, and workman's compensation insurance premiums. These costs should be paid in addition to the self-administered service rate established between the waiver participant and the employee. For example, if a waiver participant negotiates an hourly wage of $10 per hour with their self-administered services employee, mandatory employer burden costs (e.g., Social Security and Medicare taxes, Federal Unemployment Taxes, and Worker's Compensation Insurance premiums) are paid in addition to the $10 per hour wage. The employee's income tax withholding should be deducted from the negotiated wage.

7-2 Self-directed personal care reimbursement

1. To allow for accurate payroll processing, personal assistants are required to fill out all necessary paperwork designated by the EPAS participant's chosen financial management services agency. The personal assistant(s) will not be paid for any dates of service prior to the FMS agency paperwork being completed.
2. Timesheets must be submitted in a timely manner by the EPAS participant to the financial management service agency according to the payroll calendar. EPAS participants are required to receive, sign and copy all employee timesheets and submit them to the FMS agency. The participant is responsible to verify the accuracy of all hours billed by the employee(s).
3. Personal assistants may only claim reimbursement for services that are authorized by the EPAS specialist on the care plan. Care plans are valid for a maximum of one year and must be reissued annually. The EPAS participant must provide all personal assistants with a copy of the authorized care plan that clearly identifies the EPAS service requested including:
   a) The amount and frequency of the service ordered.
   b) The start and end date of the service.
   c) The category sub-task(s) and notes explaining the service to be rendered to the EPAS participant.

   Timesheets/claims must be consistent with the amount, frequency and dates authorized by the EPAS specialist in order to be paid by the financial management services agency. Any services that exceed the amount or frequency authorized on the care plan, or for which there is not an authorized care plan, are not eligible for payment and will be denied. Any claims inaccurately paid will be recovered.
4. Personal assistants are accountable for all terms, agreements, and responsibilities as defined in the employer/employee agreement form, signed upon initial hire and the EPAS participant's annual review.
5. Inappropriate personal assistant use will be reviewed by the SMA and may result in disciplinary action. Suspected misuse of personal assistant services can be reported to the Utah Office of Inspector General for review and possible investigation.

8 Employment verification

8-1 Employed by others

EPAS participants who are employed by others must work a minimum of 40 hours per month and be gainfully employed in an integrated community setting making at least minimum wage. An integrated community setting is defined as a workplace or environment where there are persons with and without disabilities employed within the same company. Gainful employment is defined as an employment situation where the employee receives consistent work and payment of at least minimum wage from an employer. Employment must be reported monthly to the service coordinator and annually to the Department of Workforce Services.

1. Employment is verified through the Department of Workforce Services (DWS) annual Medicaid review, including earning statements as required by DWS. It is the responsibility of the EPAS participant to report employment to DWS and assure they remain Medicaid eligible in order to receive EPAS services. It is also the responsibility of the participant to submit earning statements monthly if they are affected by a Medicaid work incentive premium (MWI) in which their income fluctuates.

2. Employment is also verified monthly by the service coordinator. Service coordinators are responsible to contact the EPAS participant each month and gather a report of the number of hours the EPAS participant has worked or will work that month. Service coordinators are also responsible to verify employment hours by gathering the EPAS participant's earning statements for the previous month. In the case of participants who are self-employed, the service coordinator is responsible to collect documentation indicating the amount of hours worked, the type of work activity that was performed, as well as a financial statement indicating incoming and outgoing business expenses.

3. It is the EPAS participant's responsibility to assure they are meeting the minimum hour criteria of 40 hours per month (except for those who are self-employed) according to program requirements. Every EPAS participant must accurately report the number of hours worked each month to their service coordinator, as

well as submitting monthly earning statements for the previous month to the service coordinator.

a) If the EPAS participant does not meet the 40-hour per month minimum criteria they must report this to their service coordinator. Each case is subject to a hold, suspension, or disenrollment on a case by case basis if participant is not meeting the minimum EPAS requirements.

8-2 Self-employment

EPAS participants may be self-employed. Self-employed participants must show that they are making a good faith effort to produce income and make a profit. Service coordinators will be required to verify a participant's self-employment status. In order to verify self-employment status for the EPAS program, participants must provide the following documents at least annually:

1. Proof of business registration through the State of Utah or any applicable local municipalities. This may include a valid business license issued by either the State of Utah or a local municipality.
2. Submitted Federal Income Tax forms showing profit or loss from the business (e.g., IRS Form 1040 Schedule C) if applicable.

In addition to the documents listed above, at least two of the following documents must be provided monthly to the support coordinator:

1. Log of hours worked with a description of activities.
2. Copy of invoices or receipts sent or received during the month.
3. Copy of a lease on the business location (other than primary residence).
4. Copy of bank statement showing payments to or from the business during the month.

9 Adult protective services reporting requirements

Utah law (62A-3-305) mandates any person who has reason to believe that a vulnerable adult is being abused, neglected, or exploited must immediately notify adult protective services or the nearest law enforcement office. Abuse may include physical abuse, emotional/verbal, caretaker neglect, self-neglect, or exploitation.

For definitions or more information about adult protective services, see: http://daas.utah.gov/adult-protective-services/.

10 Fair hearings

10-1 EPAS participant fair hearing rights

The State Medicaid Agency provides an eligible individual applying for or receiving EPAS services an opportunity for a hearing upon written request, if the eligible individual is:

1. Denied access to EPAS provider(s). If more than one provider is available to render the service(s),

   OR

2. Experiencing a denial, reduction, suspension, or termination of EPAS services.

The process of a fair hearing will consist of the following activities:

1. An individual and the individual's legal representative as applicable, will receive a written notice of agency action from the EPAS specialist for any of the reasons listed above. The notice of agency action delineates the individual's right to appeal against the decision.
2. The aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The Division of Integrated Healthcare may reinstate services for recipients or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than 10 calendar days after the date of action.
3. The individual is encouraged to utilize an informal dispute resolution process, directed by the EPAS specialist, to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the Department of Health and Human Services, Division of Integrated Healthcare for a formal hearing and determination.

An informal dispute resolution process does not alter the requirements of the formal fair hearing process. The individual must still file a request for hearing and a request for continuation of services within the mandatory time frame established by the Division of Integrated Healthcare. An informal dispute resolution must occur prior to

the deadline for filing the request for continuation of service and/or the request for formal hearing or be conducted concurrent with the formal hearing process.

11 Security breaches

11-1 Data security and privacy

Providers are expected to take steps to ensure that all personal information related to the individual being served is protected. This includes both Personal Health Information (PHI) as well as Personally Identifiable Information (PII). Providers should use appropriate administrative, technical and physical safeguards to preserve the integrity, confidentiality, and availability of PHI/PII that they create, receive, maintain or transmit. This includes using encrypted/secure email, fax, or other HIPAA compliant methods to transmit documents containing information about the individual being served. Providers shall ensure there is limited and controlled access to PHI/PII. In the performance of its services and operations, the provider shall make efforts to use, disclose and request only the minimum amount of PHI/PII considered reasonably necessary. The provider shall also identify and protect against reasonably anticipated threats to the security or integrity of the information, protect against reasonably anticipated, impermissible uses or disclosures; and ensure compliance by their workforce.

11-2 Breach reporting/data loss

Providers must report to the EPAS specialist in the Division of Integrated Healthcare (DIH), either by email or telephone, any breach or loss of PHI/PII. This report should be completed not more than 24 hours after the provider knows or should have reasonably known about the breach. The provider must also submit a report in writing/by email to DFHP within 5 business days of the breach. The provider will also cooperate with any investigation of the breach or data loss.

12 References

Utah Administrative Code

R414-38, PCS

R432-725, Personal Care Agency Rule

42 CFR 440.167 PCS

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I. Pharmacy Services Introduction

A. Mission Statement

The Utah Medicaid Fee for Service (FFS) Pharmacy Program Mission is to develop and manage comprehensive pharmacy benefits and prior authorization services to ensure appropriate quality and utilization for Medicaid members.

B. Purpose

The information in this manual represents available services and policies that are designed to be used in conjunction with federal regulations and sections of the Utah Administrative Code R414-60 Medicaid Policy for Pharmacy Program.

Providers must be familiar with all current Utah Administrative Code Rules and federal regulations governing the Utah Medicaid FFS Pharmacy Program.

II. Pharmacy General Policy

This manual is updated bi-monthly, and changes are announced through the Medicaid Information Bulletins (MIBs) published on the Medicaid Website. To sign up for the Utah Medicaid Newsletter and receive email notifications of policy changes and MIBs, refer to Medicaid Information Bulletins.

A. Copay Policy

When applicable, Medicaid members are required to pay a co-payment for each prescription filled as described in 42 CFR 447.56(a)(1) and Utah State Plan, Attachment 4.18-C, Page 1 under “Pharmacy Services”, with a maximum of five (5) copays per month. Medicaid members enrolled in a Managed Care Entity (MCE) have some drugs that are covered under Fee-for-Service (FFS) Medicaid. Refer to section IV, Part 5 of this Provider Manual entitled Managed Care Entity Carve-Out.
Managed Care Entity Carve-Out

Pharmacy copays for Medicaid members enrolled in an MCE will be split between FFS Medicaid and the MCE plan:

- For drugs covered by the MCE, the maximum number of copays is three (3) per month.
- For drugs covered by FFS Medicaid, the maximum number of copays is two (2) per month.

Reversal of a previously filled prescription with a co-pay will require a refund of the co-pay to the Medicaid member and will cause the next prescription filled for that Medicaid member to be adjudicated with a co-pay.

Some Medicaid members or medications are exempt from the copayment requirement as described in Utah State Plan, Attachment 4.18-C, Page 3 under sub-bullet K.

Per federal regulation (42 CFR 447.52), a Medicaid provider may not refuse service to a Medicaid member based on their patient's inability to pay their copayment.

For additional information regarding copayment, refer to R414-60-6.

B. Days Supply Policies

1. Coverage of Early Fills of Medication

   Effective 11/01/2021, Utah Medicaid has updated the Pharmacy Early Refill Policy to further improve member care. The early refill override request is now evaluated by the Pharmacy Team against medical necessity, as defined in Utah Medicaid Provider Manual General Information, Section 1, 8-1. An override is granted for early refill requests that rejects at the Pharmacy POS for Reject code 79, CC 1088 Refill Too Soon, if it is deemed medically necessary and in accordance with policy.

2. Insulin Pens

   In 2019 the FDA requested the new wording "dispense in original sealed carton" on boxes of insulin pens for safety reasons. Therefore, breaking up boxes is no longer recommended.

   Effective April 1, 2021, pharmacy point of sale claims for insulin pens may be billed for up to a 140-day supply, with a limit of one box for claims over 30-days, in accordance with the FDA's recommendation. Day supply on submitted claims should reflect the actual days the medication will last and/or expire.

   www.fda.gov/drugs/drug-safety-and-availability/fda-advises-health-care-professionals-andpatients-about-insulin-pen-packaging-and-dispensing

3. Maximum Days Supply

   Utah Medicaid will pay for up to a one (1) month supply of a medication per dispensing unless it is listed on the three-month supply list, located on the Preferred Drug List.

   Medicaid requires a three-month supply for medications on the three-month supply list following a two-month window for dose titration and stabilization. When a member presents with a new prescription or a refill of a maintenance medication, the point-of-sale system will look back 75 days to identify two (2) consecutive fills of the same medicine at the same dose, indicating a stable maintenance dose has been achieved. If found, the claim will be rejected if billed for less than a three-month supply. Once a three-month supply of a medication has been filled, all subsequent fills of the same medicine at the same dose will fill for three months, assuming sufficient refills of the prescription remain.

   For a three-month supply, Utah Medicaid fee for service members who are subject to cost-sharing will pay a single co-pay. Additionally, pharmacies will receive a single dispensing fee on prescriptions filled for a three-month supply.

   Fee-For-Service Medicaid requires members to fill a three-month supply of medication if the medication is listed on the Preferred Drug List - 3 Month Supply Required Drugs.

Pharmacy staff are encouraged to work with prescribers to make any necessary changes to prescriptions to conform to this requirement. The pharmacy may process the original prescription without having to contact the provider if there are enough refills for a three-month supply. The pharmacy may submit the Exception to 3 Month Supply Prior Authorization without having to contact the provider if they have rationale for an exception to this policy.

The mandatory three-month policy does not apply to Indian Health Service providers, or Medicaid members receiving long-term services and support in nursing facilities, intermediate care facilities, or home and community-based waiver programs based on the members certain categories of aid. While not mandatory, three-month supply fills will remain optional for these groups.

If an exception to the Mandatory Three-Month Supply fill is needed for a patient not otherwise excluded from the requirement, a prescriber may submit the “Exception to Three-Month Supply” prior authorization form.

4. Quantity Limits

Quantity limits are based on generally accepted pharmaceutical guidelines, FDA-approved labeling, efficient dosing regimens, and dosing recommendations. Refer to the Preferred Drug List for quantity limits which include opioid medications.

a) Antipsychotic Injections

Effective August 1, 2020, antipsychotic injections are restricted to members 18 years of age and older. For more information, refer to the Medicaid Information Bulletins or Preferred Drug List.

a) Short-Acting and Long-Acting Opioid Limit Exceptions

Utah Medicaid restricts short-acting opioid quantity limits to 7 days or less for children 18 years of age and younger and in pregnant women. If a claim for a short-acting opioid is submitted through the point-of-sale system for a patient 18 years and younger, the system will reject that claim. These days supply limits can be overridden when a valid “cancer pain diagnosis code” is placed on the claim. For all opioid claims billed for an 8-day supply or greater, a reject message will display to the pharmacy that states, “Opioid claims for > 7-day supply for children 18 and younger require a prior authorization.” This edit will be in addition to all existing opioid quantity limits and days supply limitations.

New claims for long-acting opioids will require at least a 7-day trial of a short-acting opioid before long-acting opioid use. When a long-acting opioid prescription is submitted, the claims adjudication system will look back 45 days to identify a short- acting opioid. If a short-acting opioid claim is not identified, the claim for the long-acting opioid will be rejected.

Cumulative limits on opioid analgesics are waived for the current treatment of cancer-related pain. Claims for opioids for the treatment of cancer-related pain must be submitted with a current valid ICD-10 diagnosis code G89.3 Neoplasm-related pain (acute) (chronic) to bypass the quantity, MME, or MED limits listed in the Resource Library.

The prescriber is responsible for providing the current correct diagnosis for narcotic analgesics for cancer pain.

The diagnosis code must be submitted electronically by the prescriber on the prescription or computer generated by prescribing software. Pharmacy providers may also obtain diagnosis codes verbally from prescribers, and note: the date, time, and name of the physician's representative providing the diagnosis code on the original prescription.

The pharmacist must enter the diagnosis code into the appropriate diagnoses field when processing a claim.

Note: If a pharmacy fills a narcotic analgesic prescription that does not comply with the requirements above, funds paid by Medicaid will be recovered through post-payment review.

5. Refill Tolerance

Utah Medicaid will pay for a prescription refill only when 80% of the previous prescription has been exhausted, except for opioid analgesics and controlled substances. The calculation is based on the most recent script fill date and quantity. Refills requested before the 80% of the days supply that has been utilized will be rejected at the pharmacy point-of-sale. For example, a prescription for a 30 days supply has been 80% exhausted on the 24th day after it was dispensed and can be refilled on the 25th day.

Effective April 1, 2020, Utah Medicaid established a refill tolerance of 85% for all controlled substances, including opioids. MME limits will still apply to opioid prescriptions.

Prescription refills must be requested by the Medicaid member, or the member's agent, based on continued medical necessity. Automatically refilled prescriptions, cycle-filled prescriptions, or medication synchronization are not eligible for reimbursement.

C. Drug Shortages

Utah Medicaid may consult the Food and Drug Administration (FDA) Drug Shortages database and the American Society of Health-System Pharmacists (ASHP) Drug Shortages List when making coverage determinations on non-preferred products. If a drug is not listed as unavailable, the onus is on the pharmacy to demonstrate to Medicaid that a product is unavailable by providing one of the following:

- an invoice from a wholesaler that shows that the product is unavailable in the marketplace along with a brief description (e.g., discontinued, on backorder with expected availability date, etc.). In the case that a wholesaler does not have a product, but the product is available in the marketplace, the expectation is that a different provider would be capable of providing the product; or
- an official written communication from a manufacturer or a wholesaler indicating that a product has been discontinued, is currently on shortage (with expected date of availability), or another statement that there are no commercially available preparations.

Note: Member preference does not constitute a medical necessity.

D. Federal Medicaid Drug Rebate Program

Utah Medicaid only covers prescription medications eligible for federal funds payment. For prescription medications to be eligible for coverage using Federal Medicaid funds, drug manufacturers must participate in the Federal Medicaid Drug Rebate Program per federal law (42 USC 1396r-8).

Note: Certain medications are exempt from the Federal Medicaid Drug Rebate Program requirement by law (e.g., vaccines).

For additional information, refer to the Medicaid Drug Rebate Program

E. Mandatory Generic

Utah Code 58-17b-606 mandates that when a multisource legend drug is available in the generic form, Utah Medicaid may only reimburse for the generic form of the drug except for drugs designated as “Brand required over generic”. For additional information regarding the mandatory generic drug policy, refer to R414-60-4.

F. Mandatory Patient Counseling

For information regarding mandatory patient counseling, refer to R414-60-8.

G. Preferred Drug List

1. Non-Psychotropic Medications

The Pharmacy and Therapeutics (P&T) Committee advises the DUR Board and the Division in choosing preferred agent(s) for each selected class of drugs based on safety and clinical efficacy.

For additional information about the P&T Committee, meeting agendas, or meeting materials refer to Utah Medicaid P&T Committee or R414-60B.

2. Psychotropic Medications

For the purposes of the Preferred Drug List (PDL), psychotropic medications are defined as the following:

- Atypical antipsychotics

- Antidepressants
- Anticonvulsant/mood stabilizers
- Anti-anxiety medications
- Epilepsy medications
- Attention deficit hyperactivity disorder stimulants

If a prescriber writes “dispense as written” on a prescription for a non-preferred psychotropic drug, the pharmacy may submit a “Dispense as Written” (DAW) Code of “1” on the claim. Submitting the DAW code will allow the claim to bypass the prior authorization requirement for the non-preferred psychotropic drug at the point of sale. Checked boxes or pre-printed forms that include “dispense as written” are not acceptable substitutes for the prescriber writing, “dispense as written” on the prescription.

Note: The DAW Code will not allow claims for the brand-name version of multisource drugs to process, even though the brand-name version of the drug is listed as non-preferred and the prescriber writes “dispense as written” on the prescription. If a Medicaid member needs the brand-name version that is listed as non-preferred, a prior authorization request must be submitted to Utah Medicaid using the Medication Coverage Exception Request prior authorization form.

For more information, refer to R414-60B and the Preferred Drug List.

H. Prescription Order

All claims for covered medications, including over-the-counter medications, must be prescribed by a licensed prescriber acting within their scope of practice according to licensure. Prescription orders must contain all required information and be issued in compliance with all state and federal laws and regulations.

1. Pharmacist Prescribing

Effective January 1, 2022, a pharmacist may prescribe a prescription drug or device for specific conditions without the oversight of a physician. These conditions are determined to be public health concerns by the Department of Health and Human Services in accordance with Utah Code § 358-17b-102. These conditions include, but are not limited to:

1. Post-exposure HIV prophylaxis
2. Pre-exposure HIV prophylaxis
3. Self-administered hormonal contraceptives
4. Smoking cessation
5. Naloxone

Effective January 1, 2022, Utah Medicaid will pay a dispensing fee for any prescription dispensed with a Medicaid-registered pharmacist individual NPI. A pharmacist who wishes to prescribe for Medicaid members will find more information on how to become a Medicaid provider here: https://medicaid.utah.gov/become-medicaid-provider/

III. Member Eligibility

For information regarding verification of a member's Medicaid eligibility, refer to R414-60-3, or the Eligibility Lookup Tool.

Medicaid members may be referred to and enrolled in the Restriction Program. For more information, contact us at 801-538- 9045 or toll-free at 800-662-9651 #900.

A. Dual Eligible Members (Medicare & Medicaid)

For information regarding dual eligible members on Medicare Part D, refer to R414-60-3.

Medicaid may cover any remaining patient liability for Medicare Part B covered drugs for dual-eligible members as described in Utah State Plan, Attachment 4.19-B, Supplement 1 to Attachment 4.19-B, Page 3.
For billing Medicare/Medicaid crossover claims, see Section I: General Information in Utah Provider Manual, 11-5.1 Medicare Crossover for more information.

IV. Pharmacy Program Coverage

A. Covered Services

1. Biologic Medications and Biosimilar Substitutions

A biosimilar is a biologic product that is highly similar to the U.S. Food & Drug Administration (FDA) approved biologic, known as reference product or parent product. To be FDA-approved as a biosimilar, the product must have the following: same mechanism of action, dosage form, strength, and route of administration as the reference product. Also, a biosimilar must have no clinically meaningful differences in terms of safety, purity, and potency when compared to the parent product.

Additional requirements must be met for a biologic to be titled as an interchangeable biosimilar. These requirements include not only showing that the product is expected to produce the same clinical result as the reference product in any given patient, but also that switching back and forth between the parent biologic product and the biosimilar causes the patient no additional risks in terms of safety or diminished efficacy as using only the reference product.

The key difference between a biosimilar and an interchangeable biosimilar is that the interchangeable biosimilar can be substituted for the reference product by the dispensing pharmacist without prescriber involvement.

The FDA publishes the "Purple Book that lists FDA-approved biological products, which includes biosimilars and interchangeable biosimilars. This publication serves as a reference to healthcare providers to determine which biological products are FDA-approved as reference products, biosimilars, or interchangeable biosimilars.

Utah Medicaid will continue to use the FDA "Purple Book" as a reference and unless otherwise limited through the prior authorization process, Utah Medicaid will not mandate interchange of biosimilars unless they are listed as interchangeable.

Utah Medicaid evaluates reference products and biosimilars for safety and efficacy and may "prefer" one or more over others. When a prior authorization is received for a "non-preferred" reference product or biosimilar the Medicaid staff will contact the requesting provider to ask that they switch to the "preferred" version. As per above, Utah Medicaid will not mandate interchange/substitution of biosimilars unless they are listed as interchangeable.

2. Compounded Prescriptions

   Covered compounds may contain both covered and non-covered ingredients; however, if a compound contains non-covered ingredients, then it must be submitted with the Submission Clarification Code = 8.

   Utah Medicaid requests that pharmacies closely review the Compound Billing Alert Fax Blast to ensure compound claims are being billed correctly. For additional information regarding compounds, refer to R414-60-11.

   Note: Dispensing fee does include the preparation costs for compounded prescriptions. A pharmacy may not charge a Medicaid member an additional fee for any service that is reimbursed as part of the dispensing fee.

3. Cough & Cold Products

   Under R414-60-5, Medicaid covers prescription cough and cold preparations meeting the definition of a covered outpatient drug.

4. Diabetic Testing Supplies

   a) Continuous Glucose Monitors (CGM)
      Preferred glucose monitors are based on the preferred test strips available on the Preferred Drug List for Medicaid members at no charge. Claims for preferred glucose monitors can be submitted using the billing information included on the Preferred Drug List (PDL) under Diagnostic Products.

      Effective April 1, 2021, Utah Medicaid covers CGM through the pharmacy point of sale system. Coverage for all CGMs will require a clinical prior authorization. Please refer to the Preferred Drug List for a list of preferred and non-preferred CGM products.

   b) Diabetic Testing Strips and Lancets
      Preferred blood glucose test strips on the Preferred Drug List are a Medicaid covered benefit through the pharmacy program, up to a maximum of 200 strips per month. Prescriptions for quantities over 200 test strips require prior authorization using the Medication Coverage Exception Request prior authorization form.

Claims for non-preferred diabetic supplies must be submitted through the medical supply program as Durable Medical Equipment (DME) and will not be authorized through the pharmacy point-of-sale system.

5. Drugs to Promote Fertility
   Drugs to promote fertility may be covered for eligible members with specific genetic conditions or heritable traits as well as members undergoing gonadotoxic cancer treatments or other medically necessary treatments that are expected to render them permanently infertile (excluding voluntary sterilization) either pre or post treatment. Please refer to the All Providers General Information Section I Manual Chapter 8-22 Genetic Carrier Screening and In Vitro Fertilization and Chapter 8-23 Fertility Preservation for eligibility information
6. Managed Care Entity Carve-Out
   The following classes of medications and individual drugs are carved out from MCE coverage and are part of the FFS Medicaid benefit:
   - Transplant Immunosuppressive Drugs
   - Attention Deficit Hyperactivity Disorder (ADHD) Stimulant Drugs
   - Antipsychotic Drugs
   - Antidepressant Drugs
   - Anti-anxiety Drugs
   - Anticonvulsant Drugs
   - Hemophilia Drugs
   - Opioid Use Disorder Treatments
   - Ultra- High- Cost Drugs (greater than or equal to $1 million per dose)
   - Alcohol Use Disorder Treatments
7. Medical Billing for Prescription Medications Using HCPCS or CPT Codes
   Pharmacy-related HCPCS and CPT code coverage can be found using the Coverage and Reimbursement Code Lookup. Providers shall review the HCPCS NDC Crosswalk using the Fee Schedule Download Tool to ensure the NDC being used is covered. For additional information contact the Utah Medicaid Pharmacy Team at 801-538-6155 option 3, 3, 2.
8. Opioids
   a) Short-Acting Opioid Initial Fill
      Utah Medicaid restricts the initial fill of short-acting opioids that exceed a 7-day supply or 3 days for dental providers. When a claim for a short-acting opioid is submitted to Utah Medicaid, the pharmacy claims processing system will determine whether the member has had a prescription for the same medication in the previous 60 days. If the member has not had a claim for the same medication in the previous 60 days, the system will treat the claim as an initial fill and allow no more than a 7-day supply. If a claim has been filled for the member for the same medication in the previous 60 days, then the claims processing system will allow the claim to process for up to a

30-day supply; however, the claim will be subject to all limitations and restrictions.

(1) MME limit: Opioid Naïve Member Initial Fill

Effective August 1, 2021, the following edits apply:

- Soft messaging educational campaign stating “A max limit of 50 MME for opioid naïve members is recommended by the CDC”
- Immediate release, the short-acting opioid formulation must be filled before a long-acting opioid
- Day supply limitations - 3 days supply for dental providers and 7 days for all other providers
- Individual opioid quantity limits

b) Morphine Milligram Equivalents (MME) & Cumulative Morphine Equivalent Dosing (MED)

Utah Medicaid uses MME and cumulative daily MED methodology when adjudicating all opioid claims for the treatment of non-cancer pain.

- January 1, 2019, the pharmacy claims adjudication system began using two sets of MED thresholds, depending on member opioid claim history in the last 90 days
  - 90 MED limit is applied to prescriptions for members who have not had a claim for an opioid in the last 90 days from the index opioid prescription
  - 180 MED limit is applied to prescriptions for members who have had a claim for an opioid in the last 90 days from the index opioid prescription
- July 1, 2019, the 180 MED threshold was reduced to 150 MED
- January 1, 2020, the 150 MED threshold was reduced to 120 MED
- July 1, 2020, the 120 MED threshold was reduced to 90 MED

In accordance with the CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR, effective December 1, 2023, the MME values for oral hydromorphone, methadone, and tramadol have been updated. Other policies regarding MME and quantity limits remain unchanged.

Opioid	Current MME Factor	MME Factor effective 12/1/2023
Hydromorphone	4	5
Methadone	3	4.7
Tramadol	0.1	0.2

c) Non-Opioid Alternatives
Utah Medicaid recommends non-opioid analgesics, antidepressants, and anti-seizure medications for the treatment of chronic pain. The PDL has a variety of FDA-approved, CDC recommended, non-opioid treatment options for pain available for Utah Medicaid members, and many are available as a three-month supply. Refer to the Preferred Drug List for covered non-opioid options.

9. Outpatient Cancer Therapy
For information about outpatient cancer therapy, refer to R414-60-7.

10. Sodium Fluoride Chewable Supplements
Effective June 1st, 2024, Utah Medicaid covers chewable fluoride supplements for members age 6 to 16 years. For more information, please refer to the Preferred Drug List & Resource Document and R414-60-5.

11. Tobacco Cessation Products
Both over the counter and prescription tobacco cessation products are available under the pharmacy program for Medicaid members with a prescription. The prescriber can provide a prescription to be filled by the pharmacy for the member to be covered by Medicaid. For additional information, refer to Utah Medicaid Tobacco Cessation Program.

12. Vaccines
a) COVID-19 Vaccines
- Utah Medicaid will continue to cover vaccine counseling. This service is open to members eligible for Traditional EPSDT coverage. Counseling may be performed for any vaccine. This service may not be billed during the same visit that a vaccine was delivered.
- Coverage for the COVID-19 uninsured group for testing, treatment, and vaccination, terminated at the end of the PHE 5/12/2023.
- Effective 7/1/23, COVID-19 Treatments, and COVID vaccines will no longer be carved out. Providers should bill qualified services to the member’s managed care plan if the member is enrolled in such a plan.
- Copays for COVID-19 treatment, vaccines, and tests will continue to be waived for one year and one quarter after the end of the PHE. Effective 10/1/2024, copays will no longer be waived on claims that have a COVID-19 diagnosis.
- Effective 10/01/2024, Utah Medicaid will continue to cover all Food and Drug Administration approved COVID-19 vaccines. Vaccines that were previously granted Emergency Use Authorization under the COVID-19 Public Health

Emergency will no longer be covered after the American Rescue Plan Act COVID-19 vaccination coverage period ends on 9/30/2024.

- Effective 10/01/2024, the COVID vaccines administration fee is updated to $14.10 when processed through the pharmacy point of sale system. To receive the administration fee of $14.10, pharmacy providers must submit the code "MA" in the professional service code field. If no "MA" is submitted in the professional service code field, the pharmacy will be paid only for the cost of the vaccine (lesser of logic) and associated dispensing fee.

b) Claims in POS

Claims for adult Medicaid members (age 19 and older) for Hepatitis B, pneumonia, seasonal and pandemic flu, and herpes zoster vaccines administered by pharmacists can be processed through the pharmacy point of sale.

c) Vaccines For Children Program

Claims for pediatric Medicaid members (age 18 and younger) for vaccines eligible through the Vaccines for Children Program must be submitted through the Vaccines for Children Program. Immunizations will only be eligible for a dispensing fee with no reimbursement for the immunization.

For additional information regarding reimbursement, refer to R414-60-7

B. Non-Covered Services

For information on non-covered services and limitations that apply to all Utah Medicaid programs and the circumstances in which a Medicaid member may be billed for non-covered Medicaid services, refer to R414-60-5.

Pharmacy prior authorizations must be initiated by a Medicaid prescriber. Forms and criteria information can be found on the Utah Medicaid Pharmacy web page, Prior Authorization. For prescriptions covered by the member's MCE, contact the MCE for their PA procedures. Refer to the Resource Library for updated MCE billing information.

C. 72-Hour Supply

Per R414-60-5, a pharmacy may dispense a covered outpatient drug that requires prior authorization for up to a 72-hour supply without obtaining prior authorization during a medical emergency. The pharmacist should use professional judgment to define a medical emergency. All subsequent claims must satisfy all prior authorization criteria or other limitations for the medications.

The pharmacy must submit prior authorization type code (461-EU)=2 and prior authorization number submitted (462-EV)=72. The 72-hour override is limited to two per month per NDC per member. All copay and dispensing fee rules apply. For additional information regarding pharmacy prior authorizations, refer to R414-60.

D. Continuation of Care Policy

Members transitioning to Medicaid from other payers may encounter differences in pharmacy coverage (preferred / non-preferred status) or clinical prior authorization resulting in claim denial. Exceptions to non-preferred or clinical prior authorization may be made when a request is received for continuation of care.

Continuation of care (COC) is defined as evidence of the member being on the requested medication for a minimum of 60 out of the last 90 days (measured from when the PA is received) unless the medication is used emergently. Evidence, or supporting documentation, to request support of approval must be submitted and include at least one of the following:

- Confirmation of previous approval or fills through a Managed Care Entity (MCE) or other commercial plans
- Chart notes demonstrating the member has been taking the requested medications
- Fill history obtained from the controlled substance database(CSD) or dispensing pharmacy claims history
- E-mail messages provided by prescriber clinical staff
- Letter of medical justification
- Medicaid claims history
- Verbal or written attestation of medical need provided by prescriber clinical staff
-

Continuation of care may not be approved in any of the following situations:

- Non-preferred dosing when the member can reasonably use preferred dosing to make up for the non-preferred requested dosing
- Non-preferred dosage forms (capsule/tablet or tablet/capsule) unless clinical rationale is provided by supporting documentation
- Non-preferred brand/generic unless clinical rationale is provided by supporting documentation

E. ADHD Stimulants

Utah Medicaid policy supports the safe and appropriate use of ADHD stimulant medications. This policy is developed in alignment with the American Academy of Pediatrics and the University of South Florida clinical guidelines.

Effective July 2020, age edit limitations apply when a claim for an ADHD stimulant is processed through the pharmacy point of sale:

- ADHD stimulant prescriptions are allowed for children 4 years of age and older, unless otherwise specified on the Preferred Drug List:

Also, effective April 2021, a multiple agent edits, and a cross-class edit limitation will apply when claims for ADHD stimulants are processed through the pharmacy point of sale:

- Three or more unique ADHD stimulant medications were prescribed concurrently for at least 30 days in the last 45 days across all ages.
- Cross-class prescribing of ADHD stimulant medications from the amphetamine class and the methylphenidate class for at least 30 days in the last 45 days for children under 18 years of age.

Effective January 1, 2022, a peer-to-peer educational intervention was implemented to prescribers of high dose stimulant medications. This education intervention emphasizes prescribing within FDA approved labeling and potential risks of high dose prescribing.

Exceptions to ADHD stimulant safety edits are reviewed on a case-by-case basis by submitting the ADHD Stimulants Prior Authorization Form.

F. New Drug Products

Any new drug product(s) will require a prescriber to submit a New to Market Drugs prior authorization request to Utah Medicaid. For additional information regarding new drug products, refer to R414-60-9

G. Off-Label Use

Utah Medicaid may restrict coverage of a drug to the FDA-approved indication (labeled indication) or compendia per federal law 42 U.S.C. 1396r-8(k)(6). Prescribers may request prior authorization by submitting the Medication Coverage Exception Request.

H. Rare Disease

The "Rare Disease Medications" prior authorization form will be required for approval of medications that treat a rare disease and for which prior authorization is required but there is not a drug-specific form available. In determining which drugs will require the “Rare Disease Medications” PA form, the Department will include (but not be limited to) consideration of the drug FDA approval status:

- “Orphan status designation” approval: drugs and biologics intended for the safe and effective treatment, diagnosis, or prevention of rare disorders that affect fewer than 200,000 people in the U.S.
- “Rare pediatric disease” approval: “the orphan [drug population] subset must be serious or life-threatening and the serious or life-threatening manifestations of the orphan subset must primarily affect individuals aged from birth to 18 years.”

Effective September 1, 2020, Rare Disease Medications Prior Authorization is required for any medications that have orphan drug designation as mentioned above and may be required for other, non-orphan medications for rare diseases.

I. Ultra-High-Cost Drugs

Ultra-High-Cost Drugs (UHCDs), defined by Utah Medicaid, as medications that are greater than or equal to one million dollars per dose. These medications are carved out of the DRG (diagnosis-related group) and the Managed Care plans and require prior authorization as stated on the Preferred Drug List. Providers administering an Ultra-high-cost drug shall submit the Ultra-High-Cost Drug Invoice Submission Form for reimbursement. Providers may submit the Ultra High-Cost Drug Written Claim of Business Confidentiality. State staff will audit these services one year after the Ultra-High-Cost Drug Invoice Submission Form is submitted to the state with the Ultra High-Cost Drug AAC Payment Follow-up Form.

V. Drug Utilization Review Board (DURB) Program

The purpose of the Utah Medicaid DUR Program is to promote evidence-based best clinical practice as well as identify patterns of fraud, abuse, gross overuse, and inappropriate or suboptimal treatment. We aim to partner with prescribers, pharmacists, and Medicaid patients to enhance prescribing and dispensing practices as well as medication use by individual patients. Pharmacy staff utilizes communication tools, such as motivational interviewing, to promote and reinforce best practices in the delivery and administration of pharmacy benefits.

For information about the Drug Utilization Review (DUR) Board, meeting agendas, or meeting materials, refer to the Utah Administrative Code R414-60A, and Utah Medicaid Drug Utilization Review Board.

A. Prospective Drug Utilization Review

Prospective drug utilization review involves a review of drug therapy before each prescription is filled or delivered to a member and includes counseling of the member or their caregiver. This counseling is based on evidence-based predetermined clinical standards.

1. Attention Deficit Hyperactivity Disorder (ADHD) Stimulants
   Stimulant medications are utilized first-line to treat ADHD. These agents have high misuse potential and are associated with significant, lasting adverse effects when taken at chronically high doses. Point-of-sale edits and prior authorization requirements have been implemented based on guideline recommendations to minimize concurrent use of different classes of stimulant medication and prevent utilization of unsafe chronic stimulant doses.

2. Benzodiazepine and Opioid Concurrent Use
   Utah Medicaid has begun a multi-stage effort to identify and limit the concurrent filling of benzodiazepine and opioid medications. This initiative supports CDC safety guidance that recommends against combined use, which is associated with the risk of fatal overdose. Currently, an automated process monitors and reports when an individual is co-prescribed opioids and benzodiazepines. The peer-to-peer team conducts outreach

to identified prescribers to alert them of patients receiving concurrent therapy, provide education around concurrent use avoidance, and encourage prescription drug monitoring program (PDMP) use before prescribing a Schedule II controlled substance, per the Federal HR6, SUPPORT for Patients and Communities Act.

Combined use of opioids and benzodiazepines potentiate respiratory depression, which may result in nonfatal overdose and death. Utah Medicaid supports FDA labeling and CDC best practice and safety standards which advise against concurrent use. (https://www.cdc.gov/drugoverdose/)

- July 1, 2019: Concurrent prescribing of long-acting opioid medications and benzodiazepines are restricted through the pharmacy point of sale system. When a claim for either a long-acting opioid or a benzodiazepine is submitted, the system will look back 45 days to find any paid claims for either benzodiazepines or long-acting opioids. If a paid claim for a benzodiazepine is found, the long-acting opioid claim will be rejected. Likewise, if a paid claim for a long-acting opioid is found, the benzodiazepine claim will be rejected. Any exceptions to this concurrent use restriction will be evaluated through the prior authorization process, using the Opioid and/or Opioid-Benzodiazepine Combination prior authorization form.
- October 1, 2019: Utah Medicaid deployed a Drug Utilization Review (DUR) hard edit when a short-acting opioid claim is filled concurrently with a benzodiazepine. The DUR hard edit will require pharmacist input of an NCPDP override code, documenting the intervention made, before the claim will process. All other existing opioid edits will apply to the processing of opioid claims.

  Acceptable Professional Service Codes: CC, M0, MB, MP, PE, P0

  Reason of Service Code: 1B, 1G, 2A, 2B, 3A, 3B, 3C, 3D, 3E, 3G, 3K, 4A, 4B, 4C, 4D, 4E

  Utah Medicaid encourages filling pharmacists to incorporate these standards when filling opioid–benzodiazepine prescriptions:

  - Routinely check the controlled substance database with the filling of each opioid prescription
  - Proactively counsel patients about the risks of respiratory depression when combined use is identified
  - Proactively offer naloxone and educate on the appropriate use
  - Proactively outreach to prescribers to consider other, safer combinations

3. Gabapentin/Pregabalin Concurrent Use

   The Drug Utilization Review Board reviewed the safety and misuse/abuse potential of gabapentin and pregabalin during the January 2020 meeting. To promote best practice and safety standards that align with the Food and Drug Administration (FDA) labeling, Utah Medicaid set prospective drug utilization review quantity limits for gabapentin at 3,600 mg/day and pregabalin at 600 mg/day effective April 1, 2020. In addition, concurrent use of gabapentin and pregabalin will not be permitted. Claims processed

through the point-of-sale system that exceeds established quantity limits or use standards will require prior authorization.

4. Medication-Assisted Treatment (MAT) for Opioid Use Disorder

   The Utah Medicaid PDL includes medications used for the treatment of opioid use disorder. Refer to the Preferred Drug List for coverage options.

   Effective January 1, 2021, Utah Medicaid will limit the use of opioid medications in members who are also receiving medications to treat opioid use disorder (MAT). When a claim for an opioid medication is processed through the pharmacy point of sale system, the system will look back to identify if a claim for medication-assisted treatment (MAT) has been processed in the last 45 days. If the system recognizes that a claim for MAT has been processed in the last 45 days, the system will limit the opioid to a supply of 7 days or less, regardless of the prescribed quantity/duration. If the system does not identify a concurrent claim for MAT in the last 45 days, then the opioid will process without a 7-day limitation. All opioid policy limits still apply.

5. Opioid Use in Pregnancy

   In March 2016, the FDA strengthened warnings about the risks related to opioid use and potential misuse, abuse, and addiction. One of those risks is Neonatal Abstinence Syndrome (NAS) or Neonatal Opioid Withdrawal Syndrome (NOWS) which may occur in infants who are chronically exposed to opioids in utero.

   NAS/NOWS is a withdrawal syndrome that occurs in infants who were exposed to opioids in utero. The syndrome is characterized by tremors, irritability, poor feeding, respiratory distress, and seizures, all of which develop shortly after birth. From 2004 to 2014, the incidence of NAS in the United States increased from 1.5 to 8.0 per 1,000 hospital births, a more than fivefold increase. Carefully consider any use of opioids in the management of pregnant individuals. This policy does not apply to pregnant women on methadone maintenance for the treatment of opioid use disorder.

   - October 1, 2019: Utah Medicaid restricts opioid quantity limits to 7 days or less for pregnant individuals.
     - If a claim for an opioid is submitted through the point-of-sale system for more than a 7-day supply for a pregnant individual, the system will reject that claim.

B. Retrospective Drug Utilization Review

Retrospective drug utilization interventions involve a review of claims data or other historic records to inform policy and create interventions to improve patient outcomes. Outcome measures are derived from CMS guidance and measures outlined by the National Committee for Quality Assurance (NCQA).

1. Antipsychotics in Children

Utah Medicaid implemented a new policy on October 1, 2019, to monitor and manage antipsychotic (AP) medications prescribed to members 19 years of age and younger.

Retrospective Drug Utilization Review (DUR) peer to peer educational interventions that support the American Academy of Child and Adolescent Psychiatry best practices for use of AP in children addresses the following:

- Use of other first-line services (psychosocial counseling and safer medications) before initiation of AP
- Dosing of AP should follow the “start low and go slow” approach
- Identification of “higher than recommended” doses for AP
- Careful and frequent monitoring of AP-related side effects
    - Metabolic screening
    - Body Mass Index, weight gain
    - Assessments for movement disorders
- Use of AP in very young children (e.g., younger than 6 years old)
- Use of multiple concurrent AP (17 years of age and younger only)

Utah Medicaid requires a diagnosis code on all prescription claims for AP medications. Prescribers must include the diagnosis codes with each prescription for an AP given to a child 19 years of age and younger. Pharmacies are required to enter the diagnosis code into the point-of-sale system when processing a claim for an AP. Retrospective peer-to-peer outreach will address off-label use of AP in this vulnerable population.

High dose limits for AP will be established in the pharmacy point of sale system. Very high doses of AP have not been proven effective in children and may be associated with a greater incidence of adverse effects, including movement disorders. Claims for AP submitted to Utah Medicaid that exceed the pre-established limits will be rejected at the pharmacy point of sale and require prior authorization.

a) Recommended Monitoring of Children for Antipsychotic-Related Side Effects

Effective April 1, 2023, “Antipsychotics in Children” prior authorization requests will no longer require documentation of metabolic monitoring for children receiving antipsychotics. Utah Medicaid strongly supports the American Academy of Child and Adolescent Psychiatry, the American Diabetes Association, and American Psychiatric Association recommendations that measurements be taken prior to or immediately after an antipsychotic prescription and regularly during treatment. However, removing this metabolic testing requirement intends to further enhance access and mental health care services for children served by Medicaid.

Children enrolled in Medicaid receive antipsychotic medications at a substantially higher rate than non-Medicaid pediatric populations. Antipsychotic use in children is frequently “off label” and prescribed before safer, first-line options have been trialed. Antipsychotic medications can have severe side effects including metabolic changes, weight gain, and movement disorders. These side effects can be irreversible. Because of

these risks, Utah Medicaid recommends the inclusion of documentation of monitoring of antipsychotic-related side effects OR clinical rationale for the lack thereof when submitting the "Antipsychotics in Children" prior authorization.

The American Academy of Child and Adolescent Psychiatry endorse the American Diabetes Association and American Psychiatric Association recommendations that children receiving antipsychotic medication should have side effects monitored via parameters measured at treatment initiation and regularly repeated thereafter, including:

Parameter	Frequency of Monitoring
Personal and family history of obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease	Treatment initiation, annually
Weight	Treatment initiation, months 1, 2, 3, and annually
Waist circumference	Treatment initiation, annually
Blood pressure	Treatment initiation, 3 months, annually
Fasting plasma glucose	Treatment initiation, 3 months, annually
Fasting lipid profile (HDL, LDL, TG, TC) *	Treatment initiation, 3 months, then every 6 months

HDL: high-density lipoprotein

LDL: low-density lipoprotein

TG: triglyceride

TC: total cholesterol

2. Hemophilia Medication Management

Fee-for-service members and their families receive comprehensive care management services provided by a multidisciplinary team of healthcare professionals from the Hemophilia Treatment Centers and the Utah Medicaid Pharmacy Team, per national treatment guidelines.

Care management includes but is not limited to:

- claims review
- verification of monthly eligibility and ongoing enrollment requirements
- contact with eligible FFS Medicaid members to assess their hemophilia needs and well-being
- continuous outreach to ensure adherence and transparency of care
- coordinating with in-home nursing and the Hemophilia Treatment Centers as necessary

Members of the care team from the Utah Medicaid Pharmacy include clinical pharmacists and pharmacy technicians that received comprehensive training from the Hemophilia Treatment Centers, as well as online training.

3. Hepatitis C Medication Adherence

   Adherence to Hepatitis C antiviral medication therapy is essential for ensuring a treatment cure for undetectable viral loads. Pharmacy staff telephonically reach out to patients who have been non-adherent to Hepatitis C medications during a course of therapy to identify adherence barriers and provider support. Follow-up is conducted to promote medication adherence for the duration of antiviral treatment.

VI. Billing

Utah Medicaid requires all pharmacy claims to be submitted electronically through the pharmacy point-of-sale system using the National Council of Prescription Drug Plan (NCPDP) version D.0 standard. The point-of-sale system provides pharmacists with the ability to submit pharmacy claims electronically with “real-time” claim processing. To assist pharmacies in submitting electronic claims, Utah Medicaid posts an NCPDP version D.0 payer sheet located in the Resource Library.

Utah Medicaid reviews all pharmacy claims to identify inappropriately billed prescriptions. Medicaid will work with the pharmacy to correct erroneous claims within the timely filing requirement. Repeat issues may be referred to OIG for further investigation per Utah Code Section 63A-13-3.

A. 340B Billing

Covered entities participating in the 340B Program must comply with all 340B Program requirements https://www.hrsa.gov/opa/index.html. States shall collect Medicaid rebates for covered outpatient drugs, unless the drug was subject to a 340B Drug Discount Program discount (42 U.S.C. §1396r-8(j)(1)) and indicated as such per the state’s policies. Medicaid excludes claims from drug rebate invoicing if the provider indicates a 340B drug was dispensed.

340B Program compliance rests entirely on the covered entity. 340B-covered entities can be sanctioned for causing duplicate discounts or drug diversion (42 U.S.C. § 256B).

Each 340B-covered entity should carefully review its claims to ensure the indicators and actual acquisition costs were correctly billed. A covered entity identifying 340B claims that were billed inappropriately should resubmit claims to Medicaid to correct the 340B indicator(s) or correct the actual acquisition cost submitted within the timely filing requirement.

If the covered entity is unable (due to timely filing deadline or otherwise) or unwilling to submit a corrected claim, the 340B covered entity must work directly with the manufacturer to resolve the duplicate discount issue.

1. 340B Billing for Medical Claims

   All claims submitted to Utah Medicaid from a 340B covered entity for medications that were purchased through the 340B program must be submitted with the provider 340B

actual acquisition cost as the billed charges and the "TB" or "JG" modifier after the HCPCS code on each claim line.

Claims submitted without the provider 340B actual acquisition cost as the billed charges and the "TB" or "JG" modifier on the claim line indicate that the covered entity purchased the medication outside of the 340B program and Utah Medicaid will pursue the federal Medicaid drug rebate on those claims.

- JG: Drug or biological acquired with 340B drug pricing program discount
- TB: Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes

Reporting is mandatory for the following providers:

Not Paid Under OPPS				
Hospital Type (determined by CMS)	Pass-through Drug (SI "G")	Separately Payable Drug (SI "K")	Vaccine (SI "F" "L" or "M")	Packaged Drug (SI "N")
CAH	TB, Optional	TB, Optional	N/A	TB or JG, Optional
Non- Excepted Off-Campus PBD	TB	TB	N/A	TB or JG, Optional
Paid under the OPPS, Excepted from the 340B Payment Adjustment for 2018				
Hospital Type (determined by CMS)	Pass-through Drug (SI "G")	Separately Payable Drug (SI "K")	Vaccine (SI "F" "L" or "M")	Packaged Drug (SI "N")
Children's Hospital	TB	TB	N/A	TB or JG, Optional
PPS-Exempt Cancer Hospital	TB	TB	N/A	TB or JG, Optional

For additional billing guidance refer to https://med.noridianmedicare.com/web/jfa/topics/drugs-biologicals-injections/340b-drug-program.

For dual-eligible beneficiaries who participate in both the Medicare and Medicaid programs, when a 340B covered entity submits a crossover drug claim to Utah Medicaid, it must contain a “JG” or “TB” modifier.

2. 340B Outpatient Pharmacy Point of Sale (POS) Billing (POS)

All claims submitted to Utah Medicaid from a 340B covered entity for medications that were purchased through the 340B program must be submitted with the provider 340B actual acquisition cost in the Ingredient Cost Field, a value of “8” in the Basis of Cost field, and a value of “20” in the Submission Clarification Code field.

Claims submitted without the provider 340B actual acquisition cost in the Ingredient Cost Field, a value of “8” in the Basis of Cost field, and a value of “20” in the Submission Clarification Code field indicate that the covered entity purchased the medication outside of the 340B program and Utah Medicaid will pursue the federal Medicaid drug rebate and supplemental rebate on those claims.

Claims submitted to Utah Medicaid from a 340B covered entity for medications that were not purchased through the 340B program may be submitted in accordance with Utah Medicaid and the pharmacy’s normal business practices.

340B covered entities may not utilize contract pharmacies to bill Utah Medicaid, unless the covered entity, the contract pharmacy and the State Medicaid agency have established a written arrangement to prevent duplicate discounts. Any such arrangement shall be reported to the Office of Pharmacy Affairs (OPA and Health Resources & Services Administration (HRSA), by the 340B covered entity.

B. Decimal Quantities

Pharmacies must submit claims to Utah Medicaid using the actual metric decimal quantities of medications dispensed to Medicaid members based on the National Council of Prescription Drug Plans (NCPDP) billing unit for drugs.

Rounding units, packages, or sizes, or submitting quantities that are inconsistent with the NCPDP billing unit on a claim is not allowed and will be rejected at the point of sale.

C. End-Stage Renal Disease (ESRD) Billing

The dialysis composite payment rate for all covered dialysis revenue codes is based on the Medicare ESRD Prospective Payment System base rate as identified and approved in Attachment 4.19-B on Page 12a of the Utah Medicaid State Plan.

Dialysis services should be billed as a UB-04 Claim using one of the following Revenue Codes.

Covered Dialysis Revenue Codes:

- Revenue code 0821 (Hemodialysis)
- Revenue code 0831 (Peritoneal Dialysis)
- Revenue code 0841 (Continuous Ambulatory Peritoneal Dialysis)

- Revenue code 0851 (Continuous Cycling Peritoneal Dialysis).

Each dialysis session should be billed as one (1) unit with the appropriate Revenue Code. All covered dialysis revenue codes are reimbursed at the same rate. It is not necessary to bill separately for services delivered during the dialysis session that are included in the composite payment. Claim lines submitted on the UB-04 Claim for services included in the composite rate will be denied.

Procedure codes for ESRD services with accompanying criteria and limitations can be verified by using the Utah Medicaid, Office of Healthcare Policy and Authorization, Coverage and Reimbursement Code Lookup. For additional information regarding coverage for dialysis services by ESRD facility refer to R414-19A.

D. National Prescriber Identifier

Federal regulation 42 C.F.R. 455.410(b) requires all prescriptions for Utah Medicaid members to be issued by a prescriber who is enrolled with Utah Medicaid. Prescriptions that are issued by a non-enrolled prescriber or claims submitted with a National Prescriber Identifier (NPI) not associated with an enrolled prescriber will be denied.

Utah Medicaid requires the NPI submitted on a pharmacy claim to be the NPI of the prescriber that issued the prescription. Claims submitted with an incorrect prescriber NPI will either be denied or subject to recoupment on post-payment review.

E. Procedure Codes

Outpatient pharmacy claims submitted to Utah Medicaid electronically using the NCPDP Version D.0 standard do not need to be submitted with a Current Procedural Terminology (CPT®) code or Healthcare Common Procedure Coding System (HCPCS) code.

F. Provider Administered Drugs

Provider administered drugs are administered in physician offices or outpatient facilities by doctors or eligible staff. These drugs must be reasonable, necessary, indicated for diagnoses, or effective treatments of specific illnesses or injuries based on accepted standards of medical practice. All other program plan coverage and limitations still apply.

Note: self-administered drugs shall not be billed as a provider-administered drug

As described in Utah Medicaid State Plan, 4.19-B Methods and Standards for Establishing Payment Rates - Other Types of Care, claims for covered provider administered drugs adjudicated in the PRISM system are reimbursed under the same reimbursement logic for covered outpatient drugs billed through the pharmacy point of sale system, with the exception that no professional dispensing fee will be paid.

HCPCS coverage status can be verified by using the PRISM Coverage and Reimbursement Code Lookup and coverage of the NDC can be verified using the PRISM Coverage and Reimbursement Fee Schedule Download HCPCS/NDC Crosswalk.

Additionally, claim lines for provider administered drugs must contain both the appropriate HCPCS code, HCPCS unit, and the correct National Drug Code (NDC) of the medication administered to the Medicaid member. The NDC of the product administered to the Medicaid member must be active, valid, and eligible for the federal Medicaid drug rebate in order for the claim line to be considered for reimbursement. If the submitted combination is unmatched, the claim will deny. The HCPCS to NDC crosswalk and billing requirements apply to claims administered in physician offices (CMS-1500 claim) and in outpatient settings (UB-04 claim).

Providers and interested parties who wish to submit requests for consideration of additional HCPCS to NDC matches, or to make changes to existing matches, may do so via the Physician Administered Review Request Form.

Note: NDCs must be submitted with eleven (11) digits in a 5-4-2 digit format (without dashes). NDCs submitted as ten (10) digit codes or eleven (11) digit codes with dashes will result in the claim being denied. The first five (5) digits of the NDC are the manufacturer labeler code, the middle four (4) digits are the product code, and the last two (2) digits are the package size. If one were to encounter a NDC that is less than eleven (11) digits, add the missing digits as follows:

- For a 4-4-2 NDC, add a 0 to the beginning of the code as the first digit.
- For a 5-3-2 NDC, add a 0 as the sixth digit.
- For a 5-4-1 NDC, add a 0 as the tenth digit

A covered entity using medications purchased through the 340B program should refer to the 340B chapter of this manual for additional information.

The following information must be provided on a CMS-1500 Claim Form when billing for provider administered drugs:

- NDC – Box 24D (Procedures, Services, or Supplies), shaded area
- Drug Unit Price – Box 24F ($ Charges), shaded area
- Basis of Measurement Qualifier and Units – Box 24G (Days or Units), shaded area. Use the following qualifiers:
  - ML – for milliliters
  - GR – for grams
  - UN – for units
  - F2 – for international units

When billing the CMS-1500 electronically, the information needs to be reported in the following X12 fields (contact your software vendor for specific information):

- 2410 LIN03= NDC number preceded with N4 (LIN02=N4)
- 2410 CTP05-1= Units of measure qualifier (GR, ML, UN, F2)

- 2410 CTP04= Number of units (place the number of units immediately after the units of measure qualifier)
- 2410 CTP03= Cost or Unit Price

Outpatient hospital claims that include lines for drugs must provide the NDC when billing Medicaid on the UB-04 claim form. The NDC code must be included on the claim line immediately below the REV Code and Procedure Code (Form locator 43), the Units preceded by a qualifier (Form locator 46), and the Unit Price (Form locator 47).

When billing the UB-04 electronically, the information needs to be reported in the following X12 fields (contact your software vendor for specific information):

- 2410 LIN03= NDC number preceded with N4 (LIN02=N4)
- 2410 CTP05-1= Units of measure qualifier (GR, ML, ME, F2)
- 2410 CTP04= Number of units (place the number of units immediately after the units of measure qualifier)
- 2410 CTP03= Cost or Unit Price

Provider-administered drugs that do not require payment, such as samples or those previously billed at a pharmacy, should report the appropriate HCPCS and $0.0 or $0.1 charge.

NOC (Not Otherwise Classified) HCPCS codes should only be reported for drugs that do not have a drug-specific HCPCS code (e.g. including but not limited to J3490, J3590).

For provider administered drugs used for the treatment of an opioid use disorder, a pharmacy may bill Medicaid. The pharmacy may only release this provider-administered drug used for the treatment of an opioid disorder to the administering provider or the provider's staff for treatment.

VII. Reimbursement

A. Dispensing Fee

A pharmacy may not charge a Medicaid member an additional fee for any service that is reimbursed as part of the dispensing fee.

For additional information about dispensing fees, refer to the Utah Medicaid State Plan, ATTACHMENT 4.19 B, Page 19a and R414-60-7.

B. Drug Pricing Metrics

Utah Medicaid reimburses pharmacies for prescription drugs in accordance with the Utah State Plan ATTACHMENT 4.19-B. Published pricing metrics used for reimbursement logic include Wholesale Acquisition Cost (WAC), Federal Upper Limit (FUL), National Average Drug Acquisition Cost (NADAC), and Utah Maximum Allowable Cost (UMAC).

Pharmacy submitted pricing that is included in the pricing logic includes the amount billed, the usual and customary charge billed to the private pay patient (U&C), and the ingredient cost submitted.

The focus of this article is on published pricing metrics, with an example focused on NADAC. The examples given below use NADAC; however, the general process for pricing updates applies to other published pricing metrics. Other published pricing metrics may have different update cycles, frequencies of updates, and the source of pricing data may vary.

CMS publishes updates to NADAC pricing every Wednesday which includes an effective date for the pricing update. The effective date may be on, before, or after the update publication date. These data are collected by Medi-Span and incorporated into the weekly drug file sent to Utah Medicaid. Updates to the drug file are reviewed by the Utah Medicaid Pharmacy Team each Monday (or Tuesday in the case of a Monday holiday). The load date for the pricing information is the date that the full drug file is loaded and ready in the Utah Medicaid POS system by midweek, typically on Wednesday of that week (or Thursday in the case of a Monday holiday). This means that there is approximately one week from the time CMS publishes a price update until the price is updated in the Medicaid pharmacy claims adjudication system.

The date that a claim is adjudicated can affect the pricing used on that claim with regard to the date of service, the effective date of a price change, and the load date for the pricing information. The date a price is published will not impact the pricing used for adjudication, except that it impacts the load date as the load date follows the published date by approximately one week.

For example, if a claim is adjudicated after a published pricing update impacts the claim billed NDC price, but before the new price has been loaded into the system, the claim will adjudicate at the old price. If that same claim is reversed, then rebilled after the load date, the claim will adjudicate with the newer price, provided the date of service is on or after the new effective date. This holds true for effective dates that are before the date a pricing update has been published.

Key dates for Medicaid drug pricing metrics:

- Published Date: This is the date that the pricing metric is posted. In the case of NADAC, this is the date that CMS posts the pricing information to the CMS website.
- Effective Date: This is the date that the pricing metric goes into effect.
- Load Date: This is the date that an updated pricing metric is loaded into the Utah Medicaid point of sale system.

Process for all published pricing metrics used by Utah Medicaid:

Note: the frequency of updates for each metric represents how often the catalog of priced NDCs is updated. The pricing of a single, specific NDC will not update as frequently as the

metric. For each metric, only NDCs with price changes will be modified with a pricing update.

- NADAC: The National Average Drug Acquisition Cost (NADAC) for a drug is published by CMS. This pricing information is determined by a contractor, currently Myers & Stauffer, who conducts optional surveys of pharmacies nationwide to approximate the average actual acquisition cost of prescription drugs nationwide. NADAC pricing updates occur once weekly. For more information, please refer to the Retail Price Survey.
- FUL: The Federal Upper Limit (FUL) for a drug is determined by CMS based on criteria published on the CMS website and in accordance with the final rule with comment (CMS-2345-FC), and is closely tied to NADAC pricing. FUL pricing updates occur once monthly near the end of the calendar month.
- WAC: Wholesale Acquisition Cost (WAC) is determined by manufacturers and represents the list price for a drug. The frequency of updates for WAC pricing data is dependent on the drug file vendor. Utah Medicaid currently receives drug file data from Medi-Span on a weekly basis.
- UMAC: The Utah Maximum Allowable Cost (UMAC) is determined by a contractor, currently Myers & Stauffer, who conducts mandatory surveys of Utah Medicaid pharmacy providers to approximate the average actual acquisition cost of prescription drugs for Utah Medicaid pharmacy providers. Myers & Stauffer publishes updated UMAC rates once weekly.

C. Indian Health Services

Indian Health providers are reimbursed for pharmacy services in accordance with the Utah Medicaid Indian Health Provider Manual.

D. Medication Therapy Management Reimbursement

Effective January 1, 2024, members may receive face-to-face and telephonic Medication Therapy Management (MTM) services provided by a Medicaid enrolled pharmacist in an outpatient setting.

Pharmacists shall be licensed in the state of Utah and enrolled as a provider with Utah Medicaid to provide these services. Additional information on how to become a Medicaid provider can be found here: https://medicaid.utah.gov/become-medicaid-provider/.

MTM services are covered for Medicaid enrolled adult and pediatric eligible members. Medicaid members may receive one initial MTM service and three follow-up services per calendar year. Medicaid members must be taking at least three medications to treat or prevent at least one chronic disease. Medicaid members cannot be eligible for Medicare Part D to receive these services.

Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup. For a full description of the MTM program, please see the Utah Medicaid Pharmacy website.

E. Self-Administered Hormonal Contraceptive Reimbursement

Effective January 1, 2023, Utah Medicaid will reimburse up to $20 for an annual consultation fee for services provided by pharmacists who furnish self-administered hormonal contraceptives by either prescription or by standing order in accordance with Utah Administrative Code R156-17b-621b. This reimbursement will be provided for pharmacy point of sale claims that include one of the following diagnosis codes:

- Z30.011 Encounter for initial prescription of contraceptive pills
- Z30.015 Encounter for initial prescription of vaginal ring hormonal contraceptive
- Z30.016 Encounter for initial prescription of transdermal patch hormonal contraceptive device

F. Utah Maximum Allowable Cost and NADAC

Effective October 1, 2020, UMAC pricing for antihemophilia products have been implemented to maintain the UMAC rates. For information regarding the Utah Maximum Allowable Cost (MAC), refer to R414-60-7.

For questions or concerns regarding NADAC pricing, contact Myer's National Average Drug Acquisition Cost (NADAC) Help Desk at (855) 457-5264 or info@mslcrps.com.

Pharmacies may also submit NADAC pricing inquiries using the Help Desk Form located on the Retail Price Survey | Medicaid website.

c) IX. References

Utah State Plan, Attachment 4.18-C Utah State Plan, Attachment 4.19-B

Social Security Act, §§ 1927(d)(2) and 1927(k)(3)

§ 1935

42 CFR 447.52(e)

42 CFR 455.410

42 U.S.C. §§ 1396b (i)(23) ;1396r-8; 1396r-8(g)(2)(A)

UCA Title 26, Chapter 18, Part 2 UCA 58-17b-606 Utah Administrative Code R414-60

Utah Medicaid Provider Manual

Physician Services

Division of Integrated Healthcare

Updated November 2024

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1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General information.

1-1 Physician services

The physician services program provides a scope of service to meet the basic medical needs of eligible categorically and medically needy individuals.

With the cooperation and advice of the Utah Medical Care Advisory Committee, the Department has established standards and regulations governing care for which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for reasonable and medically necessary services and supplies subject to the exclusions and limitations outlined in policy and Utah Administrative Code Title R414.

Physician services are a mandatory Medicaid, Title XIX program authorized by sections 1905(a) and 1861 (r) of the Social Security Act, 42 CFR 440.50, and Sections 26-1-5 and 26-18-3, Utah Code Annotated.

In addition to this provider manual, reference Utah Administrative Code Title R414. Health Care Financing, Coverage and Reimbursement Policy, for more information on Utah Medicaid Policy. For specific information regarding physician services, see Utah Administrative Code R414-10. Physician Services. Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

1-1.1 Associate physician

An associate physician, as defined in Utah Code 58-67-302.8, Restricted licensing of an associate physician, may enroll as a Medicaid provider.

The associate physician may provide medically necessary primary care services, consistent with the clinician's skill, training, education, and competence, to Medicaid members. Associate physician services must be performed under the direction of a collaborating physician as defined in Utah Code 58-67-807, Collaborative practice arrangement.

2 Health plans

For more information about Accountable Care Organizations (ACOs), refer to Section I: General Information, Chapter 2, Health plans.

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information, Chapter 2-1.2, Prepaid mental health plans, and the Managed Care Manual.

A list of ACOs and PMHPs with which Medicaid has a contract to provide healthcare services is found on the Medicaid website Managed Care: Accountable Care Organizations.

3 Provider participation and requirements

Refer to Section I: General Information, Chapter 3, Provider participation and requirements.

4 Record keeping

Refer to Section I: General Information, Chapter 4, Record keeping.

5 Provider sanctions

Refer to Section I: General Information, Chapter 5, Provider sanctions.

6 Member eligibility

Refer to Section I: General Information, Chapter 6, Member eligibility, for information about how to verify a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member responsibilities

For information on member responsibilities, including establishing eligibility and co-payment requirements, refer to Section I: General Information, Chapter 7, Member responsibilities.

8 Programs and coverage

Physician services involve direct patient care to secure and supervise appropriate diagnostic ancillary tests or services within the parameters of established Medicaid policy, to diagnose the existence, nature, or extent of illness, injury, or disability. In addition, physician services involve establishing a course of medically necessary treatment designed to prevent or minimize the adverse effects of human disease, pain, illness, injury, disability, defect, or other impairments to a member's physical or mental health. For more information on policy regarding physician services coverage, see Utah Administrative Code R414-10-5. Physician Services. Service Coverage.

For general information on Medicaid programs other than physician services, refer to Section I: General Information, Chapter 8, Programs and coverage, and Utah Medicaid Provider Manuals Parent Directory. Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

8-1 Definitions

Definitions of terms used in multiple Medicaid programs are in Section I: General Information, Chapter 1-9, Definitions, and Utah Administrative Code R414-1. Utah

Medicaid Program. Definitions particular to physician services are found in Utah Administrative Code R414-10-2. Physician Services. Definitions.

8-2 Emergency services program for non-citizens

For information on federal regulations, criteria, documentation, and billing, refer to Section I: General Information, Chapter 8-2.11, Emergency services program for non-citizens.

8-3 Anesthesia services

8-3.1 Prior authorization

Prior authorization (PA) is required for certain anesthesia services. Providers must determine if a PA is necessary before providing services. Failure to obtain a PA may result in payment denial by Medicaid. The surgeon is responsible for getting prior authorization for all codes with a prior authorization requirement. When Medicaid issues a PA for a procedure requiring authorization, associated anesthesia codes are added to the PA.

When an anesthesia provider bills for an ASA code associated with a CPT procedure code that requires prior authorization, the claim must include the prior authorization number issued to the surgeon. When the surgeon did not obtain prior approval, the anesthesia provider might request prior authorization retroactively. The anesthesia provider should submit a completed PA request form, the operative report, and any applicable consent forms required by Utah Medicaid. Authorization is not issued for any services in conflict with federal or state law, Medicaid policy, or procedures in which prior authorization was requested and denied.

General prior authorization information is in Section I: General Information, Chapter 10, Prior authorization. In addition, code-specific coverage and prior authorization requirements are on the Medicaid website Coverage and Reimbursement Lookup Tool.

8-3.2 Billing

Refer to Section I: General Information, Chapter 11, Billing Medicaid, and Utah Medicaid Anesthesia Fee Schedule for detailed billing instructions.

Anesthesia entails pre-anesthesia evaluation, intraoperative, and post-anesthesia care. It includes all services associated with the administration and monitoring the anesthetic/analgesic care (MAC). Postoperative pain management services may begin preoperatively, intraoperatively, or postoperatively.

8-3.3 Anesthesia time reporting

Report anesthesia time in minutes.

1. Electronic claims
    a) Enter total time in minutes in the "minutes" field with the correct MJ (anesthesia minutes) qualifier
2. Paper claim forms
    a) CMS-1500
        i. Enter the minutes in Box 24G.
        ii. Put an "M" before the minutes
        iii. Example: M531
    b) If a claim is submitted without minutes or the correct MJ qualifier, Medicaid pays one-time unit, i.e., 12 minutes or less

8-3.4 Obstetrical anesthesia – time reporting

An anesthesiologist may attend to more than one patient concurrently under continuous regional anesthesia related to neuraxial anesthesia for planned vaginal delivery.

There is a reduction in the unit value after the first hour of anesthesia time. For example, the first hour, 5-time units are calculated, for the second hour, 2.5 units, for the third and each succeeding hour of anesthesia, 1.25 units.

When billing obstetrical anesthesia, indicate total time in minutes. The PRISM System calculates the appropriate reduction in the unit value.

8-3.5 Dental services

Ambulatory surgical centers (ASC) and outpatient hospitals report dental services using CPT 41899. Anesthesia providers directly rendering services should bill CPT 00170. Refer to the Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual and the Coverage and Reimbursement Lookup tool for coverage details.

8-3.6 Procedure codes

Anesthesia procedure codes with accompanying criteria and limitations are found on the Medicaid website Coverage and Reimbursement Lookup Tool.

8-3.7 Anesthesia modifiers

Report all anesthesia services with the appropriate anesthesia CPT code(s) plus the physical status modifier. Refer to Section I: General Information, Chapter 12-7.3, Modifier used in a claim, for additional modifier information.

8-3.8 Physical status modifiers

Physical status modifiers distinguish between the levels of complexity of the anesthesia service provided. Although, when reporting a claim, there are no physical status modifiers, modifier P1, which indicates a normal healthy patient, is used in the adjudication.

Modifier	Description	Medicaid unit value
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	1
P3	A patient with severe systemic disease	3
P4	A patient with severe systemic disease that is a constant threat to life	4
P5	A moribund patient who is not expected to survive without the operation	6
P6	A declared brain-dead patient whose organs are being removed for donor purpose	Not payable

8-4 Surgical procedures

The services of an assistant surgeon are specialty services to be provided by a licensed physician, a physician assistant, or a nurse practitioner, and covered only on very complex surgical procedures.

If there are extenuating circumstances involved in a case, a physician may request a review of the case by the Utah Medicaid physician consultant for consideration for payment of an assistant. In such cases, the provider must submit a copy of the history and physical exam, the operative report, and the discharge summary for review.

CRNAs may provide services independently or under the supervision of an anesthesiologist or operating practitioner.

8-5 Pharmacy services

For more information on pharmacy services, refer to Utah Administrative Code R414-60. Medicaid Policy for Pharmacy Program, and the Pharmacy Services Provider Manual.

8-5.1 Immunizations

Most immunizations for both adults and children, when administered in-office, are a covered benefit. Both services are covered when a provider performs an evaluation and management (E&M) service and administers a covered immunization. For specific coverage, refer to the Coverage and Reimbursement Code Lookup.

Prescribers may participate in the Vaccines for Children (VFC) program, in which drug products are supplied to the provider at no cost. Reimbursement to providers participating in the VFC program is limited to E&M services and immunization administration, but not the drug product. The Centers for Disease Control and Prevention (CDC) administers the VFC program.

8-5.2 IV infusions and injections, including chemotherapy administration

When a visit to the physician's office is for the administration of a medication or chemotherapy agent, only the administered drug ("J-code") for the medication and the administration code (96400-96549) are covered. The administration fee covers the skill, evaluation, and management required to administer the chemotherapy agent. Therefore, a separate E/M is not reimbursable. However, if there are significant separately identifiable services, those services must be reported using modifier 25. Reporting an E/M with modifier 25 requires the review of supportive documentation for significant separately identifiable services beyond the services covered under administration and the medication.

When administering multiple infusions, injections, or combinations, providers report the initial service code unless protocol requires two IV sites. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first service within a group of services. In that case, the provider reports the appropriate code.

Hydration therapy requires a diagnosis and medical record documentation supporting the treatment for electrolyte imbalance or dehydration for reimbursement coverage.

IV-line flush between drugs is considered part of the drug administration service and not reimbursed separately.

Coverage of a heparin flush is limited to one payment after the infusion.

8-6 Telehealth services

Telehealth services are an additional method of delivering healthcare to patients. Refer to Section I: General Information, Chapter 8-4.2, Telehealth.

8-7 Diabetes prevention programs

Medicaid encourages providers to screen and refer their patients to evidence-based diabetes prevention programs (DPPs) recognized by the Centers for Disease Control

and Prevention (CDC) when they are found to be at risk for the development of type 2 diabetes.

DPP services include behavioral counseling and lifestyle-change programs which are proven effective when delivered to prediabetic patients at high risk for developing type 2 diabetes, specifically those with minimal physical activity, obesity, and genetic predisposition. Intensive behavioral counseling includes care management, lifestyle coaching, the facilitation of a peer support group, and the provision of clinically validated educational lessons based on a standardized curriculum focused on nutrition, exercise, stress, and weight management while allowing care plan oversight by a trained provider.

DPP services must be performed by trained lifestyle coaches who have completed a nationally recognized training program. Lifestyle coaches must be available to interact with the participants.

For a member to be considered eligible for coverage of these services, they must meet the following requirements:

1. Receive DPP from a CDC-recognized diabetes prevention lifestyle change program.
2. Meet all of the following requirements:
    a) 18 years of age or older
    b) Overweight – BMI of 25 or higher
    c) Not diagnosed with diabetes type 1 or 2
    d) Not currently pregnant
3. Have at least one of the following:
    a) Had a blood test result in the prediabetes range within the past year (includes any of these tests and results):
        i. Hemoglobin A1C: 5.7–6.4%.
        ii. Fasting plasma glucose: 110–125 mg/dL.
        iii. 2-hour plasma glucose (after a 75 g glucose load): 140–199 mg/dL.
    b) Previously diagnosed with gestational diabetes
    c) High-risk results on prediabetes risk test

i. A score of 5 or higher
ii. https://www.cdc.gov/prediabetes/pdf/Prediabetes-Risk-Test-Final.pdf

See Chapter 12-1, Coding for diabetes prevention programs, of this manual for reporting requirements of DPP services.

8-8 Diabetes self-management training

HCPCS S9455, Diabetes self-management training, is available for use by authorized diabetes self-management programs.

8-8.1 Requirements

Diabetic self-management training services are limited to an initial 10 sessions per year and must be provided through a:

1. Nationally recognized American Diabetes Association (ADA) certified diabetes educator [refer to http://www.diabetes.org] or
2. An educator certified by the American Association of Diabetes Educators (AADE) [refer to http://www.diabeteseducator.org]

Note: This program does not cover self-management training for the sole use of glucose monitoring or nutritional counseling.

For complete criteria for this service, refer to Utah Administrative Code R414-90. Diabetes Self-Management Training.

To enroll as a Medicaid-authorized diabetes self-management program, visit New Provider Enrollment Web Based Trainings or contact The Office of Medicaid Operations Provider Enrollment.

8-9 Nutritional counseling

Nutritional counseling is covered with a maximum of 1 hour for the initial assessment and intervention. For coverage limitations on reassessment and intervention, please refer to the Coverage and Reimbursement Code Lookup.

Nutritional counseling and an evaluation and management are not covered for the same provider on the same date of service. However, physicians and other qualified providers permitted to report evaluation and management services may bill with a prolonged service code to include the time for nutritional counseling.

8-10 Tobacco cessation counseling

Tobacco cessation counseling is covered with a maximum of 4 intermediate sessions and 3 intensive sessions per 12-month period.

8-11 Maternity services

Maternity services are available as pregnancy-related or postpartum services to the end of the 12th month after the pregnancy ends.

Maternity care is a global service reported with an appropriate CPT code at the time of delivery.

Unbundled services are expected to be reported by more than one provider/group.

8-11.1 Global maternity care

Global maternity care includes services typically provided in uncomplicated maternity cases during the period of pregnancy. Services include antepartum care, labor and delivery, postpartum care, and laboratory services as defined below. These are not reportable as separate services.

8-11.1.1 Antepartum care

Antepartum care includes standard prenatal services. The initial visit must be included in antepartum care and is not a separately reportable service.

Antepartum care consists of:

1. The initial and subsequent history,
2. Physical examinations,
3. Recording of weight, blood pressure, fetal heart tones,
4. Routine chemical analysis,
5. Hematocrit,
6. Maternity counseling,

7. Monthly visits up to 28-week gestation, with subsequent biweekly visits to 36-week gestation, and weekly visits after that until delivery,
8. Treatment of routine complaints accompanying pregnancy.

Diabetic glucose monitoring is part of the global maternity payment. Therefore, additional billing for an office visit, diabetes self-management training, or nutritional medical counseling for diabetic glucose monitoring in pregnancy is inappropriate.

8-11.1.2 Labor and delivery services

Labor and delivery services include admission to the hospital, admission history, physical examination, management of uncomplicated labor, vaginal delivery, and cesarean section delivery.

8-11.1.3 Postpartum care

Postpartum care includes hospital and office visits following vaginal or cesarean section delivery, a 6-week postpartum visit, and obtaining a PAP smear. Medicaid covers postpartum services to the end of the 12th month after the pregnancy ends. Family planning services are covered separately.

8-11.1.4 Laboratory services

Laboratory tests, such as hematocrit and urinalysis, provided during routine visits are included in the global care fee. Other antepartum and postpartum diagnostic services that have medical indications are reported separately.

8-11.2 Ultrasound in pregnancy

Medicaid covers up to 10 ultrasounds in a 12-month period when diagnostic information is needed.

An incompetent cervix must be diagnosed with a transvaginal ultrasound.

Ultrasounds completed for obtaining a picture of the fetus or sex determination are not covered.

8-11.3 Billing for maternity care

Group practices are not allowed to report codes separately regardless of the number of providers delivering care. The global delivery code is reported when the same physician or group practice sees the patient throughout the pregnancy. For reimbursement information, refer to Utah Medicaid State Plan Attachment 4.19-B.

8-11.4 Coding for maternity care

8-11.4.1 Gestational age

Providers are required to report the fetus's gestational age using the appropriate ICD-10 diagnosis codes Z3A.00 through Z3A.49 on all delivery claims.

8-11.4.2 Modifier UC

Providers are required to append modifier UC on claims of deliveries 39 weeks or less that are medically necessary or on deliveries 39 weeks or more, whether spontaneous or elective. If the modifier "UC" is not appended to the claim, it is understood that the claim was for an early elective delivery less than 39 weeks and 0 days and will be denied. Providers are responsible for ensuring that the codes (and modifiers when applicable) submitted for reimbursement accurately reflect the diagnosis and procedure(s) reported.

8-11.4.3 Modifier 22

All obstetrical and delivery procedure codes submitted with modifier 22 requires documentation (e.g., operative report) for review before payment. Services for enhanced payment with modifier 22 include multiple gestations or complications during the delivery, placing the mother or fetus at risk of adverse outcomes.

8-11.5 Services for pregnant women not eligible for Medicaid

Women meeting all Medicaid eligibility requirements except citizenship may be eligible for the emergency services program for non-citizens. If eligible, they may receive services for an "emergency medical condition." Labor and delivery are considered emergency medical conditions. Prenatal and

postpartum care are not considered emergency medical conditions and shall not be reimbursed. Information and criteria for these services are found in Chapter 8-2.11, Emergency services program for non-citizens, of Section I: General Information provider manual.

8-11.6 Extended services for pregnant women

The services described in this section are available to pregnant women eligible for Medicaid or the presumptive eligibility (PE) program. These services are in addition to those normally provided in uncomplicated maternity cases.

Extended services are available as pregnancy-related or postpartum services to the end of the 12th month after the pregnancy ends.

8-11.6.1 Perinatal care coordination

Perinatal care coordination is the process of planning and coordinating care and services to meet individual needs and maximize access to necessary medical, psychosocial, nutritional, educational, and other services for the pregnant woman.

Reporting of perinatal care coordination services is limited to qualified healthcare professionals acting within the scope of their license.

The service is reported using HCPCS T1017 Targeted Case Management, each 15 minutes and limited to 4 units in a 30-day period.

8-11.6.2 Prenatal and postnatal home visits

Home visits can be included in the management plan of pregnant members when there is a need to assess the home environment and its implications for the management of:

1. Prenatal and postnatal care,
2. Provide direct care,
3. Encourage regular visits for prenatal care,
4. Provide emotional support, and
5. To determine educational needs.

Reporting of prenatal and postnatal home visits are limited to qualified healthcare professionals acting within the scope of their license.

The service is reported using HCPCS H1004 Prenatal care, at-risk enhanced, follow up home visit and is limited to 6 visits during a 12-month period.

8-11.6.3 Group prenatal and postnatal education

Group prenatal and postnatal education is a classroom learning experience for improving pregnancy, labor, childbirth, parenting, and infant care. This planned educational service aims to promote informed self-care, prevent the development of conditions that may complicate pregnancy, and enhance early parenting and childcare skills.

Reporting of group prenatal and postnatal education is limited to qualified healthcare professionals acting within the scope of their license.

The service is reported using HCPCS S9446 Patient education, not otherwise classified, non-physician provider, group, per session. Group education is limited to 8 units during any 12-month period.

8-11.6.4 Nutritional assessment and counseling

Women with complex nutritional or related medical risk factors determined in initial prenatal visits may require intensive nutrition education, counseling, monitoring, and frequent consultations. They may receive service by referral from a physician, certified nurse-midwife, physician assistant, or a certified nurse practitioner to a registered dietitian.

A registered dietitian may provide nutritional assessment and counseling.

8-11.6.5 Prenatal and postnatal psychosocial counseling

Psychosocial evaluation is provided as a prenatal and postnatal service to identify members and families with high psychological and social risks, develop a psychosocial care plan, and provide or coordinate appropriate

intervention, counseling, or referral necessary to meet the identified needs of each family.

Counseling may be provided by one of the following licensed Medicaid providers:

1. Licensed clinical social worker
2. Clinical psychologist
3. Marriage and family therapist

The service is reported using HCPCS H0046 Mental health services, not otherwise specified and is limited to 12 visits during any 12-month period.

8-11.6.6 Risk assessment

Risk assessment is the systematic review of relevant member data to identify potential problems and determine a care plan. Early identification of high-risk pregnancies with appropriate consultation and intervention contributes significantly to an improved perinatal outcome and lower maternal and infant morbidity and mortality.

In addition to standard care, a care plan for high-risk members includes referral to or consultation with an appropriate specialist, individualized counseling, and services designed to address the risk factor(s) involved. A care plan for low risk members includes primary care services and additional services specific to the needs of the individual.

Reporting of risk assessment is limited to physicians or other qualified healthcare professionals acting within the scope of their license.

The service is reported using HCPCS H1000 Prenatal care, at risk assessment for a low-risk assessment or HCPCS H1001 Prenatal care, at risk enhances service, antepartum management for high-risk assessment and is limited to 2 assessments during any 10-month period.

8-11.6.7 Prenatal assessment visit (initial visit only)

The initial prenatal assessment visit is a single prenatal visit for a new patient with a confirmed pregnancy, providing an evaluation of the mental and physical status of the patient, an in-depth family and medical history, physical examination, development of the medical data and initiation of a plan of care.

Reporting of prenatal assessment visit (initial visit only) is limited to physicians or other qualified healthcare professionals acting within the scope of their license.

The service is reported using an appropriate CPT E/M code. Limited to 1 visit in any 10-month period, to be used only when the patient is referred immediately to a community practitioner because of identified risks or otherwise lost to follow-up because the patient does not return.

8-11.6.8 Single prenatal visit(s) other than initial visit

A single prenatal visit other than the initial visit is a single prenatal visit for an established member who does not return to complete care for unknown reasons. The initial assessment visit was completed, a plan of care established, one or two follow-up visits were completed, without further care provided.

Reporting the single prenatal visit(s), other than initial visit, is limited to physicians or other qualified healthcare professionals acting within the scope of their license.

The service is reported using an appropriate CPT E/M code and is limited to 3 visits in any 10-month period. The service is limited to billing only when the member is lost to follow-up for any reason.

8-11.7 Birthing center

Birthing centers are specialty units or freestanding facilities specifically designed to provide a low-cost alternative to the traditional hospital childbirth

experience for a select, low-risk population of healthy maternal patients expected to have an uncomplicated pregnancy, labor, delivery, and recovery. Birthing centers must assure quality care and a safe environment and must follow all federal, state and local laws, rules and regulations. Refer to Utah Administrative Code R432-550. Birthing Centers for health and safety standards for the organization, physical plant, maintenance and operation of birthing centers.

Birthing centers are to report facility services with revenue code 0724 Birthing center.

Authority for birthing center services is found in Section 1901 ET. Seq. and Section 1905 of the Social Security Act, and by 42 Code of Federal Regulations 440.90 [October 1, 1996, edition] which is adopted and incorporated by reference.

8-12 Laboratory services

Medicaid coverage of laboratory services is dependent upon facilities meeting the Clinical Laboratory Improvement Amendments (CLIA) provider certification requirements. In addition, coverage is limited to laboratory tests identified by the Centers for Medicare and Medicaid Services (CMS) and includes microbiology, serology, immunohematology, cytology, histology, chemical, hematology, biophysical, or toxicology.

Clinical laboratory services are furnished primarily in three distinct settings: independent clinical laboratories, physician office laboratories, and hospital-based laboratories. The type of CLIA certification needed to perform each test is determined by the complexity of the tests provided. Laboratory tests are classified into one of four categories: waived, provider-performed microscopy (PPM) procedure, moderate, and high.

Medicaid requires that laboratory services ordered must be medically necessary and appropriate to the patient’s current care and condition in order to be covered. The documentation in the medical record must support medical necessity. CLIA services

must maintain a high standard of quality and shall be provided within the limitations and exclusions specified within this chapter.

8-12.1 CLIA certification

CLIA requires entities that perform even one test, including waived tests, to meet certain federal requirements and to obtain the appropriate level of certification. If an entity performs laboratory tests, they must register with the CLIA program and can only perform those tests as authorized by their level of certification.

CMS has made available the Clinical Laboratory Improvement Amendments (CLIA) Application for Certification form, CMS-116.

The form should be completed and mailed to the address listed below:

Unified State Laboratories:

Public Health Bureau of Laboratory Improvement
4431 South 2700 West
Taylorsville, UT 84129

The CLIA regulations require all facilities performing waived and non-waived testing to file a separate application for each facility location. Each CLIA certificate represents a facility, and each facility is responsible for complying with the applicable CLIA requirements. Refer to 42 CFR §493.35(a), §493.43(a) and §493.55(a) for additional information.

8-12.2 CLIA levels of certification

CLIA has five different certificates, each indicating the level and complexity of testing that can be performed by a facility: Waived, PPM procedure, Certificate of Registration, Certificate of Compliance (COC), and Certificate of Accreditation (COA). CLIA certifications are generally effective for two years and require ongoing renewal. Each type of certification determines the level of testing a facility can perform. The categorization of tests is determined by the Food and Drug Administration (FDA).

Certificate of Waiver

Certificate of Waiver is issued to a facility that only performs waived tests.

Certificate for Provider-Performed Microscopy (PPM) Procedures

A PPM procedure certificate is issued to a facility in which a physician, midlevel practitioner, or dentist performs only specific microscopy procedures during the course of a patient's visit.

Certificate of Compliance, Accreditation, and Registration

A COC or COA is based on the agency chosen to survey the facility.
COC is issued to a facility after an inspection by a CLIA state survey agency that finds the facility in compliance with all applicable CLIA requirements.

COA is issued to a facility on the basis of the facility's accreditation by an accreditation organization approved by CMS. A non-profit accreditation organization's requirement must equal or exceed CLIA program requirements to receive CMS approval.

A Certificate of Registration (COR) is temporary and permits the facility to conduct nonwaived (moderate and/or high complexity) tests until the laboratory is inspected and found to comply with CLIA regulations. The COR is valid for no more than two years. Only facilities applying for a COC or COA will receive a COR. Under a COR, a facility is also permitted to conduct waived tests.

8-12.3 CLIA testing complexity

The FDA categorizes diagnostic laboratory tests by their complexity, from the least to the most complex:

1. Waived tests
   a) Waived tests are simple examinations and procedures that have an insignificant risk of an erroneous result.
   b) Laboratory services performed in an office are generally limited to waived tests. However, the CMS certification determines the

testing each individual provider can perform and report for reimbursement.

2. Provider-Performed Microscopy (PPM) Procedure
    a) PPM procedures are a select group of moderately complex microscopic tests that do not meet the criteria for waiver because they are not simple procedures; they require training and specific skills for test performance and they must meet certain other criteria. Controls are generally not available to monitor the complete testing process for these procedures. Therefore, only limited activities are suitable for inspection.
    b) A limited list of PPM procedure is included under this certificate type, which are categorized as moderate complexity testing. Please refer to the CMS PPM procedure document for a comprehensive list of allowed services under this level of certification.
3. Moderate complexity tests
    a) Moderate complexity tests require minimal scientific and technical knowledge.
4. High complexity tests
    a) High complexity tests are more difficult to perform or interpret than moderate and waived tests. Specialized scientific knowledge and training are required.

8-12.4 Proprietary Laboratory Analysis (PLA) codes

In accordance with the American Medical Association (AMA) coding guidelines, Proprietary Laboratory Analysis (PLA) codes for proprietary laboratory services must be reported in place of corresponding CPT codes when available. Additionally, PLA codes should not be reported with their corresponding CPT codes. If the PLA code is not available to be used by the billing laboratory, the CPT code should be billed.

8-12.5 Urine drug testing

Urine drug testing is a covered service when medically necessary for eligible, enrolled Medicaid members. Reporting of urine drug testing services is limited to a provider or laboratory CLIA certification and enrollment with Medicaid.

Medicaid considers urine drug testing medically necessary when used in conjunction with:

1. Chronic opioid therapy (COT), or
2. As part of a substance use disorder (SUD) treatment program.

Medicaid has established drug testing limits under the American Society of Addiction Medicine (ASAM) in The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine guidelines. In addition, it supports drug test type selection (presumptive or definitive and level of substances tested) and frequency that aligns with evidence-based standards and practices.

Providers are required to utilize the most medically appropriate urine drug test based on the service meeting the definition of "medically necessary service" as outline in Utah Administrative Code R414-1-2(18) and Chapter 8-1, Medical necessity, of the Section I: General Information provider manual.

8-12.5.1 Limitation for urine drug testing

Annual quantity limits for both presumptive and definitive tests promote flexible, patient-specific testing throughout treatment. In addition, Medicaid evaluates exceptions to quantity limits on a case-by-case basis through the prior authorization process.

Urine Drug Testing Limitations					
Drug test type	CPT and HCPCS codes	Level of test	Rate	Annual quantity limit	Daily quantity limit
Pre-sumptive	80305 - results obtained by direct visual reading, such as in the case of viewing urine dipsticks, urine cups, test cards, or cartridge	Waived	$11.99	60/year	1/day
	80306 - direct visual reading of test results assisted by instrumentation	Moderate	$15.99		

	80307 - tests performed utilizing instrument chemistry analyzers, such as immunoassay, chromatography, and mass spectrometry with or without chromatography	Moderate	$51.50		

Urine Drug Testing Limitations					
Drug test type	CPT and HCPCS codes	Level of test	Rate	Annual quantity limit	Daily quantity limit
Definitive	G0480 - definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers, qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es),	Moderate	$64.51	16/year	1/day
	G0481 - 8-14 drug class(es),	Moderate	$99.25		
	G0482 - 15-21 drug class(es),	Moderate	$99.25		
	G0483 - 22 or more drug class(es),	Moderate	$99.25		

8-12.5.2 Non-covered urine drug testing

Medicaid does not cover urine drug testing when not medically necessary. Urine drug testing is not medically necessary when:

1. ASAM guidelines are not met, or
2. For court ordered drug testing that does not meet ASAM guidelines.

8-12.6 Prior authorization

Refer to the Coverage and Reimbursement Code Lookup to determine if specific laboratory services are covered and for the rate of reimbursement, if covered. Some laboratory services will require prior authorization. Refer to Utah Medicaid Prior Authorization for additional information.

Exceptions to established limits for urine drug screening will be evaluated on a case-by-case basis through the prior authorization process. Urine drug screen prior authorization criteria can be found at Utah Medicaid Prior Authorization.

8-12.7 Billing

Providers must submit laboratory claims on a CMS-1500 form with the CLIA certification number appended. Failure to submit a CMS-1500 claim with the CLIA certification number will result in denial of the service. Facilities billing laboratory services on a UB-04 form are not required to append their CLIA certification number. In addition, laboratories must only submit laboratory codes whose level of complexity is permitted within their level of certification. Submission of a laboratory code that a facility is not certified to perform will result in the denial of the service.

Waived tests must be billed with a QW modifier. Refer to the Tests Granted Waived Status Under CLIA document for a list of CLIA waived tests.

Some laboratory codes allow for a technical and professional component. These codes are billed with a 26 (professional component) or TC (technical component) modifier, where applicable. Providers only completing the professional portion of the code must append modifier 26 to the claim line. Providers only completing the technical portion of the code must append the TC modifier to the claim line.

Providers submitting for the professional component of the laboratory service do not need to have a CLIA certification. This service is based on a provider practicing within their scope of licensure and training.

Medicaid rates for laboratory services are set using the CMS Laboratory Fee Schedule https://www.cms.gov/medicare/medicare-fee-for-service-payment/clinicallabfeesched/. Only the facility performing the service may submit the claim.

8-12.8 Indian health services

Indian health services (IHS) are excluded from CLIA regulations. IHS follow their own federal guidelines. The manual on laboratory services for IHS can be found at this link IHS Laboratory Services Manual.

8-12.9 Genetic testing

8-12.9.1 Definitions

Genetic testing: Genetic testing involves the analysis of chromosomes, DNA (deoxyribonucleic acid), RNA (ribonucleic acid), genes, or gene products to detect inherited (germline) or non-inherited (somatic) genetic variants related to disease or health.

Germline mutations: Mutations present in the DNA of every cell of the body, present from the moment of conception. These include cells in the gonads (testes or ova) and could, therefore, be passed on to offspring.

Diagnostic: To confirm or exclude genetic or heritable mutations in a symptomatic person. This refers to a molecular diagnosis supported by the presence of a known pathologic mutation. For the purposes of genetic testing, a symptomatic person is defined as a person with a clinical phenotype that is correlated with a known pathologic mutation.

Prognostic: To determine or refine estimates of disease natural history or recurrence in patients already diagnosed with the disease and predicts the natural disease course, e.g., aggressiveness, recurrence, risk of death. This type of testing may use gene expression of affected tissue to predict the course of the disease, e.g., testing breast cancer tissue with Oncotype Dx.

Therapeutic: To determine that a particular therapeutic intervention is potentially effective for an individual patient and determines the probability of favorable or adverse response to medications. Additionally, therapeutic testing may detect genetic variants that alter the risk of treatment, adverse events, drug metabolism, drug effectiveness, etc., (e.g., cytochrome p450 testing). Finally, the testing may detect genetic mutations that adversely affect

response to environmental exposures that are ordinarily tolerated, such as G6PD deficiency, genetic disorders of immune function, and aminoacidopathies.

8-12.9.2 Coverage

Genetic testing may require prior authorization (PA). Specific coverage on CPT or HCPCS codes is found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

Coverage of genetic testing by Medicaid is determined by using evidence-based criteria and may require review by a Medicaid consultant.

Genetic tests are laboratory studies of human deoxyribonucleic acid (DNA), chromosomes, genes or gene products to diagnose the presence of a genetic variation associated with a high risk of having or transmitting a specific genetic disorder.

Genetic testing must be medically necessary and ordered by a Medicaid enrolled provider acting within the scope of their practice.

1. Providers must be able to counsel clients on the particular genetic test ordered and the results of the test, as it applies to the member, in consultation with a genetic specialist as needed.
2. If a provider is unable to counsel a member regarding genetic testing, they must refer the member to a provider capable of providing genetic counseling before ordering the test.

The following criteria apply if there are no specific criteria for testing in Medicaid's evidence-based criteria tool. If criteria do exist, then the requirements for medical necessity will supersede the criteria in this policy. For the specific categories of testing where standards do not exist, the following criteria must be met:

Testing of an affected (symptomatic) individual's germline DNA to benefit the member (excluding reproductive testing)

Diagnostic

a) An association of the marker with the disorder has been established, and
b) Symptoms of the disease are present, and
c) A definitive diagnosis cannot be made based on history, physical examination, pedigree analysis, standard diagnostic studies/tests, and
d) The clinical efficacy of identifying the mutation has been established:
    i. Leading to changes in the clinical management of the condition, which improve clinical outcomes, or
    ii. Eliminates the need for further diagnostics or other invasive testing, or
    iii. This leads to the discontinuation of interventions that are unnecessary or ineffective.

Prognostic

e) An association of the marker with the natural history of the disease has been established
   and
f) Clinical efficacy of identifying the mutation has been established:
    i. Provides incremental prognostic information above that of standardized testing, and
    ii. Reclassifies patients into clinically relevant prognostic categories for which there are different treatment strategies, and
    iii. Reclassification leads to changes in medical management that improve clinical outcomes

Therapeutic

g) Genetic testing identifies variants of a phenotype/metabolic state that relate to different pharmacokinetics, drug efficacy or adverse drug reactions, and
h) Clinical efficacy of identifying the mutation has been established and leads to:
    i. The initiation of effective treatment,

ii. The discontinuation of treatments that are ineffective or harmful, or
iii. A change in medication that is likely to improve outcomes.

8-12.9.3 Non-covered

1. Experimental or investigational (excluding members who are participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the "Consolidated Appropriations Act, 2021")
2. Tests for screening purposes only (excluding newborn screening as defined in Utah Administrative Code R398-2. Newborn Hearing Screening), including:
   a) Preimplantation genetic diagnosis (PGD),
   b) Prenatal genetic screening, or
   c) In the absence of signs or symptoms
3. Tests, for the member or family members, performed solely for genetic counseling, family planning, or health screening
4. Tests for research to find a rare or new gene not previously identified or of unclear clinical significance
5. Direct-to-consumer (DTC) genetic tests
6. Tests of a member's germline DNA to benefit family member(s) rather than to benefit the member
7. Establishment of paternity
8. Genetic testing is not medically necessary when performed entirely for non-medical reasons (e.g., a general interest in genetic test results)

Specific coverage on CPT or HCPCS codes is found in the Utah Medicaid Coverage and Reimbursement Code Lookup. The Coverage and Reimbursement Code Lookup allows providers to search for coverage and reimbursement information by procedure code, date of service, and provider type.

8-12.10 Genetic testing policy for EPSDT eligible members

8-12.10.1 Definitions

Genetic testing: Genetic testing involves the analysis of chromosomes, DNA (deoxyribonucleic acid), RNA (ribonucleic acid), genes, or gene products to detect inherited (germline) or non-inherited (somatic) genetic variants related to disease or health.

Germline mutations: Mutations present in the DNA of every cell of the body, present from the moment of conception. These include cells in the gonads (testes or ova) and could be passed on to offspring.

Diagnostic: To confirm or exclude genetic or heritable mutations in a symptomatic person. This refers to a molecular diagnosis supported by the presence of a known pathologic mutation. For the purposes of genetic testing, a symptomatic person is defined as a person with a clinical phenotype that is correlated with a known pathologic mutation.

Prognostic: To determine or refine estimates of disease natural history or recurrence in patients already diagnosed with the disease and predicts the natural disease course, e.g., aggressiveness, recurrence, risk of death. This type of testing may use gene expression of affected tissue to predict the course of the disease.

Therapeutic: To determine that a particular therapeutic intervention is potentially effective for an individual patient and determines the probability of favorable or adverse response to medications. Additionally, therapeutic testing may detect genetic variants that alter the risk of treatment, adverse events, drug metabolism, drug effectiveness, etc., (e.g., cytochrome p450 testing). Finally, the testing may detect genetic mutations that adversely affect response to environmental exposures that are ordinarily tolerated, such as G6PD deficiency, genetic disorders of immune function, and aminoacidopathies.

8-12.10.2 Coverage

Genetic testing may require prior authorization (PA). Specific coverage on CPT or HCPCS codes is found in the Utah Medicaid Coverage and Reimbursement Code Lookup.

Coverage of genetic testing by Medicaid is determined by using an evidence-based criteria tool and may require review by a Medicaid consultant.

Genetic tests are laboratory studies of human deoxyribonucleic acid (DNA), chromosomes, genes, or gene products to diagnose the presence of a genetic variation associated with a high risk of having or transmitting a specific genetic disorder.

Genetic testing must be medically necessary and ordered by a Medicaid enrolled provider acting within the scope of their practice.

1. Providers must be able to counsel clients on the particular genetic test ordered and the results of the test, as it applies to the member, in consultation with a genetic specialist as needed.
2. If a provider is unable to counsel a member regarding pre-and post-genetic testing, they must refer the member to a provider capable of providing genetic counseling before ordering the test.

Genetic testing is medically necessary for EPSDT eligible members when there is a reasonable expectation based on family history, risk factors, or symptomatology that a genetically inherited condition exists, and any of the following clinical scenarios also exist:

1. Clinical presentation fits a well-defined syndrome for which a specific or targeted gene test is available, or
2. A definitive diagnosis cannot be made based on history, physical examination, pedigree analysis, or standard diagnostic studies or tests, or

3. There is a clinical syndrome with a broad number of potential diagnoses, and without a specific diagnosis, the medical management will include unnecessary monitoring, testing, hospitalizations, or medical setbacks, or
4. There is a clinical syndrome with a broad number of potential diagnoses, and a specific diagnosis will determine prognosis and appropriate medical management.

8-12.10.3 Documentation requirements (see genetic testing PA request form)

Documentation to support the recommendation(s) for testing must address all of the following:

1. Specific risk factors, the clinical scenario, or family history that supports the need for the requested test(s),
2. Clinical examination and conventional diagnostic testing have been unsuccessful in determining the member's specific diagnosis,
3. The members medically necessary medical management may not be determined without genetic testing, and
4. Testing may change the medical management of the member.

Where criteria do not exist, the PA requester must submit publicly accessible data from peer-reviewed scientific literature or the national databases that address the clinical validity, predictive value, or medical benefits of the genetic test.

8-12.10.4 Next Generation Sequencing (NGS)

Identifying a molecularly confirmed diagnosis promptly for an individual with a rare genetic condition can have a variety of health outcomes, including:

1. Guiding prognosis and improving clinical decision-making that can improve clinical outcome by application of specific treatments as well as withholding of contraindicated treatments for certain rare genetic conditions.
2. Surveillance for later-onset comorbidities.
3. Reducing the financial and psychological impact of diagnostic uncertainty.

4. Eliminating lower-yield testing, and additional screening(s) that may later be proven unnecessary once a diagnosis is achieved.

Next-generation sequencing (NGS) includes genetic testing options such as whole exome sequencing (WES) and whole genome sequencing (WGS) and can detect the most significant variant types, meaning genetic alterations with sufficient evidence to classify as pathogenic.

Whole Exome Sequencing (WES)

WES focuses on the genomic protein coding regions (exons). It is a cost-effective, widely used NGS method that requires fewer sequencing reagents and takes less time to perform bioinformatic analysis compared to WGS. Although the human exome represents only 1-5% of the genome, it contains approximately 85% of known disease-related variants.

WES is considered medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorders in EPSDT eligible members when all of the following criteria are met:

1. After all other appropriate diagnostic testing has been performed, and the member remains undiagnosed (e.g., targeted single-gene testing, panel testing, MRI, etc.), and
2. Results of such testing are expected to influence medical management and clinical outcomes directly.

Whole Genome Sequencing (WGS)

Whole-genome sequencing (WGS), in contrast to (WES), may detect larger deletions or duplications, triple repeat expansions, and pathogenic variants in deep intronic regions; regulatory regions that are outside of the coding regions; and untranslated gene regions.

WGS is considered medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorders in members aged less than one year of life and currently admitted to a Neonatal Intensive Care Unit (NICU), when all of the following criteria are met:

1. Test is ordered by one of the following provider types, who has evaluated the patient and family history, and recommends and/or orders the test:
    a) Neonatologist or neurologist in collaboration with a medical geneticist or certified genetic counselor
    b) The patient has been evaluated by a board-certified clinician with expertise in clinical genetics and counseled about the potential risks of genetic testing
    c) Pre- and post-test counseling is performed by an American Board of Medical Genetics or American Board of Genetic Counseling certified genetic counselor
2. Clinical indications:
    a) A definitive diagnosis cannot be made based on standard clinical workup
    b) The patient's phenotype does not clearly identify a specific disease or the patient has phenotypic characteristics outside of, or in addition to, what has been established for the disease
    c) A genetic etiology is the most likely explanation for the phenotype or clinical scenario, or the affected individual is faced with invasive procedures or testing as the next diagnostic step (e.g., muscle biopsy.)
    d) No other causative circumstances (e.g., environmental exposures, injury, infection) can explain the symptoms

8-12.10.5 Non-covered testing

Diagnostic genetic testing, for the sole convenience of information, to identify specific diagnoses for which the medical management of the member is not anticipated to be altered.

Additional types of diagnostic genetic testing that are non-covered include:

1. Experimental or investigational (excluding members who are participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the "Consolidated Appropriations Act, 2021")

2. Tests for screening purposes only (excluding newborn screening as defined in Utah Administrative Code R398-2. Newborn Hearing Screening), including:
   a) Preimplantation genetic diagnosis (PGD), or
   b) Prenatal genetic screening, or
   c) In the absence of signs or symptoms.
3. Tests, for the member or family members, performed solely for genetic counseling, family planning, or health screening
4. Tests for research to find a rare or new gene not previously identified or of unclear clinical significance
5. Direct-to-consumer (DTC) genetic tests
6. Tests of a member's germline DNA to benefit family member(s) rather than to benefit the member
7. Establishment of paternity
8. Genetic testing is not medically necessary when performed entirely for non-medical reasons (e.g., a general interest in genetic test results)

Specific coverage on CPT or HCPCS codes is found in the Utah Medicaid Coverage and Reimbursement Code Lookup. The Coverage and Reimbursement Code Lookup allows providers to search for coverage and reimbursement information by procedure code, date of service, and provider type.

8-13 Hospice services

In-home physician services are only available for individuals who have filed an election statement with a Medicare-certified hospice agency and are approved through the prior authorization process to receive the Medicaid hospice care benefit. In-home physician visits are authorized for hospice patients if the attending physician determines that direct patient management in the home setting is necessary to achieve the goals associated with the hospice approach to care.

If a patient's hospice services are discontinued for any reason, including but not limited to voluntary revocation of hospice election or loss of hospice eligibility. In that case, in-home physician visits are no longer authorized.

8-14 Medical supplies and durable medical equipment

Refer to Utah Administrative Code R414-70. Medical Supplies, Durable Medical Equipment, and Prosthetic Devices, and the Medical Supplies and Durable Medical Equipment Provider Manual.

8-15 Mental health services

Refer to Section I: General Information, Chapter 2-1.2, Prepaid mental health plans, Utah Administrative Code R414-10. Physician Services. Utah Administrative Code R414-36. Behavioral Health Services, and the Behavioral Health Services Provider Manual.

8-15.1 Evaluations and psychological testing

Mental health evaluations and psychological testing performed for physical health purposes, including before medical procedures, or to diagnose intellectual or developmental disabilities or organic disorders are carved out services from the Accountable Care Organizations (ACOs) and the Prepaid Mental Health Plan (PMHP). Providers report these services through fee for service Medicaid with the UC modifier. This carve-out policy does not apply to psychiatric consultations during a physical health inpatient hospitalization. These psychiatric consultations remain the responsibility of the ACOs. This carve-out policy does not apply to HOME enrollees.

Also, the carve-out policy does not apply to mental health evaluations and psychological testing for the primary purpose of diagnosing or treating mental health or substance use disorders. For more information on coverage of these services for mental health and substance use disorders, refer to the Behavioral Health Services Provider Manual.

8-16 Organ transplant services

Organ transplantation services are covered Medicaid services as specified in Utah Administrative Code. R414-10A. Transplant Services Standards.

8-17 Modifiers

Refer to Section I: General Information, Chapter 12-7.3, Modifier used in a claim.

8-18 Complications due to non-covered or non-authorized services

Medically necessary services resulting from complications of non-covered or non-authorized procedures are covered, as appropriate within all other applicable rules and regulations.

8-19 Chiropractic services

Coverage of chiropractic service is limited to spinal manipulation treatment. Chiropractors may use manual devices in performing manual manipulation of the spine. However, no additional payment is available for the use of the device, nor does Medicaid recognize an extra charge for the device itself.

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered.

For coverage and reimbursement information for specific procedure codes, please see the Coverage and Reimbursement Code Lookup.

8-20 Gender dysphoria treatment services

Gender dysphoria treatment is a covered service when it meets the medically necessary service criteria defined in R414-1-2(18) and when it meets the criteria below. Gender dysphoria treatment services must be of a quality that meets professionally recognized standards of health care and be substantiated by records that include evidence of such quality.

8-20.1 Psychotherapy

Members may receive psychotherapy to treat a gender dysphoria diagnosis. Members who seek pharmaceutical or surgical interventions must first undergo psychotherapy.

8-20.2 Pharmacy

Refer to the pharmacy prior authorization criteria at:
https://medicaid.utah.gov/pharmacy/prior-authorization/

8-20.3 Surgery

Members less than 18 years of age may not receive surgery to treat a gender dysphoria diagnosis regardless of medical necessity. Members 18 years of age or older may receive surgery to treat a gender dysphoria diagnosis when medically necessary and when the following criteria are met.

1. The member:
   a) Is 18 years of age or older.
   b) Has a gender dysphoria diagnosis.
   c) Has received cross-sex hormone therapy for at least 12 months except when hormone therapy is contraindicated.
   d) Has lived for at least 12 months in a gender role congruent with their gender identity.
2. There is documentation indicating clinically significant distress or impairment in social, occupational, or other important areas of functioning due to gender dysphoria.
3. The treating mental health professional has documented that the member has:
   a) Gender dysphoria,
   b) Capacity to make fully informed decisions,
   c) The ability to consent to surgery, and
   d) No history of psychiatric disorders that would interfere with the treatment or the ability to provide informed consent, or any existing psychiatric disorder is well-managed and under control.

For 8-20.3 a mental health professional means any of the following:

1. a physician who is board certified for a psychiatry specialization recognized by the American Board of Medical Specialists or the American Osteopathic Association's Bureau of Osteopathic Specialists,
2. a psychologist licensed under Chapter 61, Psychologist Licensing Act,

3. a clinical social worker licensed under Chapter 60, Part 2, Social Worker Licensing Act,
4. a marriage and family therapist licensed under Chapter 60, Part 3, Marriage and Family Therapist Licensing Act, or
5. a clinical mental health counselor licensed under Chapter 60, Part 4, Clinical Mental Health Counselor Licensing Act.

8-21 Wellness visits services

Wellness visits are covered for a maximum of one visit annually for members over the age of 21. For coverage and reimbursement information for specific codes, please see the Coverage and Reimbursement Code Lookup.

8-22 Genetic carrier screening and in vitro fertilization (IVF) services

Genetic carrier screening and in vitro fertilization (IVF) services are available for certain Medicaid eligible individuals that meet the requirements listed below. This benefit is intended to reduce the likelihood that Medicaid beneficiaries who have a serious inherited disorder, or who carry a genetic trait associated with a serious inherited disorder, pass the disorder on to their children.

Eligibility: Genetic screening and IVF services are a covered benefit for eligible members who meet the following criteria:

1. Ages 18 through 35
2. Has been diagnosed, by a physician, as having a genetic trait associated with one of the following conditions:
   a) Cystic fibrosis;
   b) Spinal muscular atrophy;
   c) Morquio syndrome;
   d) Myotonic dystrophy; or
   e) Sickle cell anemia
3. Intends to reproduce with a partner who has been diagnosed by a physician as having a genetic trait associated with the same qualified condition as the individual, or
4. One partner has been diagnosed by a physician as having myotonic dystrophy and intends to reproduce.

Genetic screening and IVF services require prior authorization. Supporting documentation of the criteria listed above is required to be submitted with each prior authorization request.

Covered Services

Carrier Screening: Carrier screening analysis for a known familial mutation may be considered medically necessary for qualifying conditions when:

1. The member and/or the member's reproductive partner is considering pregnancy, and
    a) The member has a close relative with a known pathogenetic or likely pathogenetic variant associated with a disorder; or
    b) The member's reproductive partner is a carrier for a genetic disorder; or
    c) The member or the member's reproductive partner are members of a population known to have a carrier rate of 1% or higher for a genetic condition; or
    d) The member or the member's reproductive partner has a first or second degree relative who is affected with a genetic disorder, including parents, siblings, children, grandparents, aunts, uncles, nieces, nephews, grandchildren, and half siblings.
2. Qualified conditions for carrier screening include:
    a) Cystic fibrosis;
    b) Spinal muscular atrophy;
    c) Morquio syndrome; or
    d) Sickle cell anemia
3. Carrier screening analysis for a known familial mutation is considered investigational for all other indications.
4. Carrier screening services are a covered benefit for enrolled eligible Medicaid members only and do not extend to ineligible reproductive partners.

IVF Services

IVF services may include the following:

1. Stimulation of ovulation
2. Monitoring of ovulation stimulation
3. Oocyte retrieval
4. Laboratory studies, including pre-implantation genetic diagnosis testing for genetic disorders
5. Genetic counseling
6. Embryo assessment and transfer
7. Luteal phase support
8. Thawing of cryopreserved embryos

All services which are provided as part of an IVF procedure are covered under the global reimbursement rate for the IVF procedure. This can include, but is not limited to:

1. Ovarian stimulation
    a) Excludes ovarian stimulation medications which are reported separately
2. Egg retrieval
3. Insemination
4. Fertilization
5. Embryo culture
6. Labs, including pre-implantation genetic diagnosis testing
7. Genetic counseling
8. Pathology
9. Surgical procedures
10. Radiology(ultrasound)
11. Cryopreservation and storage of sperm, ova, and embryos in connection with in vitro fertilization

Current American Society for Reproductive Medicine (ASRM) and Society for Assisted Reproductive Technology (SART) guidelines regarding limits to the number of embryos transferred must be followed.

Limitations

1. Qualified Medicaid members may receive three (3) cycles of IVF per lifetime.

2. Genetic screening services are limited to one (1) per lifetime.
3. Reimbursement for genetic counseling services is limited to physicians and physician assistants with the training and qualifications to offer genetic counseling services.

For additional code specific policy information providers may refer to the Coverage and Reimbursement Code Lookup.

8-23 Fertility preservation

Fertility preservation services are covered for members undergoing gonadotoxic cancer treatments or other medically necessary treatment that are expected to render them permanently infertile (excluding voluntary sterilization) either pre or post treatment. Qualifying members must meet the following criteria:

1. The member is post-pubertal through 40 years of age.
2. Diagnosis by a qualified healthcare professional (QHP) of a condition requiring treatment which, in the QHP's professional judgment, may pose a substantial risk of sterility or lead to iatrogenic infertility (infertility caused by treatment).
3. The member's current state of health is sufficient to undergo fertility preservation procedures.
4. The member has received infertility counseling as well as psychotherapy, when medically indicated.
5. Collection and storage of embryos, eggs or sperm is consistent with established medical practices or professional guidelines published by the American Society of Reproductive Medicine (ASRM) or the American Society of Clinical Oncology (ASCO).

Coverage

Collection and storage of embryos, reproductive tissues, eggs, and sperm must use collection and storage processes that are consistent with established medical practices or professional guidelines published by the ASRM or the ASCO.

Coverage includes the following fertility preservation services:

1. Mature oocyte cryopreservation

2. Ovarian tissue cryopreservation
3. Ejaculated/surgically extracted sperm cryopreservation
4. Embryo cryopreservation

Limitations

1. Reimbursement for cryopreservation storage is covered as a single payment and includes up to a five-year storage increment.
    a) Post cryopreservation procedures for use of eggs, sperm, or embryos are not covered.
    b) Additional five-year storage increments may only be requested for member's that retain Medicaid eligibility.

Non-covered services

1. Cryopreservation of embryos or eggs or sperm for fertility preservation purposes other than chemotherapy or other treatments that may render an individual infertile.
2. Cryopreservation of embryos or eggs or sperm for reciprocal IVF.
3. Sperm storage/banking for males requesting this service for convenience or "back-up" for a fresh specimen.

For additional code specific policy information providers may refer to the Coverage and Reimbursement Code Lookup.

9 Non-covered services and limitations

Certain services are non-covered by Medicaid because medical necessity, appropriateness, and cost-effectiveness cannot be readily determined or justified for medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

For more information on non-covered services and limitations, see Utah Administrative Code R414-10. Physician Services, Utah Administrative Code R414-1. Utah Medicaid Program, and Section I: General Information, Chapter 9, Non-covered services and limitations.

9-1 Limited abortion services

Refer to Section I: General Information, Chapter 9-1, Limited abortion services, and Utah Administrative Code R414-1B. Payment for Limited Abortion Services.

9-2 Experimental, investigational, or unproven medical practices

Refer to Section I: General Information, Chapter 9-3.3, Experimental, investigational, or unproven medical practices, and Utah Administrative Code R414-1A. Medicaid Policy for Experimental, Investigational or Unproven Medical Practices.

9-3 Sterilization and hysterectomy procedures

Sterilization and hysterectomy procedures are limited to those which meet the requirements of 42 CFR 441, Subpart F.

9-3.1 Voluntary sterilization

Voluntary sterilization means an individual decision made by the member, male or female, for voluntarily preventing conception for family planning.

1. Prior authorization must be obtained, by the surgeon, before the service is provided, refer to Utah Medicaid Prior Authorization.
2. The Sterilization Consent Form must be properly executed and submitted before the performing the procedure.

9-3.2 Sterilizations incident to surgical procedures

1. Prior authorization requirements must be met.
2. For hysterectomy procedures, a properly executed Utah Medicaid Hysterectomy Acknowledgement Form must be submitted for all hysterectomy procedures.
3. Refer to the Coverage and Reimbursement Code Lookup for specific codes which require the hysterectomy consent form.

9-4 Reconstructive and cosmetic services

For additional information, refer to Utah Administration Code R414-1-29.

As defined in Utah Administrative Code R414-1-2 (18), medical necessity shall be established through evidence-based criteria.

9-5 Medication administration

Medication administration procedures are not eligible for coverage when reported with an E/M service on the same date.

9-6 Cognitive services

Cognitive services by a provider are limited to one service per member per day. These services are defined in the CPT manual as office visits, hospital visits except for those following a global surgical procedure, therapy visits, and other types of nonsurgical services. When a second office visit for the same problem or a hospital admission occurs on the same date as another service, the physician must combine the services as one service and select a procedure code that most appropriately indicates the overall care given.

9-7 Early elective delivery

Medicaid does not cover early elective deliveries before 39 weeks and 0 days and does not consider this service medically necessary.

Prior to 39 weeks and 0 days, medically necessary delivery requires documentation of the medical indication that justifies the early delivery. The provider maintains this documentation in the member's medical record, which is subject to post-payment review.

Global delivery claims that have been denied as an early elective delivery may be refiled as antepartum and/or postpartum care services for separate reimbursement consideration.

9-8 Home telemetry

Outpatient, long-term cardiac (Holter) monitoring codes 93224, 93225, 93226, and 93227 will require prior authorization if more than 3 units of any code are reported in one year. Prior authorization will use the following criteria:

1. A cardiologist must order outpatient, long-term cardiac (Holter) monitoring
2. Member must have had a stroke or TIA with no identifiable cause

3. Member should have already had 24-hour monitoring done previously (either with outpatient, long-term cardiac monitoring, or as inpatient with telemetry)
4. Member should not be currently anti-coagulated on Warfarin for any other reason
5. Member should not have a known contraindication for Warfarin
6. Outpatient, long-term cardiac monitoring may only be authorized for the 30-day test
7. Data from the test must be reviewed and interpreted by a cardiologist

9-9 Consultation services

Consultation services are reimbursed only to a physician. Under "incident-to" service in Utah Medicaid, an advanced practice registered nurse (APRN) or physician assistant (PA) may complete the history and examination to assist the physician consultant. The APRN or PA must personally document in the medical record their portion of the work-up. The physician is responsible for the summary of findings and developing the plan of care.

9-10 Radiation treatment and management

The Centers for Medicare and Medicaid Services (CMS) has provided distinct coding and reporting guidance for delivery and management of radiation treatment.

Treatment planning

Treatment planning is reportable once per course of therapy. This is a professional service only and the physician is responsible for all the technical aspects of the treatment planning process.

Simulation

Following treatment planning, simulation is used to direct the treatment beams to the specific volume of interest. However, the inclusion of treatment devices in the simulation process typically increases the complexity.

Simulation without the inclusion of devices or with any pre-made devices (e.g., blocks, immobilization) is considered simple. The addition of custom immobilization

devices or tangential ports is an indicator of complex level of simulation. No more than one simulation should be reported on any given day.

Simple or complex device and port reporting

Providers should report devices at the beginning of the treatment course and then may report again later in the course of treatment when additional or new devices are required. Coverage for one set of treatment devices may be allowed per separate port when radiation therapy is started. However, a pair of mirror imaged opposing ports, ports that direct parallel beams such as anterior-posterior or left lateral-right lateral pairs are considered one port for reporting purposes, regardless of the complexity of the devices used to create the ports.

A pair of devices for opposing ports, constructed from drawings made by a physician on a single film, is considered for physician professional reporting purposes to be one port. Therefore, each device constructed may be reported separately by the facility. Nevertheless, the physician must be directly involved in the design, selection, and placement of the devices.

When the member has a combination of a wedge compensator and a bolus covering the same treatment port, report as a single complex treatment device rather than as a separate charge for each of the additional items of lower complexity. If beam modification devices of two distinct levels of complexity are utilized for the same treatment port, only report the highest complexity. Restraining devices and beam modification devices may be reported separately for the same port, but only report one restraining device for each volume of interest treated.

Treatment delivery

Radiation treatment delivery codes are reported once per treatment session. These codes recognize the technical component only. Treatment management codes contain only the professional component. When more than one treatment is performed on the same date of service, each treatment should be reported on a separate claim line.

Radiation treatment delivery codes are reported using a date range if the treatments are performed on consecutive days and the energy and level of service are the same; the total number is indicated in the 'units' field on the claim. If the dates of service are not consecutive or the energy or level of service is not the same, each date of service must be reported on a separate claim line.

Basic radiation dosimetry is a separate and distinct service from intensity-modulated radiation treatment (IMRT) planning. It is appropriate to report a treatment device CPT code for each complex IMRT field (i.e., gantry/table angle for step and shoot and sliding windows). It is not reported for each segment within the field.

Image Guided Radiation Therapy (IGRT) is used in conjunction with IMRT in members whose tumors are located near or within critical structures or in tissue with inherent setup variation. Although an IGRT is a different service, it may be used and documented along with IMRT treatment delivery.

Additional Reporting Guidance

To aid in the reporting of radiation therapies, please see the Radiation Management and Treatment Table. This table will assist providers in reporting the delivery and management of radiation treatments.

Note: Reporting of CPT codes 77385 or 77386 is appropriate when reporting guidance and tracking performed in an outpatient hospital setting. For freestanding non-out-patient hospital facility claims, report guidance and tracking using HCPCS codes G6015 and G6016.

Category	Code	Descriptions	IGRT (77387)-TC Bundled into Code?	IGRT (77387)-PC Bundled into Code?	Code Type (technical/ professional)
Radiation Treatment Management	77427	Radiation treatment management, 5 treatment	N	N	Professional
	77431	Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only	N	N	Professional
	77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)	N	Y	Professional
	77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	N	Y	Professional
Stereotactic Radiosurgery Treatment Delivery	77371	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Y	N	Technical
	77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	Y	N	Technical
Stereotactic Body Radiation Therapy Treatment Delivery	77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Y	N	Technical
Radiation Treatment Delivery	77401	Radiation treatment delivery, superficial and/or ortho voltage, per day	N	N	Technical
	77402	Radiation treatment delivery, => 1 MeV; simple	N	N	Technical
	77407	Radiation treatment delivery, => 1 MeV; intermediate	N	N	Technical
	77412	Radiation treatment delivery, => 1 MeV; complex	N	N	Technical

Category	Code	Descriptions	IGRT (77387)-TC Bundled into Code?	IGRT (77387)-PC Bundled into Code?	Code Type (technical/ professional)
Intensity Modulated Radiation Treatment Delivery	77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	Y	N	Technical
	77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	Y	N	Technical
Neutron Beam Treatment Delivery	77423	High energy neutron radiation treatment delivery, 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)	N	N	Technical
Proton Treatment Delivery	77520	Proton treatment delivery; simple, without compensation	N	N	Technical
	77522	Proton treatment delivery; simple, with compensation	N	N	Technical
	77523	Proton treatment delivery; intermediate	N	N	Technical
	77525	Proton treatment delivery; complex	N	N	Technical

9-11 Specific non-covered services

Medicaid does not cover the services specified below. Services not on this list are subject to general exclusions:

1. Acupuncture
2. Prolotherapy
3. Panniculectomy and body sculpturing procedures
4. Chemical peeling or dermabrasion of the face
5. Revision of minor scars not related to major trauma
6. Removal of tattoos
7. Hair transplant
8. Electrolysis
9. Surgical procedures for the reversal of previous elective sterilization, both male and female
10. Infertility studies
11. In-vitro fertilization
12. Artificial insemination
13. Surrogate motherhood, including all services, tests, and related charges
14. Prolonged educational and counseling services beyond and those in included within the initial E/M service
15. Pre-pregnancy genetic counseling

10 Prior authorization

For Medicaid medical or surgical services requiring prior authorization, the physician must obtain approval from Medicaid before service is rendered to the patient. For information regarding prior authorization, see Section I: General Information, Chapter 10, Prior authorization. Additional resources and information can be found on the Utah Medicaid Prior Authorization website.

For information on codes requiring prior authorization, manual review, or non-covered status, refer to the Coverage and Reimbursement Code Lookup.

10-1 Retroactive authorization

There are limited circumstances in which a provider may request authorization after service is rendered. These limitations are described in Section I: General Information, Chapter 10-3, Retroactive authorization.

11 Billing Medicaid

Refer to Section I: General Information, Chapter 11, Billing Medicaid, for general information about billing instructions.

11-1 Billing for assistants to surgery

The AS modifier, indicating the assistant surgeon is a physician assistant or nurse practitioner, is covered by Medicaid, while Modifier 80 Assistant surgeon is reportable strictly to a qualified surgeon. Physicians, physician assistants, and nurse practitioners may be reimbursed as assistants to surgery through their own provider number as an incident to service.

12 Coding

Refer to the Section I Provider Manual, Chapter 12, Coding, for information about coding, including diagnosis, procedure, and revenue codes.

For coverage and reimbursement information for specific procedure codes, see the Coverage and Reimbursement Code Lookup. Generally, the fees represented on the Coverage and Reimbursement Code Lookup are only for fee for service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.).

12-1 Coding related to diabetes prevention programs

Providers must report DPP services using the appropriate coding guidelines outlined by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS). In addition, when submitting claims for

DPP, providers must ensure that coverage criteria are met and that the services rendered are medically necessary.

DPP is reported with CPT codes 0403T and 0488T. Guidance for reporting these codes is outlined below. Do not report either of these codes for members diagnosed with diabetes type 1 or diabetes type 2.

0403T - Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day

0403T is reported by a CDC-recognized organization delivering a standardized DPP curriculum in a group setting. The lifestyle coach conducts a face-to-face, intensive behavior change therapy session lasting at least 60 minutes.

Report CPT code 0403T once per day. This code cannot be reported in the same 30-day time period as CPT code 0488T.

0488T - Preventive behavior change, online/electronic structured intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days.

0488T is reported by a CDC-recognized organization or provider delivering a standardized DPP curriculum online or electronically. This code is reported per 30 days of intense therapy. In-person components of the program are included when performed.

Do not report 0488T with CPT code 0403T in the same 30-day period of time covered under 0488T.

13 Resource table

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

<table>
<tr><th colspan="2">For information regarding:</th></tr>
<tr><td>Administrative Rules</td><td>Utah Administrative Code Table of Contents
Diabetes Self-Management Training. R414-90.
Dental, Oral and Maxillofacial Surgeons and Orthodontia. R414-49.
Medicaid Policy for Experimental, Investigational or Unproven Medical Practices. R414-1A.
Payment for Limited Abortion Services. R414-1B.
Physician Services. R414-10.
Transplant Services Standards. R414-10A.
Podiatric Services. R414-11.</td></tr>
<tr><td>Emergency services program for non-citizens</td><td>Section I: General Information
42 CFR 440.255</td></tr>
<tr><td>General information including:
Billing
fee for service and managed care
Member eligibility
Prior authorization
Provider participation</td><td>Section I: General Information
Claims
Managed Care: Accountable Care Organizations
Utah Medicaid Prior Authorization
Administrative Rules
Eligibility Requirements. R414-302.
Medicaid General Provisions. R414-301.
Program Benefits and Date of Eligibility. R414-306.</td></tr>
</table>

	• Utah Medicaid Program. R414-1.
Information including: • Anesthesia fee resources • Coverage and reimbursement resources • National correct coding initiative • Procedure codes with accompanying criteria and limitations	• Office of Coverage and Reimbursement Policy • Coverage and Reimbursement Code Lookup • The National Correct Coding Initiative in Medicaid
Information including policy and rule updates: • Medicaid Information Bulletins (Issued bimonthly) • Medicaid Provider Manuals • Utah State Bulletin (Issued on the 1st and 15th of each month)	• Utah Medicaid Official Publications • Utah State Bulletin
Laboratory services	• Social Security Act §1833 - Payment of Benefits • PART 493—LABORATORY REQUIREMENTS • Clinical Labs Center • Clinical Laboratory Improvement Amendments (CLIA) and Medicare Laboratory Services • CMS Clinical Laboratory Improvement Amendments (CLIA) • State Operations Manual • How to Obtain a CLIA Certificate

	• FDA Clinical Laboratory Improvement Amendments (CLIA) • CDC Clinical Laboratory Improvement Amendments (CLIA) • Utah Public Health Laboratory Clinical Laboratory Certification (CLIA) • Medicare Claims Processing Manual Chapter 16 - Laboratory Services • Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report • State Laboratories
Medicaid forms including: • Abortion Acknowledgement • Hearing Request • Hospice Prior Authorization Form • Hysterectomy Acknowledgement • PA Request • Sterilization Consent	• Utah Medicaid Forms
Medical supplies and DME	• Medical Supplies and Durable Medical Equipment Provider Manual • Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70.
Modifiers	• Section I: General Information
Patient (Member) Eligibility Lookup Tool	• Eligibility Lookup Tool
Pharmacy	• Drug Criteria Limits • Generic Prescriptions List

	• ICD-10 Reference Chart Pharmacy • Medicaid Pharmacy Program • OTC Drug List • Pharmacy Provider Manual • Medicaid Policy for Pharmacy Program. R414-60.
Prior authorization	• Prior Authorization Form • Utah Medicaid Prior Authorization
Provider portal access	• Provider Portal Access
Provider training	• Utah Medicaid Provider Training
Other	• Baby Your Baby • CDC Vaccines for Children Program • Dental, Oral Maxillofacial, and Orthodontia Provider Manual • Hospice Provider Manual • Medicaid.gov • Podiatric Services Provider Manual • Behavioral Health Services Provider Manual • RHC-FQHC Provider Manual • Vision Care Services Provider Manual • Women, Infants, and Children (WIC)
References including: • Social Security Act • Code of Federal Regulations • Utah Code	• 42 CFR 440.50 • Social Security Act 1905(a) • Social Security Act 1861 (r) • Utah Annotated Code Title 58
Tobacco cessation resources	• Utah Tobacco Quit Line (1-800-QUIT-NOW) • Way to Quit

Utah Medicaid Provider Manual

Podiatric Services

Division of Integrated Healthcare

Updated January 2018

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1 General information

This manual is designed to be used in conjunction with other sections of the Utah Medicaid provider manuals, such as Section I: General Information and the Physician Services manual.

The information in this manual represents available services when medically necessary. Services may be more limited or may be expanded if the proposed services are medically appropriate and are more cost effective than alternative services.

Practice of podiatry

The "practice of podiatry" means the examination, diagnosis, or treatment medically, mechanically, or surgically of the ailments of the human foot. In accordance with Utah Code Annotated 58-5a-5-102, the practice of podiatry is limited to the human foot and ankle with some restrictions.

1-1 General policy

Podiatric services are optional services. However, podiatric services are mandatory for individuals eligible for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) also known in Utah as Child Health Evaluation and Care (CHEC).

The purpose of the podiatry program is to increase the functioning ability of the Medicaid recipient. Podiatric services include the examination, diagnosis and treatment of the human foot through medical, mechanical, or surgical means. Services may be performed by a physician, osteopath, or podiatrist as specified by the respective professional license. Podiatric service may be provided to a Medicaid recipient who has a foot problem that causes:

1. Difficulty walking or inability to walk
2. Painful or distressing impairment which limits independent function
3. Crippling

1-2 Fee for service or managed care

This manual provides information regarding Medicaid policy and procedures for fee for service Medicaid members. A Medicaid member enrolled in an MCP (health, behavioral health, or dental plan) must receive services through that plan with some exceptions called "carve-out services," which may be billed directly to Medicaid. Medicaid members enrolled in MCPs are entitled to the same Medicaid benefits as fee for service members. However, plans may offer more benefits than the Medicaid scope of benefits explained in this section of the provider manual. Contact the Medicaid member services hotline at (844) 238-3091 for further information.

Refer to the provider manual, Section I: General Information, for information regarding MCPs.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid member enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a member enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a member's enrollment in a managed care plan. However, it is the provider's responsibility to verify eligibility and plan enrollment for a member before providing services. Therefore, if a Medicaid member is enrolled in an MCP, a fee for service claim will not be paid unless the claim is for a carve-out service.

Eligibility and plan enrollment information for each member is available to providers from these sources:

- The Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility
- Member services hotline at (844) 238-3091

1-3 Definitions

Definitions of terms used in Medicaid programs are available in the Utah Medicaid Provider Manual Section I: General Information.

2 Provider participation requirements

2-1 Provider enrollment

Refer to provider manual, Section I: General Information for provider enrollment information.

3 Member eligibility

Confirmation of member eligibility is required prior to each service or at least once per month. The member must present their Medicaid member card, and the provider must verify the member's eligibility before services are rendered. To verify eligibility, use the Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility. For more information regarding verifying eligibility, refer to Section I: General Information, Verifying Medicaid eligibility.

4 Program coverage

Procedure codes

With some exceptions, procedure codes with accompanying criteria and limitations were removed from the manual and are now found on the Medicaid website Coverage and Reimbursement Lookup Tool at:
http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php

4-1 Covered services

Covered podiatric services are limited to examination, diagnosis, and treatment described in this chapter.

Podiatric services include the following:

1. Foot incision
2. Foot excision
3. Repair, revision or reconstruction
4. Nail treatment for mycotic toenails, corns, warts or calluses when the patient has a diagnosis of diabetes, arteriosclerosis or Buerger's disease (subject to limitations see Chapter 5).
5. Radiology

6. Reasonable and necessary diagnosis and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendinitis, and other related conditions that result from, or are associated with, partial displacement of foot structures.
7. Surgical correction in the subluxated foot structure only when it is an integral part of the treatment of a foot injury.
8. Surgical correction undertaken to improve the function of the foot or to alleviate an associated symptomatic condition.
9. Medical supplies and materials used by the podiatrist over and above those usually included for the surgical procedure.

Shoes and shoe repair

10. Shoes are a Medicaid benefit only when the shoe is:
    a) Attached to a brace or prosthesis or
    b) Specially constructed to provide for a totally or partially missing foot.
        i. For coverage, documentation is required of a
            1 Previous amputation and/or
            2 Diagnosis of diabetes with previous foot ulcerations
11. Shoe repair is covered only when it relates to external modification of an existing shoe to meet a medical need. For example, leg length discrepancy requiring a shoe buildup of one inch or more.

5 Non-covered services and limitations

For additional non-covered services or limitations, refer to the Coverage and Reimbursement Lookup Tool at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

5-1 Non-covered services

The following services are not covered:

1. Preventive maintenance or routine foot care ordinarily within the realm of self-care, nursing home care, or long-term facility care is not a benefit. This includes:

a) The removal of corns, warts or calluses unless a danger to the patient exists (for example: diabetes, arteriosclerosis or Buerger's disease).
b) The trimming, cutting, clipping, or debriding of nails.
c) Other hygienic and preventive maintenance care, such as cleaning and soaking of the feet, the use of massage or skin creams to maintain skin tone of either ambulatory of bedfast patients, and any other service performed in the absence of localized illness or injury.
d) Any application of topical medication or any treatment of fungal (mycotic) infection of the toenail, except when there is limitation to ambulation or pain.

2. Supportive devices including arch supports, orthotics, or metatarsal head appliances are not a benefit.
3. Shoe repair except as it relates to external modification of an existing shoe to meet a medical need, i.e., leg length discrepancy requiring a shoe buildup of one inch or more.
4. Internal modification of a shoe is not a benefit.
5. Shoes, orthopedic shoes or other supportive devices for the feet, except when shoes are integral parts of leg braces or a prosthesis.
6. Special shoes such as:
    a) Mismatched shoes (unless attached to a brace);
    b) Shoes to support an overweight individual;
    c) Trade name or brand name shoes considered "orthopedic" or "corrective";
    d) "Athletic" or "walking" shoes.
7. Arch supports, foot pads, metatarsal head appliances or foot supports.
8. Personal comfort items and services. Comfort items include, but are not limited to arch supports, foot pads, “cookies” or other accessories, shoes for comfort or athletic shoes.
9. The manufacture, dispensing, or services related to orthotics of the feet.

5-2 Limitations

1. Limitations that apply to services provided by a physician or osteopath also apply to services provided by a podiatrist.

2. Surgical procedures on Medicaid recipients who reside in a nursing home are subject to post payment review. Recovery of payment will be made if the service was not appropriate.
3. Treatment of a fungal (mycotic) infection of the toenail is covered if there is documented clinical evidence of mycosis that causes limitation of ambulation or pain.
4. A person licensed to practice podiatry may not administer general anesthesia and may not amputate the foot.
5. Palliative care must include the specific service and must be billed by the specific service and not by using an evaluation and management (E&M) (office call) procedure code.
6. Medicaid members residing in a nursing home or long-term care facility may receive benefits from the podiatry program as indicated in covered services with the following limitations.
    a) Payment for nursing home E&M visits is not a benefit. Only services performed can be billed.
    b) These services are limited to once every 60 days and are subject to post-payment review:
        i. Foot care
        ii. Debridement of mycotic toenails
        iii. Trimming corns, warts, calluses, or nails. (Services are only available to patients with diabetes, arteriosclerosis, or Buerger's disease.)

6 Billing

For detailed billing instructions and general information about the co-payment requirement, members required to make a co-pay, exempt members, refer to Section I: General Information, Medicaid co-payments.

Co-payment

With some exceptions, Medicaid members are required to make a $3 co-payment for office visits performed by a podiatrist. The co-payment may be required for MCP and fee for service members as well as for services performed in a Federally Qualified Health Center (FQHC). The provider is responsible for determining which members

are responsible for a co-payment and to collect the co-payment at the time of service or bill the member. Medicaid automatically deducts the amount of the co-payment from the claim reimbursement.

Pregnant women are exempt from the co-payment requirement. If the system does not indicate the patient is pregnant, add pregnancy diagnosis V22.2 to the claim.

To determine if a co-pay is required, use the Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility.

Palliative care coding

Bill palliative care for the specific service code and not by an office call or E&M code.

6-1 Prior authorization

Some services, particularly surgical services, require the podiatrist to obtain prior authorization (PA) from Medicaid before service. Failure to obtain prior authorization can result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization before providing services.

Exceptions may be made, with appropriate documentation, if the service provided is emergent or the member is retroactively eligible for the dates of service requested.

Additional prior authorization information is in the provider manual, Section I: General Information. Code-specific coverage and prior authorization requirements are found on the Coverage and Reimbursement Lookup Tool at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

7 References

State Plan Amendment, Attachment 3.1-A, Amount, duration, and scope of medical and remedial care and services provided to the categorically needy.

Code of Federal Regulations, Medical or other remedial care provided by licensed practitioners, title 42, sec. 440.60.

Utah Medicaid Provider Manual

Physical Therapy and Occupational Therapy Services

Division of Integrated Healthcare

Updated January 2024

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1 General information

The purpose of the physical therapy and occupational therapy programs is to increase the ability of a Medicaid member, with a temporary or permanent disability, to function at a maximum level through the rehabilitative process.

Rehabilitation goals must include:

1. Evaluation of the potential of each member
2. Factual statement of the level of functions present
3. Identification of goal(s) that may reasonably be achieved
4. Predetermined space of time and concentration of services that would achieve the goal(s)

The Medicaid program is designed to provide services within financial limitations. The objectives of the program are to:

1. Provide scope of service
2. Give supplementary information
3. Outline limitations
4. Give instructions concerning prior authorizations, billing, and utilization which direct the provider to accomplish the goals the provider has identified for the member

1-1 Objectives of physical and occupational therapy

Must include:

1. Evaluation and identification of the existing problem (not anticipated problem)
2. Evaluation of the potential level of function actually achievable
3. Restoration of functions which have been lost due to accident or illness
4. Establishment of functions lacking due to defects of birth
5. Termination or transfer of responsibility for identified procedures to family, guardians, or other caregivers
6. Increased level of adaptation, independence, or participation in everyday life activities for the member

1-2 General policy

Physical therapy (PT) and occupational therapy (OT) are optional services. Physical therapy and occupational therapy services are mandatory for individuals under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Physical therapy and occupational therapy as described in this manual are a benefit of the Utah Medicaid program. Physical therapy services must be provided by a licensed therapist. Services may be performed by a physical therapy assistant under the supervision of a physical therapist. Occupational therapy services must be performed by an occupational therapist or by an occupational therapy assistant.

This manual is designed to be used in conjunction with other sections of the Utah Medicaid provider manual, such as Section I: General Information.

2 Health plans

Information specific to Managed Care Entities (MCEs) can be found in Section I: General Information, Chapter 2, Health plans.

Refer to Section I: General Information Chapter 1-7, Fee for service and managed care, for information regarding MCEs and how to verify if a Medicaid member is enrolled in an MCE.

3 Provider participation requirements

To enroll as a Medicaid Provider refer to Section I: General Information Chapter 3, Provider participation and requirements.

3-1 Provider credentials

3-1.1 Physical therapist

A Medicaid provider who practices physical therapy must meet all of the following:

1. Graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the

American Physical Therapy Association, or its equivalent
2. Licensed by the State in which the provider practices
3. Enrolled as a provider for the Utah Medicaid program

3-1.2 Occupational therapist

A Medicaid provider who practices occupational therapy must meet all of the following:

1. Graduate of a program of occupational therapy approved by both the Council on Medical Education of the American Medical Association and the Accreditation Council for Occupational therapy (ACOTE), or its equivalents
2. Licensed by the State in which the provider practices
3. Enrolled as a provider for the Utah Medicaid program

4 Record keeping

Refer to Section I: General Information, Chapter 4, Record keeping.

5 Provider sanctions

Refer to Section I: General Information, Chapter 5, Provider sanctions.

6 Member eligibility

Refer to Section I: General Information, Chapter 5, Provider sanctions.

7 Member responsibilities

For information on member responsibilities including establishing eligibility and co-payment requirements, refer to Section I: General Information, Chapter 7, Member responsibilities.

8 Program coverage

Most procedure codes with accompanying criteria and limitations have been removed from the provider manual and are now found on the Medicaid Coverage and Reimbursement Lookup.

8-1 Definitions

Definitions of terms used in other Medicaid programs are available in Section I: General Information, Chapter 1-9, Definitions.

Definitions specific to the content of this manual are provided below:

Supervision: to act under the requirements of Utah Code Section 58-42a-306 of the Occupational Therapy Practice Act, or Section 58-24b-304 of the Physical Therapy Practice Act.

Occupational therapist: an individual who is licensed as an occupational therapist and meets the practice requirements in the Utah licensing Occupational Therapy Practice Act Rule, R156-42a.

Occupational therapy: services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided to a recipient by or under the direction of a qualified occupational therapist.

Occupational therapy assistant: a person licensed to practice occupational therapy under the supervision of an occupational therapist.

Physical therapist: an individual who is licensed as a physical therapist and meets the practice requirements in the Utah licensing Physical Therapy Practice Act Rule, R156-24b.

Physical therapy: services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided to a recipient by or under the direction of a qualified physical therapist.

Physical therapy assistant: a person licensed to engage in the practice of physical therapy, subject to the provisions of the Physical Therapy Practice Act, Subsection 58-24b-401(2)(a).

Physical medicine and rehabilitation: also referred to as Physiatry or Rehabilitation Medicine: a branch of medicine concerned with evaluation and treatment of, and coordination of care for, persons with musculoskeletal injuries, pain syndromes, and/or other physical or cognitive impairments or disabilities. The primary focus is on maximal restoration of physical and psychological function, and on alleviation of pain.

8-2 Covered services

Refer to the Coverage and Reimbursement Lookup for additional covered services.

8-2.1 Physical therapy and occupational therapy

To receive PT or OT services the member must be referred by a Doctor of Medicine, osteopathy, dentistry, or podiatry. Therapy services must require a level of proficiency and complexity, and/or the condition of the member must be such that therapy services can only be safely and effectively performed by a therapist.

Therapy services must be ordered, in writing, by a physician, physician assistant, or nurse practitioner as authorized by law.

Therapy sessions are limited to one PT session per day and one OT session per day. The evaluation and the first treatment may be billed on the same date of service.

Therapy services must be:

1. Professionally appropriate according to standards in the field

2. Utilize professionally appropriate methods and materials
3. In a professionally appropriate environment

Provision of service must be with the expectation:

1. Condition under treatment will improve in a reasonable and predictable time
2. Length of time and number of treatments will be predicted by Physical Therapy Association Guidelines
3. Service must be reasonable and necessary to the treatment of the member's condition

Treatment session: Physical therapy and occupational therapy treatment sessions should be based on the Medicaid member's specific medical condition and be supported in the treatment plan. A treatment session may include (post payment review):

1. Evaluation
2. Reassessment of the member's deficits, progress, rehabilitation potential, plan, and goals
3. Therapeutic exercise, including neuromuscular reeducation, coordination, and balance
4. Therapeutic oral motor, laryngeal, pharyngeal, or breathing exercises
5. Functional training in self-care and home management
6. Functional training in and modification of environments (home, work, school, or community), including biomechanics and ergonomics
7. Manual therapy techniques, including soft tissue mobilization, joint mobilization, and manual lymphatic drainage
8. Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, orthotics, and prosthetic devices
9. Airway clearance techniques
10. Compensatory or adaptive communication/swallowing

techniques and skills
11. Integumentary repair and protection techniques
12. Management of positioning, eating, and swallowing to enable/progress safe eating and swallowing
13. Electrotherapeutic modalities, physical agents and mechanical modalities when used in preparation for other skilled treatment procedures
14. Management of positioning, eating, and swallowing to enable/progress safe eating and swallowing
15. Training in assistive technology and adaptive devices, e.g., speech generating devices
16. Training in the use of prosthetic devices
17. Training of the member, caregivers, and family in home exercises, activity programs, and the development of a comprehensive maintenance program

Documentation of treatment sessions should include:

1. Date of treatment
2. Specific treatment(s) provided that match the procedure codes billed;
3. Total treatment time
4. The individual's response to treatment
5. Skilled ongoing reassessment of the individual's progress toward the goals
6. Any progress toward the goals in objective, measurable terms using consistent and comparable methods
7. Any problems or changes to the plan of care
8. Name and credentials of the treating clinician

Note: Documentation should be done in accordance with the clinician's professional organization (e.g., APTA or AOTA) standards.

Reevaluation: A reevaluation is indicated when there are new clinical findings, a rapid change in the individual's status, or failure to respond to physical

therapy interventions. There are several routine reassessments that are not considered reevaluations. These include ongoing reassessments that are part of each skilled treatment session, progress reports, and discharge summaries.

Reevaluation is a more comprehensive assessment that includes all the components of the initial evaluation, such as:

1. Data collection with objective measurements taken based on appropriate and relevant assessment tests and tools using comparable and consistent methods
2. Making a judgment as to whether skilled care is still warranted
3. Organizing the composite of current problem areas and deciding a priority/focus of treatment
4. Identifying the appropriate intervention(s) for new or ongoing goal achievement
5. Modification of intervention(s)
6. Revision in plan of care if needed
7. Correlation to meaningful change in function
8. Deciphering effectiveness of intervention(s)

Documentation of reevaluation should include all the components of the initial evaluation, in addition to:

1. Discussion regarding the appropriateness of continuing skilled therapy
2. List of current problems and deciding a priority/focus of treatment
3. Identifying the appropriate intervention(s) for new or ongoing goal achievement
4. Modification of interventions(s)
5. Revision of plan of care, as needed
6. Correlation to meaningful change in function
7. Deciphering effectiveness of intervention(s)

Note: Documentation should be done in accordance with the clinician's professional organization (e.g., APTA or AOTA) standards.

8-3 Physical therapy

Medicaid considers physical therapy services medically necessary when:

1. Therapy is aimed at preventing disability or improving, adapting or restoring functions which have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality.
2. Therapy is for conditions that require the unique knowledge, skills, and judgment of a physical therapist for education and training that is part of an active skilled plan of treatment.
3. There is an expectation that the therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period of time.

8-3.1 Evaluation

An initial physical therapy evaluation does not require a prior authorization unless the evaluation is performed by a Home Health Agency. See the Home Health Services provider manual. Evaluations are limited to one per calendar year; a written prior authorization is required beyond this limit.

The evaluation is essential to:

1. Determine if physical therapy services are medically necessary
2. Gather baseline data
3. Establish a treatment plan,
4. Develop goals based on the data

The initial evaluation is usually completed in a single session. An evaluation is required before implementing any PT treatment. Evaluation begins with the administration of appropriate and relevant assessments using standardized assessments and tools.

The evaluation should include (post payment review):

1. Prior functional level, if acquired condition
2. Specific standardized and non-standardized tests, assessments,

and tools
3. Summary of baseline findings
4. Objective, measurable, and functional descriptions of an individual's deficits
5. Summary of clinical reasoning and consideration with recommendations
6. Plan of care with specific treatment techniques or activities to be used in treatment sessions that should be updated as the individual's condition changes
7. Frequency and duration of treatment plan
8. Functional, measurable, and time-framed long-term and short-term goals based on appropriate and relevant evaluation data
9. Rehabilitation prognosis
10. Discharge plan that is initiated at the start of PT treatment

8-4 Occupational therapy

Medicaid considers occupational therapy medically necessary in selected cases when the following applies:

1. To learn or re-learn daily living skills (e.g., bathing, dressing, and eating) or compensatory techniques to improve the level of independence in the activities of daily living.
2. To provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, or injury.
3. There is a reasonable expectation that occupational therapy will achieve measurable improvement in the member 's condition in a reasonable and predictable period of time.

9 Non-covered services and limitations

9-1 Non-covered services

Refer to the Coverage and Reimbursement Lookup for additional non-covered services.

Physical therapy and occupational therapy services are not covered for:

1. Social or educational needs
2. Stable chronic conditions which cannot benefit from physical or occupational therapy services
3. No documented potential for improvement or no progress shown
4. Reached maximum potential for improvement and/or has achieved stated goals (see limitations regarding maintenance visits for EPSDT clients)
5. Non-diagnostic, non-therapeutic, routine, repetitive, or reinforced procedures; or maintenance therapy for non-pregnant adults
6. Residents of ICF/ID
   a) An ICF/ID facility must provide and pay for PT or OT services when a member residing in the facility requires PT or OT services as part of the plan of care
   b) Evaluation and therapy are components of the treatment plan and are the responsibility of the facility
7. Physical therapy or occupational therapy services in excess of one session per day
8. Physical therapy or occupational therapy services for maintenance. (Exception: EPSDT program eligible members.)
9. Physical therapy and occupational therapy services not included in the written plan of care
10. Physical therapy treatment for CVA which begins more than 60 days after onset of the CVA
11. Occupational therapy treatment for CVA which begins more than 90 days after onset of the CVA
12. Occupational therapy treatment of conditions other than one related to traumatic brain, spinal cord, or hand injury; neurodevelopment deficits, or CVA
13. Occupational therapy is not a benefit through Home Health except for EPSDT members and pregnant women
14. Occupational therapy if the child/family is able to follow prescribed program independently

15. Occupational therapy that does not require the skilled services of a licensed occupational therapist or licensed occupational therapy assistant
16. Conditions which can reasonably be expected to spontaneously improve with:
    a) Age and development
    b) As the member resumes normal activity
17. Physical therapy or occupational therapy service is not considered reasonable and necessary when the potential for rehabilitation is insignificant in relation to the extent and duration of occupational therapy
18. If at any point in treatment, there is no longer the expectation of significant improvement in a reasonable time. (This is based on Medicaid's best professional judgment

9-2 Limitations

Physical therapy and occupational therapy services for maintenance are limited to EPSDT program eligible members and to one PT and one OT maintenance visit per month for care-giver training, to provide routine, repetitive or reinforced procedures of routine care in the residence.

9-2.1 Physical therapy limitations

1. Physical therapy services for Traditional Medicaid members are limited to twenty (20) therapy sessions, per member, per calendar year, when criteria are met. (The evaluation is NOT counted as one of the 20 sessions.) Prior authorization is required for more than 20 sessions per calendar year.
2. Physical therapy and occupational therapy services for Non-Traditional Medicaid members are limited to sixteen (16) total aggregate physical or occupational therapy sessions, per member, per calendar year, when criteria are met. (The evaluation is NOT counted as one of the 16 sessions). Prior authorization is required for more than 16 sessions per calendar year. (Note: On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan ended, and members formerly enrolled in the NTM plan will have the same benefits as the Traditional benefit plan starting on January 1, 2024.

Information regarding NTM services will remain in the Utah Medicaid Provider Manuals until January 1, 2025, for reporting and eligibility purposes.)

3. Physical therapy services must be performed by a physical therapist or by a physical therapy assistant under the supervision of a physical therapist.
4. Treatments that do not require the skills of a physical therapist may be administered by a physical therapy assistant. These same treatments may require the skills, knowledge, and judgment of a Physical Therapist where the member's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications. If such treatments are given prior to, but as an integral part of, a skilled physical therapy procedure, these treatments would be considered part of the physical therapy service.
5. Ultrasound, Shortwave, Microwave Treatments, and similar modalities must always be performed by a physical therapist.
6. The skills of a physical therapist are required for gait evaluation and training when provided to a member whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality.
7. Gait evaluation and training that cannot reasonably be expected to improve significantly the member's ability to walk; such services by a physical therapist would not be considered reasonable or medically necessary. Repetitious exercises to improve gait, maintain strength and endurance, and assist in walking, such as provided in support for feeble or unstable members, are appropriately provided by supportive personnel (e.g., PT/OT Assistant or nursing personnel).
8. Range of motion (ROM) tests and therapeutic exercises constitute physical therapy if required to be performed by or under the supervision of a physical therapist, due either to the type of exercise employed or condition of the member.
9. Generally, ROM exercises related to the maintenance of function do not require the skills of a physical therapist and are not reimbursable
   a) ROM exercises that require the skills of a physical therapist when they are part of active treatment of a specific disease which has resulted in the loss or restriction of mobility (as evidenced by physical therapy

notes showing the degree of motion lost and the degree to be restored)

b) Such exercises, either because of their nature or condition of the member, may be performed safely and effectively by a physical therapist

10. Wound debridement is covered if hydrotherapy is used to facilitate the debridement
    a) A simple bandage change is not reimbursable as a physical therapy treatment
11. For limitations to PT/OT in Home Health refer to the Home Health Services Utah Medicaid Provider Manual.

9-2.2 Occupational therapy limitations

1. Occupational therapy services must be performed by an occupational therapist or by an occupational therapy assistant under the supervision of an occupational therapist.
2. Occupational therapy services for Traditional Medicaid members are limited to twenty (20) therapy sessions, per member, per calendar year, when criteria are met. (The evaluation is NOT counted as one of the 20 sessions.) Prior authorization is required for more than 20 sessions per calendar year.
3. Occupational therapy and physical therapy for Non-Traditional Medicaid members are limited to sixteen (16) total aggregate physical or occupational therapy sessions, per member, per calendar year, when criteria are met. (The evaluation is NOT counted as one of the 16 sessions). Prior authorization is required for more than 16 sessions per calendar year. (Note: On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan ended, and members formerly enrolled in the NTM plan will have the same benefits as the Traditional benefit plan starting on January 1, 2024. Information regarding NTM services will remain in the Utah Medicaid Provider Manuals until January 1, 2025, for reporting and eligibility purposes.)
4. Occupational therapy is limited to conditions resulting from traumatic brain injury, spinal cord injury, hand injury, congenital anomalies or developmental disabilities causing neurodevelopmental deficits, or CVA

(treatment must begin within 90 days of the incident).

a) Other conditions are not covered

5. Occupational therapy in the home is a benefit for EPSDT members and pregnant women when the home is the most appropriate and cost-effective place for the service to be provided.

10 Prior authorization

Prior authorization (PA) is required for occupational and physical therapy services, if limitations are exceeded. Failure to obtain prior authorization will result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization before providing services. Exceptions may be made if any of the conditions listed in section 10-3 of the Medicaid Section 1 Provider Manual are met.

General prior authorization information can be found in the provider manual, Section I: General Information. Code specific coverage and prior authorization requirements are provided on the Medicaid Coverage and Reimbursement Lookup.

For the purposes of determining when limitations have been met for occupational and physical therapy, Utah Medicaid considers each date of service to be one (1) visit, regardless of how many modalities are provided on that date of service.

Specify whether the services being requested are for physical therapy or occupational therapy, and the desired number of visits you are requesting, on each prior authorization request. Prior authorizations will be issued for the number of visits allowed, based on medical necessity and providers will bill for the individual modalities that were provided on each visit. Visits are authorized based on the documented diagnosis, history, and goals of the plan of treatment (not to exceed one PT visit per day and one OT visit per day).

The evaluation and the first treatment visit may be billed on the same date of service.

Note: All claims are subject to national correct coding requirements and MUE limitations, regardless of the number of units authorized.

10-1 Prior authorization criteria

Prior authorization requests for treatment are reviewed and approved or denied based on the information submitted to the Prior authorization unit.

The provider must include in the request for treatment (post payment review):

1. Prior Authorization Request Form (found at: https://medicaid.utah.gov, Forms)
2. Written plan of treatment for the member or a document which includes:
   a) The diagnosis and the severity of the medical disorder or disability
   b) The prognosis for progress within a reasonable and predictable time to an identified level
   c) The expected goals and objectives for the member
   d) A plan that explicitly states the method(s) of treatment to be used and the discharge goals
   e) The start and anticipated end date of therapy, number of visits requested and frequency of visits
   f) Relevant documentation showing recent patient progress (i.e., sufficient recent clinic notes or a summary of recent patient progress)

11 Billing

Refer to Section I: General Information, Chapter 11, Billing Medicaid, for more information about billing instructions.

11-1 Billing procedure

For coverage and reimbursement information for specific procedure codes, see the Medicaid Coverage and Reimbursement Code Lookup.

Billing codes

Report physical and occupational therapy services with the appropriate modifier:

1. “GP” modifier for physical therapy
2. “GO” modifier for occupational therapy

12 Coding

Refer to Section I: General Information, Chapter 12, Coding, for information about coding, including diagnosis, procedure, and revenue codes.

For coverage and reimbursement information for specific procedure codes, see the Medicaid Coverage and Reimbursement Code Lookup. Generally, the fees represented on the Coverage and Reimbursement Code Lookup are only for fee for service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.).

13 Reimbursement

A rehabilitation facility providing therapy services must be enrolled as a Medicaid provider. The rehabilitation facility must bill for services using the assigned Medicaid procedure codes. Service claims must be submitted from the Medicaid rehabilitation facility provider. Therapists providing services for the agency may not bill directly for services.

14 Resource table

For information regarding:	
Administrative Rules	Utah Administrative Code Table of Contents R156-24b, Physical Therapy Practice Act Rule R156-42a, Occupational Therapy Practice Act Rule R414-1, Utah Medicaid Program R414-14, Home Health Services
General information including: Billing Fee for service and managed care	Section I: General Information Claims Managed Care: Accountable Care Organizations

Member eligibility Prior authorization Provider participation	Utah Medicaid Prior Authorization Eligibility Requirements. R414-302. Medicaid General Provisions. R414-301. Program Benefits and Date of Eligibility. R414-306.
Information including policy and rule updates: Medicaid Information Bulletins (Issued bimonthly), Medicaid Provider Manuals, Utah State Bulletin (Issued on the 1st and 15th of each month)	Utah Medicaid Official Publications Utah State Bulletin
Medicaid forms including: PA Request	Utah Medicaid Forms
Medical supplies and DME	Medical Supplies And Durable Medical Equipment Provider Manual Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70.
Modifiers	Section I: General Information
Patient (Member) Eligibility Lookup Tool	Eligibility Lookup Tool
Prior authorization	Prior Authorization Form Utah Medicaid Prior Authorization
Provider portal access	Provider Portal Access
Provider training	Utah Medicaid Provider Training
References including: Social Security Act Code of Federal Regulations Utah Code Utah State Plan Amendment (SPA)	42 CFR 440.70 Social Security Act 1905(a) Social Security Act 1861 (r) Utah Annotated Code Title 58 Utah State Plan Amendment (SPA)

Utah Medicaid Provider Manual

Rural Health Clinics and Federally Qualified Health Centers Services

Division of Integrated Healthcare

Updated September 2024

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1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly noting, the specific link that is not working and the page number where the link is.

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General information.

1-1 General policy

This manual establishes the requirements for coverage and reimbursement of rural health clinic (RHC) and federally qualified health center (FQHC) services for Medicaid members receiving medically necessary services, as authorized by Section 1833, Section 1861(aa), and Section 1834(o) of the acts.

2 Health plans

For more information about Accountable Care Organizations (ACOs), refer to Section I: General Information, Chapter 2, Health plans.

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information Chapter 2-8, Prepaid mental health plans, and the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual.

Two individual tabs on the Medicaid website, Managed Care: Accountable Care Organizations and Prepaid Mental Health and Substance Use Disorder Plans, identify which ACOs and PMHPs Medicaid has a contract with that allow those organizations to provide health care services to Medicaid members.

3 Provider participation and requirements

Refer to Section I: General Information, Chapter 3, Provider participation and requirements.

4 Record keeping

Refer to Section I: General Information, Chapter 4, Record keeping.

5 Provider sanctions

Refer to Section I: General Information, Chapter 5, Provider sanctions.

6 Member eligibility

Refer to Section I: General Information, Chapter 6, Member eligibility, for information about verifying a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Medicaid members not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member responsibilities

For information on member responsibilities, including establishing eligibility and co-payment requirements, refer to Section I: General Information, Chapter 7, Member responsibilities.

8 Program coverage

8-1 Definitions

Definitions of terms used in multiple Medicaid programs are in Section I: General Information, Chapter 1-9, Definitions, and Utah Administrative Code R414-1. Utah Medicaid Program.

Definitions specific to RHC and FQHC are at Title 42: Public Health, Federal Health Insurance for the Aged and Disabled, Subpart X—Rural Health Clinic and Federally Qualified Health Center Services.

8-2 Telemedicine

Refer to Section l: General Information, Chapter 8, Programs and coverage.

8-3 Covered services

Services provided at FQHCs and RHCs are primarily outpatient health care services, including routine diagnostic and laboratory services provided by physicians, nurse practitioners, certified nurse midwives, or physician assistants. FQHC or RHC rendering these services must comply with all applicable federal, state, and local laws. While FQHC can perform all allowable services to an RHC, federal law explicitly lists certain services as FQHC services. These services include, but are not limited to:

1. primary preventive services,
2. diagnostic testing such as mammography, pelvic, diabetes, glaucoma, prostate cancer, and colorectal cancer screening tests,
3. bone mass measurement,
4. blood tests for cardiovascular screening, and
5. ultrasound screening for abdominal aortic aneurysm,
6. diabetes outpatient self-management services,
7. medical nutrition therapy services.

Clinic services include:

1. Services and supplies furnished incident to the professional services of a physician, nurse practitioner, certified nurse-midwife, physician assistant, or other licensed health professional to provide necessary medical care.
2. The service or supply should be:
   a) Of the type commonly furnished in a physician's office and would be covered if delivered directly by the practitioner
   b) Of a type rendered either without charge or included in the clinic bill
   c) Provided as an incidental, although integral, part of a physician's professional service
   d) Drugs and biologicals furnished incident to the practitioner's professional services are included provided they cannot be self-administered by the member
3. Basic laboratory services for the immediate diagnosis and treatment of illness or injury. Coverage of laboratory services must comply with the

CMS Clinical Laboratory Improvement Amendments (CLIA) requirements.

4. Part-time or intermittent visiting nurse service and related medical supplies, other than drugs and biologicals, if the clinic is in an area where the Secretary has determined there is a shortage of home health agencies. These visits are covered if a registered nurse or licensed practical nurse provides services in the member's residence following a treatment plan. Additionally, a review of the treatment plan must occur every 60 days. and the services would not otherwise be available to that individual. Additional information for these services is in the Home Health Services provider manual.
5. Other ambulatory services which are otherwise provided in the State Plan Amendment. Services must meet all requirements of the State Plan and provider eligibility.
6. Clinics may provide emergency medical care as a first response to common life-threatening injuries and acute illness. Additionally, they must have available drugs and biologicals commonly used in life-saving procedures. RHCs and FQHCs are not subject to Emergency Medical Treatment & Labor Act (EMTALA) regulations. However, FQHCs must provide telephone access, including after hours, to an individual with the qualifications and training to exercise clinical professional judgment in assessing a patient's need for emergency medical care, and if appropriate, to refer that patient to an appropriate provider or facility.
7. Diabetes self-management training (DSMT).
   a) FQHCs – Offer DSMT services. A face-to-face encounter is required and must be provided as part of an encounter to qualify for coverage. Therefore, FQHC cannot report these services separately.
   b) RHCs - Do not offer DSMT services. Nevertheless, registered dieticians' or nutrition professionals' services might be considered incidental to services in the RHC setting.
8. FQHCs must provide preventive health services onsite or by arrangement with another provider and include:
   a) well-child services,
   b) pediatric eye, ear, and dental screening,

c) mental health and substance use referrals,
d) services that enable individuals to use the services of the health center (including outreach and transportation services,
e) prenatal and perinatal services,
f) voluntary family planning services, and
g) immunizations against vaccine-preventable diseases.

9. While preventive health services are not generally within the scope of RHC, they must provide:
   a) direct routine diagnostic and laboratory services,
   b) various laboratory tests onsite, and
   c) arrangements with one or more hospitals to deliver medically necessary services that are not available at the RHC.

8-3.1 Dental coverage

A member's eligibility type restricts which providers can perform dental services. For information concerning dental coverage and provider restrictions see Dental, Oral Maxillofacial, and Orthodontia Services provider manual, Chapter 8 Programs and coverage.

9 Non-covered services and limitations

Certain services are non-covered by Medicaid because medical necessity, appropriateness, and cost-effectiveness cannot be readily determined or justified for medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

For more information on non-covered services and limitations, see R414-2A. Inpatient Hospital Services, Rule R414-3A. Outpatient Hospital Services, Utah Administrative Code R414-1. Utah Medicaid Program, and Section I: General Information, Chapter 9, Non-covered services and limitations.

9-1 Non-covered services

The following services are not covered for RHC or FQHCs:

1. Personal care services for visiting nurses,
2. Homemaker or chore

3. The technical component of laboratory services or the use of diagnostic testing equipment is not covered. However, exceptions may be related to some preventive services encompassed in primary care. These services may have a technical component, such as laboratory service or diagnostic testing equipment.
4. In general, if not part of the RHC or FQHC benefits, technical services are not reportable on RHC/FQHC claims; this includes technical components of services with professional and technical components.
5. For FQHCs only:
    a) The technical component of mandated preventive services, together with laboratory tests included in the FQHC visit,
    b) preventive primary services such as group or mass information programs,
    c) health education classes,
    d) group education activities,
    e) eyeglasses,
    f) hearing aids,
    g) ambulance services,
    h) prosthetic devices, and
    i) durable medical equipment.

9-2 Limitations

Reporting encounters for RHCs and FQHCs is limited to one encounter per day per patient. Encounters with more than one health professional or multiple visits with the same health professional on the same day constitute a single visit. The provider may bill up to, but not exceeding, the established encounter rate.

An individual encounter rate is established for each clinic. The encounter rate will be a blended rate of all service costs, exclusive of costs or encounters for carve-out services. For example, if a clinic itemizes multiple services provided to a single patient at a single location on the same day. In that case, reimbursement is made at the established encounter rate regardless of the total claim.

10 Prior authorization

Providers must verify prior authorization requirements before rendering services. Claims must be submitted with the prior authorization number that was issued to the provider. Charges will not be paid when prior authorization is required and there is no valid prior authorization approval on file. For information regarding prior authorization, see Section I: General Information, Chapter 10, Prior authorization. Additional resources and information may be found on the Utah Medicaid Prior Authorization website.

For information on codes requiring prior authorization, manual review, or non-covered status, refer to the Coverage and Reimbursement Code Lookup.

11 Billing

Refer to Section I: General Information, Chapter 11, Billing Medicaid, for more information about billing instructions.

11-1 Billing code

Delivered services must be reported using the appropriate CPT codes.

11-2 Mobile units

In accordance with Medicare requirements, each permanent FQHC requires a separate agreement. Mobile units of an FQHC approved site are not required to enroll or bill separately but must comply with Medicare health and safety standards.

12 Cost sharing

The Medicaid program may require certain members to pay for services or benefits, referred to as cost sharing. Cost sharing amounts may include such items as premiums, deductibles, co-insurance, or co-payments.

Refer to Attachments 4.18-A through H of the Utah State Plan for additional cost sharing information.

13 Reimbursement

There are two payment methodologies available, the prospective payment system (PPS) and the alternative payment method (APM). The FQHCs may elect reimbursement under either method. However, RHCs are paid only under PPS.

13-1 Prospective payment system

The Department pays each clinic the amount, on a per visit basis, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services and adjusted to consider any increase or decrease in the scope of services furnished by the clinic during that fiscal year. The PPS is a standardized rate that is the average of a clinic's reasonable costs for providing Medicaid services divided by the total number of visits by Medicaid patients to obtain an average per visit cost rate.

The Department makes supplemental payments for the difference between the amounts paid by ACO's that contract with clinics and the amounts the clinics are entitled to under the PPS as they are estimated and paid quarterly to them. In addition, the Department makes quarterly interim payments no later than 30 days after the end of the quarter based on the most recent prior annual reconciliation. Finally, as necessary, the Department settles annual reconciliations with each clinic.

13-2 Behavioral and mental health services

All Medicaid members who receive behavioral health services or mental health services from a RHC or FQHC in Utah should submit claims directly to Utah Medicaid. Providers should not submit claims to the patient's prepaid mental health plan (PMHP). This exception applies only to mental health services.

Claims for medical services should be submitted to the member's Medicaid ACO or Utah Medicaid directly if the member is not enrolled in a Medicaid ACO.

13-3 Alternative payment method for FQHCs

FQHCs may also adopt an alternative payment method so long as that rate results in payments that are no less than would have been received under the PPS. If an FQHC elects to change its payment method in subsequent years, it must elect to do so no later than 30 days before the beginning of the FQHC's fiscal year by written notice to the Department.

An FQHC is required to calculate the Ratio of Covered Beneficiary Charges to Total Charges Applied to Allowable Cost as part of its agreement with the federal government. As part of that calculation, it allocates allowable costs to Medicaid. The Department multiplies the Medicaid allowable costs by the Medicaid charge percentage to determine the amount to pay. The Department makes interim payments based on billed charges from the FQHC, which reduce the annual settlement amount. Third-party liability collections by the FQHC for Medicaid patients also reduce the final cost settlement.

An FQHC participating in the APM must provide the Department with its annual cost reports and other cost information necessary to calculate the annual settlement within six months from the close of its fiscal year, including its calculations of its anticipated settlement. The Department reviews submitted cost reports and provides a preliminary payment, if applicable, to FQHCs. Within 12 months after the end of the FQHC's fiscal year, the Department conducts a review or audit of submitted cost reports and makes a final settlement. This process allows for inclusion of late filed claims and adjustments processed after the submitted cost report was prepared. If the Department overpaid an FQHC, the FQHC must repay the overpayment. If the Department underpaid an FQHC, the Department must pay the FQHC the underpaid amount.

The Department compares the APM reimbursements with those calculated using the PPS methodology described and pays the greater amount to the FQHC.

14 References

1. Social Security Act, Title 19, Section 1905 (l)(1) and (2)(A)
2. United States Code 42 § 254b. Health Centers [42 USC 254b]

Utah Medicaid Provider Manual

School-Based Skills Development Services

Division of Integrated Healthcare

Updated September 2024

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Introduction

School-based skills development services are Medicaid-covered medically necessary diagnostic, preventative, and treatment services. These services include therapeutic interventions designed to ameliorate motor impairments, sensory loss, communication deficits, and/or psycho-social impairments. These services are specifically designed to enhance a student's health and functional abilities and/or prevent further deterioration. They are necessary for the student to benefit from special education.

General information, pertaining to Utah Medicaid providers and Medicaid billing, is located in the Section 1: General Information provider manual on Utah Medicaid's website.

1 Program standards

1-1 Authority

The Medicaid Catastrophic Coverage Act of 1988, Section 411(k)(12) permits Medicaid to pay for related services included in a Medicaid eligible recipient's IEP when services are medically necessary and are covered in the Medicaid State Plan, for students who are 3 to under 21 years old.

1-2 Definitions

The following definitions apply to this program:

Administrative fee: The fee assessed to cover costs incurred by the Department of Health and Human Services to administer the Medicaid program.

Clean claim: A claim that can be processed as submitted without obtaining any additional information from the provider of the service or from a third party.

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, designed to ensure Medicaid eligible recipients from birth through age twenty have access to needed medical care.

Federal financial participation (FFP): The federal share of Medicaid payments authorized and directed under Section 1903(a) of the Social Security Act.

HIPAA: The federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance,

protect the confidentiality and security of healthcare information, and help the healthcare industry control administrative costs.

Individualized Education Plan (IEP): A written plan for a student with a disability developed and implemented in accordance with the Utah State Board of Education Special Education Rules.

Local Education Agency (LEA): The Utah school districts, the Utah Schools for the Deaf and Blind (USDB), and all Utah public charter schools that are established under state law that are not schools of an LEA.

Maximum allowable costs: The percentage of costs incurred by the LEA to deliver covered skills development services to the Medicaid population.

Medicaid administrative claiming (MAC): is a means by which the states' LEAs are able to claim partial reimbursement for administrative activities that support and ensure the integrity and delivery of Medicaid services provided both within the school setting and through coordination with community Medicaid providers.

Medically necessary service: A service that is reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endanger life, are causing suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap, and there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

Related services: Developmental, corrective, and other supportive services required to assist a student with a disability to benefit from special education. Related services are identified in the Individuals with Disabilities Education Act (IDEA), Part B Regulations, 34 CFR Section 300.34. Not all related services are considered medically necessary.

Skilled nursing services: School-based skills development services provided to medically fragile students in special education who require continuous, one-to-one skilled nursing throughout their school day, in accordance with a physician's order.

Special education: Instruction which is specially designed to meet the unique needs of a student with a disability.

State match: The current percentage of the State's share of Medicaid expenditures as defined in 42 CFR 433.10.

Utah Health Information Network (UHIN): a nonprofit, broad-based coalition of Utah healthcare insurers, providers, and others, including local government entities that provides a private and secure gateway for electronic data exchanges.

1-3 Program eligibility

1. LEAs may bill Medicaid for covered related services rendered to students when the LEA is an enrolled provider with Utah Medicaid and has a current, signed contract and provider agreement with the Department of Health and Human Services.
2. LEAs may bill Medicaid for covered related services rendered to students, if all of the following criteria are met:
    a) The student is Medicaid eligible and is between the ages of 3 and 21.
        i. The LEA may check Medicaid eligibility by sending a student list to the school-based program manager, using the Eligibility Lookup Tool at www.medicaid.utah.gov, or by calling 1-801-538-6155 or 1-800-662-9651, and following the prompts.
    b) The student must have a Medicaid-covered related service specified in their IEP and receive these services from a qualified provider.

2 Scope of services

The direct services outlined in this section must be rendered in accordance with a provider order, except personal care. The student's IEP may be used as the document of medical necessity for provider orders if the information stated includes the provider's recommendation for services, the scope, frequency, duration of services, and the provider's signature and date.

LEAs not wanting to use the IEP as a provider order must complete a provider order separate from the IEP.

2-1 Covered direct services

1. School-based skills development services Include:
    a) Evaluation and assessment for the purpose of identifying and documenting a special education student's health related service need.
        i. Both initial evaluations and assessments, along with re-evaluations and assessments, are covered by Medicaid, as long

as the evaluated and/or assessed service results in IEP placement.

ii. Evaluations and assessments that do not result in IEP placement for the evaluated or assessed service are not covered by Medicaid.

b) Motor skills development services are rehabilitative, active or restorative therapies designed to enhance a student's fine and gross motor skills including muscle coordination and strength, ambulation, range of motion, grasp and release, and oral motor functioning. Examples of these services are occupational therapy and physical therapy.

i. Motor skills development services may be provided in an individual or group setting.

c) Communication skills development services are speech, language, and hearing services designed to enhance a student's ability to communicate through the development of functional expressive speech, functional use of adaptive equipment and devices, or improved oral-motor functioning. An example of this service is speech language pathology.

i. Speech, language, and hearing services may be provided in an individual or group setting.

d) Personal care

i. The following services must be performed under proper supervision per the Final Supervision and Licensure Appendix 3 and in accordance with Utah Code section 58-1-307 and Admin Code R156-31b-701b. The student's IEP may serve as the service plan for personal care services.

1 Activities of Daily Living (ADLs) such as: toileting, hand washing, eating, and bathing

2 Administer over-the-counter medications according to the manufacturer/FDA directions

3 Administer prescription ointments per a licensed health care provider order/prescription

4 Administer non-controlled medications per a licensed health care provider order/prescription

5 Administer medication through tubes per a licensed health care provider order/prescription
6 Administer eye/ear drops: prescribed or over the counter
7 Administer gastrostomy tube feeding: changing empty bags and clipping/unclipping the feeding line to the port (but not replacing a port)
8 Tasks related to stoma care, including pouch changes, measuring intake and output, and skin care around the stoma area
9 Changing a catheter bag
10 Oxygen management: assisting with applying nasal cannulas, adjusting the flow of O2 within prescribed parameters, and the temporary removal of O2 tubing to facilitate ADLs
11 Measure and record electronic vital signs (such as pulse oximeter or blood pressure) and take weights and temperatures
12 Perform routine ventilator respiratory care but may not adjust settings
13 Clean established trach tubes and routine surface suctioning but may not provide deep suctioning
14 Nail care: clipping and filing toe and fingernails (for non-diabetic individuals)

ii. Personal care services shall not be performed as a group service; however, one or more students may be served one-at-a-time sequentially.

e) Skilled nursing

i. Skilled nursing services require the provider to have appropriate licensure per the Final Supervision and Licensure Appendix. In addition to the services stated under the personal care section, these providers may render the following in accordance with their licensing and training as outlined in Utah Code section 58-1-307 and Admin Code R156-31b-701a:

1 Routine respiratory care, including management of ventilator settings
2 Standard tracheotomy care includes cleaning and suctioning, whether surface or deep suctioning
3 IV management
4 Evaluations and assessments (RNs only)
5 Emergency interventions
6 Seizure monitoring

ii. Nursing services that are considered observational or stand-by in nature are not covered.

iii. Skilled nursing services must be in accordance with a prescribed provider order and be stated in the student's plan of care. The order may be signed by a physician, NP, or PA.

f) Behavioral health services are designed to mitigate behaviors such as aggression, self-abuse, property destruction, severe non-compliance or withdrawal when, and to the extent, those behaviors significantly impact a student's ability to benefit from special education. Examples of these services include behavioral redirection, counseling, and psychological services.

i. Behavioral health services may be provided in an individual or group setting.

g) Vision and hearing adaptation services are (necessitated by a student's absence or loss of vision and/or hearing) are specifically designed adaptation training services to develop/enhance a student's functional abilities to assist him or her to benefit from special education. Examples of these services are orientation and mobility as well as aural/auditory rehabilitation.

2. Telehealth

a) Utah Medicaid covers medically necessary, non-experimental, and cost-effective services provided via telehealth. Telehealth is a two-way, real-time interactive communication to facilitate contact directly between a student and a provider. This electronic communication uses interactive telecommunications equipment that includes, at a minimum, audio and

video equipment that complies with HIPAA and UHIN privacy and security standards for telehealth.

i. Covered telehealth services include but are not limited to the following:
   1 Consultation services
   2 Evaluation and management services
   3 Mental health services
ii. Reporting requirements for provided telehealth services are the same as those provided when the student is present (in person).
iii. There are no geographic restrictions for telehealth services.
iv. Providers at the originating site receive no additional reimbursement for the use of telehealth services.

For more information regarding telemedicine, please refer to Utah Medicaid's Section 1: General Information provider manual.

3. Service categories and service plans
   a) Services that may be stated in a student's IEP as a category; i.e. social skills, transition skills, functional skills, daily living skills, self-help, etc., must be broken down. The Medicaid covered services to be rendered must be stated in the related services section.
      i. Example: if social skills services include behavioral interventions, the LEA can state "behavior" in the related service section of the IEP.
   b) Services that may be stated in a student's IEP as a plan, i.e. health plan, must be broken down. The Medicaid covered services to be rendered must be stated in the related services section of the IEP.
      ii. Example: If an IEP states, "health plan", but the actual service to be rendered is speech, then the IEP should say "speech" in the service section of the IEP.

4. Credentials and supervision
   a) The Supervision and Licensure Appendix 3 outlines the licensure, certification, and other credentials required to deliver and/or supervise the delivery of Medicaid covered school-based skills development services.

2-2 Non-covered services/activities

1. The following services and activities are outside of the scope of the school-based skills development services and are not reimbursable under this program:
    a) Durable and non-durable medical equipment (including assistive technology devices), appliances, and supplies. When medically necessary, these items are available to a Medicaid eligible student through other programs and enrolled providers.
    b) Services provided prior to the implementation (or subsequent to the expiration) of a student's IEP.
    c) Medicaid covered related services, which are not specified in a student's IEP.
    d) Services specified in a student's IEP, but the nature or purpose of the activity is:
        i. Academic or educational and covered under the state's educational "core curriculum" including addition, subtraction, multiplication, letter and sound identification, reading, history, science, and other services that do not meet the criteria of medically necessary services;
        ii. To teach consumer and homemaker skills, including, but not limited to, shopping, budgeting, bed making, table setting, vacuuming, dishwashing, and laundry skills;
        iii. Extracurricular in nature, including training and participation in regular physical education, recreational and cultural activities, athletics/sports, and special interest/leisure activities;
        iv. Any other service that may be appropriate for the related service section of an IEP, according to the USBE standards, but are not Medicaid covered services as outlined in this manual, (e.g., adapted physical education); or
        v. Vocational or job training activities designed to prepare a student to obtain or maintain paid or unpaid employment (such as objectives written to address specific job skills and work habits, use of public transportation, community awareness and access, and following work related directions).

2-3 Service coordination

1. The LEA is responsible to coordinate the provision of school-based skills development services with students' primary and specialty providers.
2. Utah Medicaid providers should be familiar with coverage of preventative, diagnostic, treatment, and outreach services for EPSDT-eligible recipients in order to assist families to appropriately utilize Medicaid benefits available.

3 Service payment

3-1 Billing authority

The LEA, along with the education authority, is solely responsible to ensure that it is legally authorized to submit a claim to Medicaid in accordance with all state and federal laws.

3-2 Claims processing

1. Upon enrollment in the Medicaid program, LEAs will receive instructions and assistance from the Medicaid agency to enable them to submit claims monthly.
2. LEAs must be able to submit claims using HIPAA compliant software using the UHIN tool.
3. Payment will be made to the LEA for students who are Medicaid eligible during the billing period.
4. The LEA is responsible for submitting clean claims to Medicaid and for working through rejected claims with its clearinghouse and/or UHIN when appropriate.
5. Submitted claims must contain the following information:
   a) The names of all (Medicaid) students who received Medicaid covered related services during the billing period;
   b) Each student's date of birth and social security number or Medicaid identification number;
   c) The number of units of covered service(s); and
   d) The dates of service during the billing month
6. Providers should not be listed individually on school-based skills development claims.

3-3 Billing codes, usage, limitations, and specifications

1. LEAs must submit claims to Medicaid in order to justify its reported direct care service costs and receive its monthly interim payment.
2. LEAs must use correct CPT/HCPCS codes on claims per the School-Based Skills Development Code List Appendix 1 and the School-Based Skills Development Audiology Code List Appendix 2.
    a) LEAs may only submit claims for dates when a Medicaid covered service is rendered to a student.
3. Billing for time
    a) When submitting the CPT/HCPCS codes for time, the minutes must be rounded. If the resulting time is 0 to less than 8 minutes, do not bill for the time. If the resulting time is 8 to 15 minutes, 1 unit of nursing services may be billed.
        i. The following is an example of rounded minutes when using the T1002 and the T1003 codes: If a nurse rendered services for 34 minutes, bill 2 units. If a nurse rendered services for 39 minutes, bill 3 units.
    b) Services billed using CPT/HCPCS codes for time may only be billed for the day that the services are rendered. Partial minutes cannot carry over from one day to the next in order to complete a unit.
        i. The following is an example: 9 minutes of nursing services on Tuesday cannot be added to 6 minutes of nursing services on Wednesday to make one whole 15-minute unit.
    c) LEAs may bill for nursing services during transportation using the appropriate code, when deemed necessary. In order to bill for nursing services during transportation, the total nursing minutes stated in the IEP must also include the minutes for transportation. Nursing minutes are billed in 15-minute increments.
        i. Simply stating “transportation” in the IEP, or adding time to transportation in the IEP, is not sufficient. This does not clearly identify the expected time associated with the nursing services, nor does it clearly tie the “transportation” activities to a specific related service.

ii. Example: If a student receives 2,000 weekly nursing minutes at school, and also receives nursing services on a bus for 30 minutes a day, five days a week, the total time stated in the IEP must be 2,150 in order for the LEA to bill for both services.

3-4 ICD-10 diagnosis codes

1. LEAs will use the full list of ICD-10 diagnosis codes as appropriate for the associated rendered service.
   a) LEAs will include the appropriate ICD-10 diagnosis code on submitted claims to Medicaid.

3-5 State match and administrative fee

1. State match
   a) The LEA will receive a quarterly bill for the estimated state match, pertaining to direct care services. The bill will be sent 45 days prior to the beginning of each new quarter and payment must be made at least 15 days prior to the start of the quarter.
   b) State match requirements for administrative services will be accomplished through certified public expenditures (CPE).
2. Administrative fee
   a) The LEA will receive a bill for the administrative fee 45 days prior to the beginning of the fourth quarter of each state fiscal year. The administrative fee will be calculated as a percentage of the total Medicaid payments. It will include both FFP and state match amounts paid to the LEA for school-based skills development services during the state fiscal year.
      i. The administrative fee is calculated as follows:

Fiscal Year Medicaid Payments	Fiscal Year Administrative Fee
$1-$500,000	3 percent of total
$500,000- $1,000,000	$15,000 + 2 percent of amount exceeding $500,000
Greater than $1,000,000	$25,000 + 1 percent of amount exceeding $1,000,000

3. LEA monthly Medicaid payments will be placed on hold if the state match or the administrative fee is not paid.

4 Documentation

4-1 Documentation requirements

The school-based skills development LEA must maintain sufficient records to fully justify the Medicaid covered related services rendered, its claims submitted to Medicaid, and its reported costs.

1. IEP – the IEP must demonstrate the following:
   a) That the student received service(s) pursuant to an IEP which met the requirements in accordance with Chapter 1-4, Program eligibility, of this manual.
   b) That the dates of the IEP cover the billing month on the claim.
   c) That the Medicaid covered related services rendered to the student during the month match the services outlined in the student's IEP.
   d) That the CPT/HCPCS codes included on a claim are pursuant to a service stated in the IEP.
2. Rendering and supervising providers
   a) The rendering provider(s) met the required licensure, certification, or other criteria described in the Supervision and Licensure Appendix 3 or was supervised by an individual who met the requirements per Appendix 3.
      i. That the rendering provider has signed and dated the documentation of services rendered.
         1 That the signature is handwritten or electronic.
         2 That the signature is legible.
      ii. That the rendering provider and the supervising provider (if applicable) have both signed and dated the documentation of services rendered.
         1 The documentation must clearly state both the rendering and the supervising provider names.
         2 The documentation must clearly indicate who rendered the service.
         3 The documentation must clearly indicate who supervised the service.

iii. Electronic signatures are acceptable when the LEA has a system to maintain an auditable signature record, and when the LEA has a way to protect against modification of the record after the signature.

1 The LEA and the person whose name is represented by the electronic signature, are responsible for the authenticity of the signature.

b) That the rendering and supervising providers, who possess current licensure and NPIs, are known to Medicaid and have completed the provider enrollment process, with the exception para professions and teachers.

3. Clinical notes

a) The LEA must maintain clinical documentation to justify the costs reported to Medicaid. The clinical notes must include the following:

i. The student's name;

ii. The type of service rendered;

iii. The date the service was rendered;

iv. The duration of time spent rendering the service; and

v. A clinical description of the services rendered:

1 Clinical notes must include the exact activities performed with the student. The exact activities demonstrate how the service was rendered.

2 Clinical notes must be in line with the standards of practice for each rendering and/or supervising provider's specialty.

4. Skilled nursing service documentation must also ensure that the number of 15-minute units on a claim was billed correctly.

4-2 Record retention

1. All documentation pertinent to a claim submitted by the LEA to Medicaid must be kept for a period of five years after the date of payment.

a) Records must be retained even after a student leaves the LEA.

5 Cost reporting

5-1 Annual direct care cost reports

1. On an annual basis LEAs must submit a report outlining the costs associated with rendering covered direct care services to students that are eligible for this program. The annual reports should include the following information:
   a) Salary and benefits for staff rendering covered direct care services to students.
      i. This expense should be broken out to reflect the percent of the expense that is funded through state/local funds, IDEA, or other federal funds.
      ii. Salary and benefit expense may only be included for staff that have participated in the time study and only for the period in which they participate in the time study.
   b) Contracted staff costs for rendering covered direct care services to students
      i. This expense should be broken out to reflect the percent of the expense that is funded through state/local funds, IDEA, or other federal funds.
      ii. Contracted staff expense may only be included for contracted staff that have participated in the time study and only for the period in which they participate in the time study.
   c) Costs for allowable materials and supplies used to provide covered direct care services.

5-2 Quarterly administrative cost reports

1. On a quarterly basis LEAs must submit a report outlining the costs associated with administering this program. The quarterly reports should include the following information:
   a) Salary and benefits for staff rendering direct care services to students, as well as the salary and benefits for staff providing administrative support of this program.
      i. This expense should be broken out to reflect the percent of the expense that is funded through state/local funds, IDEA, or other federal funds.

ii. Salary and benefit expense may only be included for staff that have participated in the time study and only for the period in which they participate in the time study.

b) Contracted staff costs for providing administrative support of this program.
   i. This expense should be broken out to reflect the percent of the expense that is funded through state/local funds, IDEA, or other federal funds.
   ii. Contracted staff expense may only be included for contracted staff that have participated in the time study and only for the period in which they participate in the time study.
c) Other costs including:
   i. Staff travel and training costs;
   ii. Staff professional dues and fees; and
   iii. Materials and supplies.

6 Random moment time study

1. The random moment time study is a mechanism for identifying and categorizing Medicaid administrative and direct care activities performed by LEA employees. This serves as the basis for developing claims for the costs of administrative activities that may be properly reimbursed under Medicaid. It is also used to calculate the maximum allowable cost for the annual cost reconciliation for direct care services.
2. Participating Utah LEAs must participate in the time study for three periods per year. The first period is from mid-August to December 31 and the second period is from January 1 to June 30. The third period is the summer period, beginning July 1 and ending mid-August. No time study will be generated during the summer period. The sample period will run from the day after the last regular school day until the day before the first regular school day for any participating LEA. An average of the two (2) previous sampling periods' time study results will be used to calculate claims for the summer sampling period. No Medicaid funding will be available to an LEA for a quarter in which it failed to complete an approved time study.

3. LEAs must work with the Department's time study vendor to enroll time study participants in to three categories:
   a) **Paraprofessionals**– Included in this category are paraprofessionals, interveners, and any other aides that provide covered direct care services
   b) **Clinical providers** – Included in this category are the following:
      Physical therapists
      Physical therapy assistants
      Physical therapy aides
      Occupational therapists
      Occupational therapy assistants
      Occupational therapy aides
      Orientation and mobility specialists
      Psychologists
      Social workers
      Hearing specialists
      Audiologists
      Audiology aides
      Speech and language pathologists
      Speech language technicians
      Speech language pathology aides
      RNs or LPN physicians
      Augmentative/assistive communications teams
      Counselors/mental health practitioners
   c) **Administrative staff** – Include staff that support this program, but do not render direct care services. These may include the following:
      Special education directors or coordinators
      Medicaid coordinators
      Special education staff assistants
4. The time study will produce statewide percentages for 3 cost pools associated with the three participant categories. These will be used for the direct care cost settlement and administrative claiming.
   a) The paraprofessional and clinical provider time studies will result in separate direct care service percentages.

b) The paraprofessional, clinical provider, and administrative staff time studies will result in separate administrative activity percentages.
5. The LEA must ensure an 85% compliance rate with the quarterly time study.

7 Medicaid administrative claiming

1. Utah LEAs may claim Medicaid administrative Federal Financial Participation (FFP) for a share of the costs incurred to perform activities which support the proper and efficient operation of the Medicaid program in schools. Some or all of the costs of these administrative activities may be reimbursable at a 50% match rate. The quarterly cost reports will be used to calculate the administrative claim.
   a) The objective of the Medicaid administrative claim is to isolate and identify only those LEA costs that are associated directly with administrative activities that support the provision of Medicaid covered health related services in the Medicaid program.
   b) The LEA may submit the Medicaid administrative claim to the Department of Health and Human Services through the Department approved process.

7-1 Participation criteria

1. In order for an LEA to claim Medicaid administrative funding, the following criteria must be met:
   a) the LEA must be enrolled as a Medicaid provider;
   b) the LEA must actively bill Medicaid for direct care services;
   c) the LEA must participate in the Department approved time study;
   d) the LEA must attend required trainings; and
   e) the supported activity must be necessary for the proper and efficient administration of the Medicaid State Plan.

7-2 Cost data

1. Cost data will be submitted by the district quarterly. Calculations from the cost data will be used to support the quarterly administrative claim. The following elements will be used to calculate the administrative claim:
   a) Employee level salary data
      i. This information comes in a quarterly report from the LEA

b) Employee benefit data
    i. This information comes in a quarterly report from the LEA
c) Contracted staff costs
    i. This information comes in a quarterly report from the LEA
d) The district's indirect cost rate
    i. This information is published annually by the USBE
e) The district's Medicaid discount factor
    i. This is the percentage of the total students in the LEA that are Medicaid eligible
f) The statewide time study percentages related to Medicaid administrative services for each of the staff cost pools
    i. This includes the teachers and paraprofessionals, clinical providers, and administrative staff

2. This will be calculated separately for each of the three staff cost pools and then will be combined and reduced by 50% to isolate the federal share of the administrative FFP.
3. The Department will then pay the LEAs for the administrative claim.

8 Direct care payment

1. Utah LEAs may claim Federal Financial Participation (FFP) through Medicaid for a share of the costs incurred to render covered direct care services to Medicaid eligible students.
    a) Medicaid's regulations prohibit payments to governmental agencies in amounts which exceed an agency's costs to provide a service. LEAs, as governmental entities, are not allowed to make a profit.
2. The objective of the direct care payment reimbursement process is to isolate and identify only those LEA costs that are associated directly with rendering Medicaid covered direct care services.
3. A cost settlement is used to assure LEAs are reimbursed for the maximum allowable cost.

8-1 Maximum allowable cost

1. The maximum allowable cost is calculated using the annual cost report data for direct care costs. The following elements will be used to calculate the maximum allowable cost:
   a) Employee level salary data
      i. This information comes in a quarterly report from the LEA
   b) Employee benefit data
      i. This information comes in a quarterly report from the LEA
   c) Contracted staff cost
      i. This information comes in a quarterly report from the LEA
   d) The district's indirect cost rate
      i. This information is published annually by the USBE
   e) The LEA's Medicaid IEP student ratio
      i. This is calculated by dividing the number of Medicaid eligible students in an LEA, with a Medicaid covered related service on their IEP, by the number of students in the LEA with Medicaid covered related services on their IEP.

$$\frac{\text{(\# of Medicaid students /w qualified services on IEP)}}{\text{(Total \# of students /w qualified services on IEP)}}$$

      ii. On an annual basis each participating LEA must submit to the Department a list of students who have a qualified service on their IEP. Medicaid will request this list from the LEAs on November 1st
   f) The statewide time study percentages related to direct care services for each of the direct care staff cost pools.
      i. This includes the teachers and paraprofessionals and clinical providers.
   g) This will be calculated separately for each of the two direct care staff cost pools and then will be combined for the total maximum allowable cost for each LEA.

8-2 Interim payment

1. Due to the fact that payment is based on actual costs, interim payments will be made to the LEAs until a cost settlement can be finalized.
2. In advance of the school year, the interim payment is determined by taking the maximum allowable cost calculation from a previous period and applying that as an estimate of the anticipated cost of the coming year.
3. In an effort to minimize a payback situation, the LEAs will select to receive 80% or 90% of the estimated maximum allowable cost to be paid out monthly.
    a) At any time during the year, the LEAs may request to reduce the interim payments.
        i. If billing for direct care services decreases during the year, the Department may hold or reduce interim payments in an effort to assure the estimated maximum allowable cost is still representative of the current situation.

8-3 Cost settlement

1. At the conclusion of the school year, the Department will perform a cost settlement by comparing the interim payments made throughout the year with the actual maximum allowable costs for the year.
    a) If the maximum allowable cost exceeds the interim payments, the Department will pay the difference to the LEA.
    b) If the interim payments exceed the maximum allowable costs, the Department will invoice the LEA for the difference.
    c) If the interim payments are equal to the maximum allowable cost, no action is required.
2. The LEA is responsible to ensure that the Medicaid funds it receives as part of the school-based skills development program are only used to support and enhance the provision of Medicaid-covered related services.

Utah Medicaid Provider Manual

Speech-Language Pathology and Audiology Services

Division of Integrated Healthcare

Updated July 2023

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1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General information.

1-1 General policy

Speech-language pathology and audiology services are federally mandated covered benefits for pregnant women and members eligible under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Speech-language and audiology services for eligible Medicaid members, who do not qualify for the pregnant women or EPSDT programs, see the Utah State Medicaid Plan.

Speech-language therapy and/or audiology services must have a physician referral, be pre-authorized (if applicable), and be provided by a speech-language pathologist**Error! Bookmark not defined.** or audiologist, respectively. The total medical care of each speech-language and/or audiology member is under the direction of a physician. The provider reviews the plan of care and the results of treatment as often as the member's condition requires. If in their professional judgment, no progress is shown, the provider is responsible for discontinuing treatment and notifying the physician of treatment discontinuance.

Medical necessity

For information regarding medical necessity refer to Section I: General Information, Chapter 8-1 Medical necessity.

Speech-language therapy and audiology services

Speech-language therapy evaluation should consider audiological issues and other physical (organic) conditions restricting proper speech and language development. These must be addressed in a comprehensive treatment plan which includes speech/language therapy. Speech-language therapy without such a plan may be denied until a comprehensive plan is documented and submitted for review.

1-2 Fee for service or managed care

This manual provides information regarding Medicaid policy and procedures for fee for service Medicaid members.

For more information about Accountable Care Organizations (ACOs), refer to Section I: General Information, Chapter 2, Health plans.

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information, Chapter 2-1.2, Prepaid Mental Health Plans, and the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual.

A list of ACOs and PMHPs with which Medicaid has a contract to provide health care services is found on the Medicaid website Managed Care: Accountable Care Organizations.

1-3 Definitions

Definitions of terms used in other Medicaid programs are available in Section I: General Information of the Utah Medicaid Provider Manual (Section I: General Information). Definitions specific to this manual are provided below.

The information found in the Speech-Language Pathology and Audiology Licensing Act, Title 58, Chapter 41 may supersede the definitions below.

Audiologist: An individual specifically trained and licensed to perform the functions of an audiologist as described in the state of Utah Speech Pathology and Audiology Licensing Act Title 58, Chapter 41.

Audiology aide: An individual who meets the minimum qualifications as described in the state of Utah Speech Pathology and Audiology Licensing Act Title 58, Chapter 41.

Direct supervision/immediate supervision: The supervising licensee is present and available for face-to-face communication with the person being supervised when and where services are being provided.

Provider: Speech-language pathologist or audiologist who is a Medicaid provider.

Speech-language pathologist or speech therapist:
An individual specifically trained and licensed to perform the functions of a speech-language pathologist as described in the state of Utah Speech Pathology and Audiology Licensing Act Title 58, Chapter 41.

Speech-language pathology aide:
An individual who meets the minimum qualifications as described in the state of Utah Speech Pathology and Audiology Licensing Act Title 58, Chapter 41.

2 Provider participation requirements

Refer to Section I: General Information, Chapter 3, Provider participation and requirements.

3 Member eligibility

Refer to Section I: General Information, Chapter 6, Member eligibility, for information about how to verify a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

4 Program coverage

Procedure codes

Procedure codes, with accompanying criteria and limitations, are now found on the Coverage and Reimbursement Code Lookup.

4-1 Covered services

Information regarding speech-language pathology and audiology services for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) eligible Medicaid members see the EPSDT Services Manual.

4-1.1 Speech-language

Overview

Speech pathology services include evaluation, diagnosis and therapy services. Speech pathology services are provided to treat disorders related to traumatic brain injuries, cerebrovascular accidents, and disabilities which qualify members to receive speech-generating devices and to treat swallowing dysfunction.

Plan of care required

A written plan of care established by the speech-language pathologist is required. The plan of care must include:

1. Member information and history
2. Current medical findings
3. Diagnosis
4. Previous treatment (if applicable)
5. Planned treatment
6. Anticipated goals
7. The type, amount, frequency and duration of the services to be rendered

Speech evaluation

All eligible Medicaid members are allowed one speech evaluation per year.

Speech augmentative communication devices, voice prosthetics, and voice amplifiers

Information regarding specific codes can be found on the Coverage and Reimbursement Code Lookup.

Covered speech-language services for pregnant members

Medicaid policy allows:

1. Diagnostic treatment for purposes of evaluation in instances where definitive examinations and tests are not possible to administer because of the condition of the member.
2. Fifteen (15) annual visits.

3. Initiating treatment without delay, where an evaluation indicates the need for immediate service.

Non-covered speech-language services for pregnant members

The following services are not Medicaid benefits, including treatment for:

1. Social, education, or developmental needs.
2. Members who have stable, chronic conditions cannot benefit from communication services.
3. Members with no documented evidence of capability or measurable improvement.
4. Residents of an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) (included in the per diem resident rate).
5. Voice anomalies such as pitch, tone, quality, or rhythm, except when due to accident, illness, birth defect, or injury.
6. Non-diagnostic, non-therapeutic, routine, repetitive or reinforcing procedures, such as practicing word drills or using a communication board, such as a PECS, or picture board or other procedures that may be carried out effectively by the member, family, or care givers.

Limitations

Speech-language services are available for:

1. A diagnosis of cerebral vascular accident (CVA). Treatment must begin within 90 days of the incident.
2. A diagnosis of traumatic brain injury. Treatment must begin within 18 months of the injury.
3. Use of a speech generating device.
4. Treatment for swallowing dysfunction.

Speech therapy for cognitive purposes must be ordered by a physician and must include a plan of care. Speech therapy for cognitive disorders should typically begin after speech therapy for dysphagia and motor function speech issues have been addressed. Speech therapy for cognitive purposes is limited to 15 visits per 12-month period.

Speech therapy for the use of a speech generating device is limited to 8 visits per 12-month period.

Treatment for swallowing dysfunction and/or oral function is limited to 10 per 180-day period.

4-1.2 Audiology services

Audiology services include preventive, screening, evaluation, and diagnostic services.

Pregnant members

Audiology services include preventive care, screening, evaluation, diagnostic testing, hearing aid evaluation, and prescription for a hearing aid, ear mold services, fitting, orientation, and follow-up. A hearing aid battery provision is included in these services. Audiologic habilitation includes, but is not limited to speech, hearing, and gestural communication.

Medicaid reimburses two primary services and one subsequent service for Medicaid members: a diagnostic examination, an assessment for a hearing aid(s) and, when appropriate, a hearing aid or assistive listening device. Medicaid also reimburses repairs on hearing aids.

Examination and assessment

Diagnostic audiology evaluations require a written physician's order and include procedures which may be used for a hearing aid assessment and any other diagnostic tests appropriate for the specific diagnosis as ordered by the physician.

For specific code coverage refer to the Coverage and Reimbursement Code Lookup.

If a recommendation for a hearing aid assessment is made, a written physician's referral or request is required. If subsequent hearing testing shows a change in the hearing thresholds or the need for a new hearing aid, then

medical clearance must be obtained before proceeding with the hearing aid refitting.

The purpose of the physician's medical clearance is to determine if the change requires medical intervention; if not then a hearing aid assessment may be performed with a referral. The hearing aid assessment, to determine candidacy for amplification, must include the following: pure-tone air conduction and bone conduction thresholds; speech reception thresholds and speech discrimination scores for each ear; most comfortable loudness (MCLs) and uncomfortable loudness (UCLs); diagnosis as to the type of hearing loss for each ear (i.e. conductive, sensorineural, or mixed); and the pure-tone average (PTA) loss for 500 Hz, 1000 Hz, and 2000 Hz in each ear.

Hearing aids

Hearing aids require prior authorization (see 6-2 Hearing aids). The hearing aid may be provided by an audiologist or by a provider of hearing aid supplies. All services, including conformity evaluation and initial ear molds, are included in each rate to cover a period of 12 months.

Limitations

1. Hearing aids must be guaranteed by the manufacturer for a period of at least one year.
2. The initial ear mold, fitting of the hearing aid on the member, and necessary follow-up procedures (i.e. conformity evaluation, counseling, adjustments, testing batteries, etc.) are part of the global rate and will not be reimbursed separately. The global rate covers a period of 12 months.
3. If a follow-up examination results in a recommendation for a different model of hearing aid, the original aid must be exchanged for another aid within the 60 days allowed by retailers. No rental may be charged.
4. The provider must accept the return of a new hearing aid within 60 days if the physician or audiologist determines that the hearing aid does not meet specifications.

5. Services requested for members who reside in an ICF/ID facility are the responsibility of the facility under "active treatment" regulation. Exception: This does not include the provision of the hearing aid appliance which may be billed separately to Medicaid.
6. The physician's statement must be retained on file by the provider of the hearing aid for a period of 3 years.
7. Hearing aids may be replaced every 5 years when medically appropriate. Exceptions may be made for unusual circumstances, e.g., accident, surgery, or disease.

Assistive listening device

Assistive listening devices require prior authorization. The hearing loss criteria are the same as that for hearing aids. This device can be provided in lieu of a hearing aid for members who are not capable of adjusting to a hearing aid. If the member meets the hearing loss criteria, the audiologist shall look at various facts including the member's ability to care for hearing aids, whether the member will wear the hearing aid, whether the member desires a hearing aid, and what are the expected results, in order to determine whether a hearing aid or an assistive listening device would be the most appropriate item, to meet the hearing needs of the member.

4-1.3 Hearing aid replacement, repair, and rental replacement

Hearing aid replacement is authorized when medically necessary at an interval of 3 years for EPSDT-eligible beneficiaries. When requesting a replacement hearing aid, a new medical examination, referral letter, and audiology evaluation is required. Documentation showing the Manufacturer Suggested Retail Price (MSRP) must be submitted with the prior authorization request.

Repair

1. Hearing aid repairs and related services do not require prior authorization.
2. Repairs over $15 must be itemized. Medicaid will only reimburse the actual cost of the parts.

3. Medicaid reimburses using code V5014 for hearing aid repairs. If the repair is sent out of a vendor's facility for repair, the vendor will be reimbursed for the manufacturer's invoice plus an additional $15. When billing, attach a copy of the manufacturer's original invoice to the request. If the repair is completed by the vendor directly, the vendor will be reimbursed for the vendor's invoice which must include the cost for time and parts, plus an additional $15.
4. Hearing aid repairs are only available to EPSDT-eligible members and pregnant women.

Rental

Prior authorization is required for hearing aid rental. If a hearing aid must be sent away for repair Medicaid will pay for a rental hearing aid if a member requires a "loaner" hearing aid. This service is not to exceed 2 months.

5 Non-covered services and limitations

For further information and additional non-covered services and limitations refer to the Coverage and Reimbursement Code Lookup.

6 Prior authorization

For information regarding prior authorization, see Section I: General Information, Chapter 10, Prior authorization. Additional resources and information may be found on the Utah Medicaid Prior Authorization website.

For information on codes requiring prior authorization, manual review, or non-covered status, refer to the Coverage and Reimbursement Code Lookup.

6-1 Speech-language pathology

Some therapy sessions require prior authorization. Failure to obtain prior authorization can result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization before providing services. Exceptions may be made, with appropriate documentation, if the service provided is emergent or the member is retro-eligible for the dates of service requested.

A prior authorization request includes a Request for Prior Authorization form (PA request) and a plan of care for the member or a document outlining all of the following:

1. Diagnosis and severity of the condition
2. Prognosis for progress
3. Objectives of the specific treatment
4. Detail of the method(s) of treatment
5. Frequency and length of treatment sessions and duration of the program

A prior authorization will be given for a maximum of a 6-month treatment period.

6-1.1 Extended service requests

A new prior authorization request must be submitted for an extended service request. The request must include the same elements as the first PA request, as well as a:

1. New plan of treatment
2. Progress report on the previous treatment objectives
3. Medical evaluation from both the clinician and the physician
4. The evaluation includes supplemental data such as:
   a) Post-treatment progress made
   b) Family problems that may hinder progress
   c) Expected treatment termination date

6-2 Hearing aids

To receive prior authorization, all the following are required for pregnant members:

1. A physician's order stating the member has been medically cleared for hearing aid use. Retained in the member's file.
2. The results of a comprehensive audiometric exam performed by the audiologist to identify the kind of hearing loss (i.e. conductive loss, sensorineural loss, or mixed loss), speech testing to include the speech reception thresholds and speech discrimination scores, and the pure-tone average.
3. The kind of hearing loss, conductive loss, sensory-neuro loss, or mixed.
4. The type of hearing aid requested; monaural or binaural, and the respective code.

5. An audiogram or form that reports the hearing evaluation test or decibel loss will include for both right and left ears: Hearing thresholds at 250, 500, 1000, 2000, 4000 and 8000 Hz.
6. Final unaltered purchase invoice of the hearing aid(s) requested.

Additional information for pregnant members:

1. If the hearing test shows an average hearing loss in one ear of 35 dB or greater, based on the standard PTA (500, 1000, 2000 hertz) for that ear, a monaural aid may be authorized.
2. Binaural hearing aids are reimbursed only under one of two circumstances:
    a) Must be verified with an average hearing loss of 30 dBs based on the standard PTA for both ears.
    b) The member is blind, and a monaural hearing aid may be contraindicated.

Note: A binaural hearing aid is one unit for billing purposes.

7 Billing

Refer to Section I: General Information, Chapter 11, Billing Medicaid, for more information about billing instructions. For further information refer to the Coverage and Reimbursement Code Lookup.

8 Resource table

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

For information regarding:	
Administrative Rules	• Utah Administrative Code Table of Contents • Medicaid Policy for Experimental, Investigational or Unproven Medical Practices. R414-1A. • General Rule of the Division of Occupational and Professional Licensing. R156-1.

	• Global Definitions of Levels of Supervision. R156-1-102a. • Speech-Language Pathology and Audiology Licensing Act Rule. R 156-41. • Services Available. R414-1-6(q).
General information including: • Billing • Fee for service and managed care • Member eligibility • Prior authorization • Provider participation	• Section I: General Information • Claims • Managed Care: Accountable Care Organizations • Utah Medicaid Prior Authorization Administrative Rules • Eligibility Requirements. R414-302. • Medicaid General Provisions. R414-301. • Program Benefits and Date of Eligibility. R414-306. • Utah Medicaid Program. R414-1.
Information including: • Coverage and reimbursement resources • National correct coding initiative • Procedure codes with accompanying criteria and limitations	• Office of Coverage and Reimbursement Policy • Coverage and Reimbursement Code Lookup • The National Correct Coding Initiative in Medicaid
Information including policy and rule updates: • Medicaid Information Bulletins (Issued bimonthly) • Medicaid Provider Manuals • Utah State Bulletin (Issued on the 1st and 15th of each month)	• Utah Medicaid Official Publications • Utah State Bulletin
Medicaid forms including: • Hearing Request	• Utah Medicaid Forms

• PA Request	
Modifiers	• Section I: General Information
Patient (Member) Eligibility Lookup Tool	• Eligibility Lookup Tool
Pharmacy	• Drug Criteria Limits • Generic Prescriptions List • ICD-10 Reference Chart Pharmacy • Medicaid Pharmacy Program • OTC Drug List • Pharmacy Provider Manual • Medicaid Policy for Pharmacy Program. R414-60.
Primary Care Network plan services	• Primary Care Network (PCN) Provider Manual • Medicaid Primary Care Network Services. R414-100.
Prior authorization	• Prior Authorization Form • Utah Medicaid Prior Authorization
Provider portal access	• Provider Portal Access
Provider training	• Utah Medicaid Provider Training
Other	• Baby Your Baby • CDC Vaccines for Children Program. • Dental, Oral Maxillofacial, And Orthodontia Provider Manual • Hospice Provider Manual • Medicaid.gov • Podiatric Services Provider Manual • Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual • RHC-FQHC Provider Manual • Vision Care Services Provider Manual • Women, Infants and Children (WIC)
References including: • Social Security Act • Code of Federal Regulations • Utah Code	• 42 CFR 440.110(c) • 42 CFR 485.711(b) • Social Security Act 1905(a) • Social Security Act 1861 (r) • Utah Annotated Code Title 58

	• Utah State Statute Title 26
Tobacco cessation resources	• Utah Tobacco Quit Line (1-800-QUIT-NOW) • Way to Quit

Utah Medicaid Provider Manual

Targeted Case Management for Early Childhood

Division of Integrated Healthcare

Updated July 2023

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1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General information.

1-1 Targeted case management for early childhood

Targeted case management (TCM) services are available for Medicaid-eligible children birth through age 3, to assist members in accessing needed medical, social, educational, or other services and ensure that services are coordinated among all agencies and providers involved. Targeted case management regulations, as described in 42 CFR 440.169, require that case managers assist eligible members to obtain coordinated services by conducting a comprehensive assessment of needs, developing a care plan, providing referrals to services, and performing monitoring and follow-up activities.

2 Health plans

For more information about Accountable Care Organizations (ACOs), refer to Section I: General Information, Chapter 2, Health plans.

For more information about Prepaid Mental Health Plans (PMHPs), refer to Section I: General Information, Chapter 2-1.2, Prepaid mental health plans, and the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual.

A list of ACOs and PMHPs with which Medicaid has a contract to provide health care services is found on the Medicaid website Managed Care: Accountable Care Organizations.

3 Provider participation and requirements

Refer to Section I: General Information, Chapter 3, Provider participation and requirements.

3-1 Provider credentials

Medicaid providers of targeted case management services to EPSDT-eligible members ages 0 through 4 must meet additional criteria defined by the State Plan or as outlined in contractual agreements between the Department of Health and Human Services and contracted parties, such as local health departments.

4 Record keeping

Refer to Section I: General Information, Chapter 4, Record keeping.

4-1 Record keeping requirement for targeted case management

The case manager must maintain sufficient documentation for targeted case management services billed. Documentation should include the date of service, member name, name of provider agency and signature of provider, place of service, units of service, and a description of the case management activity. Follow-up targeted case management services must be documented in 15-minute intervals.

The following documents must be contained in each client's case file:

1. A written individualized needs assessment which documents the client's need for targeted case management services. An initial assessment should be documented in the initial assessment form, with plan for follow-up services.
2. A written individualized targeted case management service plan which identifies the services the client is to receive and who will provide them

5 Provider sanctions

Refer to Section I: General Information, Chapter 5, Provider sanctions.

6 Member eligibility

It is the responsibility of the provider to verify the member's eligibility prior to every rendered service. For additional information regarding member eligibility refer to Section I: General Information Chapter 6, Member eligibility.

Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member responsibilities

For information on member responsibilities, including establishing eligibility and co-payment requirements, refer to Section I: General Information, Chapter 7, Member responsibilities.

8 Programs and coverage

For additional information regarding services provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, see 42 CFR 441 Subpart B Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under 21. For information regarding case management services, see 42 CFR 440.169 Case Management Services. Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

8-1 Definitions

Case management services: means services that assist individuals eligible under the State Plan in gaining access to needed medical, social, educational, and other services.

Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT): means a federally mandated program that provides comprehensive and preventive health care services for children age birth through 20 years who are enrolled in Traditional Medicaid.

Early childhood: means Medicaid-eligible members ages 0 through 4.

Medical home: means an approach to providing comprehensive primary care that facilitates partnerships between patients, clinicians, medical staff, and families. A medical home may extend beyond a clinical practice to include specialty care, educational services, family support, and more.

Targeted case management services: means case management services furnished to defined target groups without regard to requirements related to statewide provision of services or comparability.

8-2 Target group

Targeted case management services are a covered benefit for Medicaid-eligible children ages birth to 4, for whom the service is determined to be medically necessary. Case management services begin when the family is contacted and accepts services. Services continue until the case manager determines they are no longer needed or until the family voluntarily terminates services. Services are considered medically necessary when a needs assessment is completed by a qualified case manager and criteria defined by State Plan Supplement to Attachment 3.1-A, Section E - Target Group and Supplement to Attachment 3.1-B, Section E - Target Group are met and documented.

The Utah Medicaid program provides coverage of targeted and home and community-based waiver services (HCBWS) case management for a variety of other target groups. There are separate rules and provider manuals to address the scope of services and reimbursement methods for the other target groups. Since a Medicaid client may qualify for targeted or waiver case management services under other target groups, it is imperative that before providing services, the case manager determine if other agencies are already providing targeted or waiver case management for the client, as only one targeted case management provider will be reimbursed for the same or overlapping dates of service. Coordination of all services is an essential component of targeted case management.

8-3 Additional participation requirements for case management providers

Refer to Chapter 3 Provider participation and requirements and Chapter 3-1 Provider credentials for general information regarding provider participation and credentialing.

Additional participation requirements for Medicaid providers of targeted case management services to EPSDT-eligible members may be found in State Plan Supplement to Attachment 3.1-A, Page 2, Section E and Supplement to Attachment 3.1-B, Page 2, Section E.

8-4 Coordination of targeted case management training curriculum with local health departments

Licensed providers or non-licensed individuals employed or contracted with agencies that specialize in providing case management services to children, such as local health departments, are subject to training requirements developed in coordination with the Department of Health and Human Services. Such training requirements may be outlined in contractual agreements between the Department and individual local health departments.

Non-licensed individuals who provide targeted case management services must complete a targeted case management course approved by the Division of Integrated Healthcare, which fulfills training curriculum requirements outlined in State Plan Supplement to Attachment 3.1-A, Page 2, Section E and Supplement to Attachment 3.1-B, Page 2, Section E.

8-5 Referrals

Case managers may utilize reports provided by the Division of Integrated Healthcare, which detail demographic information and recent claim history for eligible members in each county, to facilitate case management services.

Case management services may include referrals to community resources, focusing on linking the child with necessary medical, social, educational, and other resources

that address unmet needs. Local community resources, if available, are preferable to out-of-area providers. Referrals may be issued after an initial assessment.

8-6 Scope of service

The Code of Federal Regulations Title 42 Part 440.169 defines activities that case managers provide in assisting eligible individuals obtain coordinated services, which includes:

1. Performing a comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services, to include activities such as taking client history, completing documentation, and gathering information from other sources knowledgeable about the individual's needs.
2. Developing a care plan based on information collected through the assessment, which includes goals, and a course of action.
3. Referrals and related activities, such as scheduling appointments for the individual
4. Monitoring and follow-up activities to ensure the quality and appropriateness and determine whether adjustments in the care plan or service arrangements with providers are necessary.

The State Plan, under Supplement to Attachment 3.1-A, Attachment #4b, Page 2, Section H - Definition of Services and Supplement to Attachment 3.1-B, Page 1, Section H - Definition of Services identifies additional covered services under the targeted case management service benefit for Medicaid eligible children ages 0 – 4, which includes:

1. Assisting the member to establish and maintain eligibility for entitlements other than Medicaid.
2. Coordinating delivery of services for the member, including EPSDT screenings and follow-up.

Contractual agreements for targeted case management services between the Department of Health and Human Services and individual local health departments define additional service agreements, which may include visits to the home of the

child to facilitate case management activities, providing information to families about the establishing a “medical home” for the child, and/or maintaining communication with the child’s primary care provider.

9 Non-covered services and limitations

Certain services are non-covered by Medicaid because medical necessity, appropriateness, and cost-effectiveness cannot be readily determined or justified for medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

For more information on non-covered services and limitations, see Utah Administrative Code R414-1 - Utah Medicaid Program, and Section I: General Information, Chapter 9, Non-covered services and limitations.

9-1 Non-covered activities for targeted case management

Medicaid case management services do not include direct services, such as medical, educational, or social services to which a child has been referred. For example, if a child is linked to a Medical home, any services provided by the Medical home, such as a physical exam, would not be billed as part of case management activities. In accordance with federal Medicaid guidelines, the following activities are not considered targeted case management and should not be billed to Medicaid:

1. Documenting targeted case management services, except for time spent developing the written needs assessment, service plan, and progress notes.
2. Providing training or instruction to the child or others, unless the activity is specifically designed to assist the child, parent, or caretaker to independently obtain needed services for the child.
3. Directly assisting with personal care, activities of daily living, or providing routine services (including courier services).
4. Direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, or provision of a Medicaid-covered service. For example, providing medical and psycho-social evaluations, treatment, therapy, and counseling that are otherwise

billable to Medicaid under other categories of service, are not reimbursable as targeted case management.

5. Direct delivery of foster care services, including but not limited to research gathering and completion of documentation required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster care placements, serving legal papers, home investigations, providing transportation, administering foster care subsidies or making foster care placement arrangements.
6. Traveling to the child's home or other location where a covered case management activity will occur, or time spent transporting a child or a child's family members.
7. Providing services for or on behalf of other family members who do not directly assist the child to access needed services. For example, counseling the child's sibling or helping the child's parent obtain a mental health service are not reimbursable.
8. Recruitment activities in which the agency or case manager attempts to contact potential recipients of case management services.

9-2 Limitations on reimbursable services

9-2.1 Team case management

Targeted case management services provided to an eligible member by more than one case manager employed by or contracted with the same agency or program is reimbursable only when all the following conditions are met:

1. All members of the team meet the qualifications described in Chapter 3 Provider participation requirements and Chapter 8.3 Additional participation requirements for case management providers.
2. Documentation of billed services is maintained in a single case file.
3. All services are delivered under a single case management service plan.
4. Team members coordinate with one another to ensure only necessary, appropriate, and unduplicated services are delivered by the case management team.
5. Time spent by two or more members of the team on the same targeted case management activity may be billed only by one team case manager.

6. The family understands the roles of individual team members.

9-2.2 Shared case management

Targeted case management services billed by case managers from more than one agency or program during the same or overlapping dates of service for the same child will be considered for reimbursement only if the Division has received documentation to support the need for the expertise of two case management providers. A letter signed by the case managers of both agencies must be submitted to the Division, which must (1) fully explain the need for shared case management, (2) document the specific and non-duplicative services to be provided by each case manager, (3) specify the time period during which shared case management will be required, and (4) include a copy of the needs assessments and service plans from both case managers and a written statement from the Local Interagency Council (LIC) or the Local Interagency Coordinating Council (LICC) if a council has reviewed the child's need for shared case management services.

If approved by the Division, case managers sharing case management responsibilities for a child may bill for their participation in LIC/LICC meetings for the time during which the child's needs are addressed.

NOTE: The Home and Community-Based Services program must ensure that State Plan benefits are utilized before targeted case management services can be billed by waiver case managers.

Payment cannot be made for targeted case management services for which another payer is liable, nor for services for which no payment liability is incurred. Medicaid reimbursement is not available for services provided free of charge to non-Medicaid recipients, except as permitted for the State’s Title V, Maternal and Child Health program under Section 1902 (a)(11)(B) of the Social Security Act.

10 Prior authorization

For Medicaid medical or surgical services requiring prior authorization, the physician must obtain approval from Medicaid before service is rendered to the patient. For information regarding prior authorization, see Section I: General Information, Chapter 10, Prior authorization. Additional resources and information can be found on the Utah Medicaid Prior Authorization website.

For information on codes requiring prior authorization, manual review, or non-covered status, refer to the Coverage and Reimbursement Code Lookup.

10-1 Retroactive authorization

There are limited circumstances in which a provider may request authorization after service is rendered. These limitations are described in Section I: General Information, Chapter 10-3 Retroactive authorization.

11 Billing Medicaid

Refer to Section I: General Information, Chapter 11, Billing Medicaid, for general information about billing instructions.

The agency may bill Medicaid for targeted case management services if the following criteria are met:

1. The activities are delineated in the member's case management service plan, and
2. The time spent in the activity involves a face-to-face encounter, telephone or written communication with the child, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring the child obtains the necessary services documented in the targeted case management service plan.

Service payment determination for targeted case management services are described in State Plan Attachment 4.19-B Page 29B Payment for Targeted Case Management Services for EPSDT Eligibles, and additional payment arrangements are

described in contractual agreements between the Department of Health and Human Services and individual contracted agencies.

Targeted case management services, when coded according to guidelines described in Chapter 12 Coding, is considered a carved-out service. A Medicaid member's ACO is not responsible for payment of these services; services should be billed directly to the state.

12 Coding

Refer to the Section I Provider Manual, Chapter 12 Coding, for information about coding, including diagnosis, procedure, and revenue codes.

For coverage and reimbursement information for specific procedure codes, see the Coverage and Reimbursement Code Lookup. Generally, the fees represented on the Coverage and Reimbursement Code Lookup are only for fee for service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.).

12-1 Targeted case management codes

Providers of targeted case management for Medicaid eligible children ages 0-4 should use the following codes when reporting case management services:

CODES	DESCRIPTION	AGE	LIMITS
T1023	Program intake assessment, per encounter	0 - 4 years	1
T1017	Targeted case management, each 15 minutes	0 - 4 years	99

Utah Medicaid Provider Manual

Targeted Case Management for Individuals with Serious Mental Illness

Division of Integrated Healthcare

Updated September 2024

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1. General policy

Targeted case management is a service that assists Medicaid members in the target group to gain access to needed medical, social, educational, and other services. The overall goal of the service is not only to help Medicaid members access needed services, but to ensure that services are coordinated among all agencies and providers involved.

1-1 Authority

The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272, COBRA) added targeted case management to the list of optional services which can be provided under the State Medical Plan.

1-2 Target group

1. This target group is comprised of Medicaid members with serious mental illness and includes adults with serious mental illness and children with serious emotional disorders, and individuals with substance use disorders (including their Medicaid-eligible children who are at risk for the development of a substance use disorder).

2. Currently, Utah Medicaid also covers targeted case management to the following target groups or case management through the following home and community-based (HCBS) waivers:

   <u>Targeted case management target groups</u>
   Early childhood (Ages 0-4)
   Pregnant members

   <u>HCBS waivers (providing case management services)</u>
   1. Physical disabilities waiver
   2. Community supports waiver for individuals with intellectual disabilities or other related conditions
   3. New choices waiver (for individuals who are deinstitutionalized)
   4. Waiver for individuals aged 65 or older
   5. Waiver for technology-dependent children

6. Acquired brain injury waiver
7. Medically complex children's waiver
8. Community transitions waiver
9. Limited supports waiver

There are separate rules and provider manuals to address the scope of services and reimbursement methods for the other case management groups. Since a Medicaid member may qualify for targeted or waiver case management services under other case management groups, it is imperative that before providing targeted case management services under this targeted case management program, the case manager determine if other agencies are already providing targeted or waiver case management for the client to ensure there is no duplication of case management activities.

1-3 Definitions

Centers for Medicare and Medicaid Services (CMS) means the agency within the federal Department of Health and Human Services that administers the Medicare and Medicaid programs and works with states to administer the Medicaid program.

DHHS means the Utah Department of Health and Human Services.

Division of Integrated Healthcare (DIH) means the organizational unit in DHHS that administers the Medicaid program in Utah. Before July 1, 2022, this was the Division of Medicaid and Health Financing in the Utah Department of Health. Beginning July 1, 2022, this is the Division of Integrated Healthcare in DHHS.

Division of Occupational and Professional Licensing (DOPL) means the division within the Utah State Department of Commerce responsible for occupational and professional licensing.

Healthy Outcomes Medical Excellence Program (HOME), means the program operated by the University of Utah, means a voluntary managed care program for Medicaid members who have a developmental disability and mental health or behavioral challenges. HOME is a coordinated care program that provides to its

enrollees, medical services, mental health/substance use disorder services and targeted case management services. When Medicaid members enroll in HOME, they are removed from their PMHP and physical health plan enrollment, if enrolled.

Health plan means a federally defined plan under contract with DHHS to provide specified physical health care services to Medicaid members enrolled in the plan.

Institution for Mental Diseases (IMD) means, pursuant to 42 CFR §435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

Prepaid Mental Health Plan (PMHP) means the mental health and substance use disorder managed care plan operating under the authority of the Department of Health and Human Service's 1915(b) waiver.

SUMH means the Office of Substance Use and Mental Health in the Division of Integrated Healthcare**.**

1-4 Qualified targeted case management providers

1. Qualified providers of targeted case management services are:

    a) Licensed social service worker under supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 who is qualified to provide supervision;

    b) Individual who has obtained a qualifying bachelor's degree and is actively engaged in meeting DOPL requirements to obtain license as a social service worker in accordance with state law, and is under supervision of a licensed mental health therapist identified in C. 1 below who is qualified to provide supervision;

c) Licensed advanced substance use disorder counselor (ASUDC) or licensed substance use disorder counselor (SUDC) under the general supervision of a licensed mental health therapist identified in C.1 of this Chapter;

d) Licensed certified advanced substance use disorder counselor (CASUDC) or licensed certified advanced substance use disorder counselor intern (CASUDC-I) under direct supervision of a licensed mental health therapist identified in C.1 of this Chapter, or a licensed ASUDC who are qualified to provide supervision;

e) Licensed certified substance use disorder counselor (CSUDC) or licensed certified substance use disorder counselor intern (CSUDC-I) under direct supervision of a licensed mental health therapist identified in C.1 of this Chapter, a licensed ASUDC or a licensed SUDC who are qualified to provide supervision;

f) Licensed registered nurse;

g) Licensed practical nurse under the supervision of a licensed registered nurse or a licensed mental health therapist identified in C. 1 of this Chapter;

h) Individual who is not licensed who is at least 18 years old and under the supervision of an individual identified in C.1., C.2., or C.3.b. of this Chapter, a licensed social service worker or a licensed registered nurse; or a licensed ASUDC or licensed SUDC when targeted case management services are provided to individuals with a substance use disorder.

   Non-licensed individuals must complete the training curriculum and certification requirements specified in Chapter 1-5;

i) Registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL to the extent the activities are supervised by qualified faculty, staff, or designee and the activities are a defined part of the training program;

j) Individual enrolled in a qualified substance use disorder counselor education program, exempted from licensure in accordance with Section 58-1-307 of the Utah Code and under DOPL-required supervision; or

k) Behavioral health coach.

2. In addition to the primary service providers specified in B. above, individuals in C.1., C.2., and C.3., below, may also provide this service:

   a) Licensed mental health therapist practicing within the scope of practice defined in the individual's respective licensing act and licensed under Title 58-60, Mental Health Professional Practice Act, as:

      i. Physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;

      ii. Advanced practice registered nurse (APRN), specializing in psychiatric mental health nursing;

      iii. APRN intern specializing in psychiatric mental health nursing;

      iv. Psychologist qualified to engage in the practice of mental health therapy;

      v. Certified psychology resident qualifying to engage in the practice of mental health therapy under the supervision of a licensed psychologist;

      vi. Physician assistant specializing in mental health care in accordance with Section 58- 70a- 501 of the Utah Code;

      vii. Clinical social worker;

      viii. Certified social worker or certified social worker intern;

      ix. Marriage and family therapist;

x. Associate marriage and family therapist;

xi. Clinical mental health counselor;

xii. Associate clinical mental health counselor;

xiii. Master addiction counselor; or

xiv. Associate master addiction counselor.

b) An individual working within the scope of their license in accordance with Title 58 of the Utah Code:

i. Licensed physician and surgeon or osteopathic physician regardless of specialty;

ii. Licensed APRN regardless of specialty working within the scope of the Nurse Practice Act and competency;

iii. Licensed APRN intern regardless of specialty working within the scope of the Nurse Practice Act and competency; or

iv. Other medical practitioner licensed under state law, most commonly licensed physician assistants regardless of specialty when practicing within the physician assistant's skills and scope of competence.

c) An individual exempted from licensure as a mental health therapist:

i. In accordance with Section 58-1-307 of the Utah Code, a student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL to the extent the activities are supervised by qualified faculty, staff, or designee and the activities are a defined part of the training program; or

ii. In accordance with Subsection 58-61-307(2)(h) of the Utah Code, an individual who was employed as a psychologist by a state, county or municipal agency or other political subdivision of the state prior to July 1, 1981, and who subsequently has maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of his official duties for that agency or political subdivision.

Supervision (when applicable) of individuals above must be provided in accordance with requirements set forth in Title 58 of the Utah Code, and the applicable profession's practice act rule as set forth by the Utah Department of Commerce and found at the Department of Administrative Services, Division of Administrative Rules, at: https://rules.utah.gov/publications/utah-adm-code.

In addition, all individuals providing targeted case management services must know Medicaid regulations pertaining to targeted case management as described in this provider manual.

1-5 Targeted case management training curriculum

1. To meet the SUMH's training standards and become certified to provide targeted case management services, all non-licensed individuals will be required to:
    a) Successfully complete the SUMH's training curriculum and pass a written examination which tests basic knowledge, attitudes, ethics, and skills related to the provision of targeted case management services; and

    b) Successfully complete the SUMH's targeted case management practicum requirement.

2. To continue to be a qualified provider of targeted case management services, the individual must successfully complete the SUMH's recertification requirements.

1-6 Client rights

1. Targeted case management services cannot be used to restrict the client's access to other services available under the Utah Medicaid State Plan.

2. The client (or the client's guardian if applicable) must voluntarily choose targeted case management services and be given a choice in the selection of their targeted case manager. Clients can also choose to discontinue targeted case management services at any time.

3. The case manager will not condition receipt of targeted case management services on the receipt of other Medicaid-covered services, or condition receipt of other Medicaid-covered services on receipt of targeted case management services.

4. Targeted case management clients will have free choice of any qualified Medicaid providers of other medical care unless restricted due to enrollment in a Health Plan, the PMHP, or a program providing services authorized under 1915(a) of the Social Security Act (i.e., HOME).

1-7 Substance use disorder (SUD) treatment in licensed SUD residential treatment programs (ASAM levels 3.1, 3.3, 3.5, 3.7) and mental health treatment in licensed mental health residential treatment programs

When SUD residential treatment programs and mental health residential treatment programs are reimbursed on a per diem bundled payment basis in accordance with Chapter 2-13, Substance use disorder (SUD) treatment in licensed SUD residential treatment programs (ASAM levels 3.1, 3.3, 3.5, 3.7), and Chapter 2-17, Mental health treatment in licensed mental health residential treatment programs, of the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services, targeted case management services are included in the per diem bundled payment and cannot be reported separately.

2. Scope of service

2-1 Covered services/activities

1. Targeted case management is a service that assists Medicaid members in the target group to gain access to needed medical, social, educational, and other services. The overall goal of the service is not only to help Medicaid members to access needed services, but to ensure that services are coordinated among all agencies and providers involved.

   Individuals who are employed by or contracted with an entity specified in Chapter 1-5, A. solely or as part of their duties to provide targeted case management services, may assist clients to gain access to needed medical services, including rehabilitative mental health/substance use disorder services provided by that entity.

   The entity's providers (e.g., physicians, mental health therapists, nurses, etc.) who provide rehabilitative mental health/substance use disorder services to clients in accordance with Chapter 2 of the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services or other medical services, may not report day-to-day discussions with other internal treatment providers regarding coordination of their respective services as targeted case management. These discussions are considered an integral part of the entity's services delivery. (See Chapter 2-2, N. below.)

2. Medicaid reimbursement for targeted case management is dictated by the nature of the activity and the purpose for which the activity was performed. When reported in amounts that are reasonable (given the needs and condition of the particular client), the following activities/services are covered by Medicaid under targeted case management:
   a) Assessing the client to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Assessment activities include taking client history, identifying the needs of the client and completing related documentation, gathering information from other sources such

as family members, medical providers, social workers, other providers, and educators, if necessary, to form a complete assessment of the client;

b) Developing a written, individualized, and coordinated case management service plan based on the information collected through an assessment that specifies the goals and actions to address the medical, social, educational, and other services needed by the client, with input from the client, the client's authorized health care decision maker, and others (e.g., the client's family, other agencies, etc.) knowledgeable about the client's needs, to develop goals and identify a course of action to respond to the assessed needs of the client;

c) Referral and related activities to help the client obtain needed services, including activities that help link the client with medical (including mental health and substance use disorder), social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers of needed services and scheduling appointments for the client;

d) Assisting the client to establish and maintain eligibility for entitlements;

e) Coordinating the delivery of services to the client, including EPSDT well-child health exams and follow-up (see the Utah Medicaid Provider Manual for EPSDT Services);

f) Contacting non-eligible or non-targeted individuals when the purpose of the contact is directly related to the management of the client's care. For example, family members may be able to help identify needs and supports, assist the client to obtain services, provide case managers with useful feedback and alert them to changes in the client's status or needs;

g) Instructing the client or caretaker, as appropriate, in independently accessing needed services;

h) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the targeted case management service plan

is effectively implemented and adequately addressing the needs of the client, which activities may be with the client, family members, providers or other entities, and conducted as frequently as necessary to help determine such matters as whether services are being furnished in accordance with the client's case management service plan, whether the services in the case management service plan are adequate, whether there are changes in the needs or status of the client, and if so, making necessary adjustments in the case management service plan and service arrangements with providers; and

i) Monitoring the client's progress and continued need for targeted case management and other services.

3. Covered targeted case management services provided to Medicaid members transitioning to a community setting will be made available for up to 30 consecutive days of a covered stay in a medical institution.

2-2 Non-covered services/activities

In accordance with CMS guidelines, the following services and activities are not considered targeted case management and may not be reported as targeted case management services:

1. Documenting targeted case management services - with the exception of the time spent developing the written needs assessment, service plan, and 180-day service plan review - is not reimbursable as targeted case management. (See Chapter 3-2, Required documentation.)

2. Teaching, tutoring, training, instructing, or educating the client or others, except in so far as the activity is specifically designed to assist the client, parent, or caretaker to independently obtain needed services for the client.

   For example, assisting the client to complete a homework assignment, creating chore or behavioral charts and other similar materials for clients or families, or instructing a client or family member on nutrition, budgeting, cooking, parenting

skills or other skills development is not reimbursable as targeted case management;

3. Directly assisting with personal care or activities of daily living (bathing, hair or skin care, eating, etc.) or instrumental activities of daily living (assisting with budgeting, cooking, shopping, laundry, home repairs, apartment hunting, moving residences, or acting as a protective payee) are not reimbursable activities under targeted case management;

4. Performing routine services including courier services. For example, running errands or picking up and delivering food stamps or entitlement checks are not reimbursable as targeted case management;

5. Direct delivery of an underlying medical, educational, social or other service to which the client has been referred, or provision of a Medicaid-covered service. For example, providing medical and psycho-social evaluations, treatment, therapy and counseling that are otherwise reportable under other categories of service (e.g., services described in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services), are not reimbursable as targeted case management;

6. Direct delivery of foster care services, including but not limited to research gathering and completion of documentation required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster care placements, serving legal papers, home investigations, providing transportation, administering foster care subsidies or making foster care placement arrangements.

   Children in state custody (foster care) have DHHS case workers. When DHHS case workers refer a child to a local mental health and/or substance abuse authority/PMHP or to the local authority's designated mental health and substance use disorder services provider/PMHP, the purpose is for the provision of rehabilitative services outlined in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.

Therefore, there should be few circumstances where the local mental health and/or substance abuse authority/PMHP or the local authority's designated mental health and substance use disorder services provider/PMHP would also provide targeted case management services to a child in state custody.

If the local mental health and/or substance abuse authority/PMHP or the local authority's designated mental health and substance use disorder services provider/PMHP determines there is a case management need, this should be communicated to the child's DHHS case manager. If the DHHS case manager agrees that the treatment provider also should provide some of the targeted case management services the child requires, and the services will not constitute the direct delivery of foster care services as specified in the first paragraph of this subsection F, then the entity may do so. This agreement must be clearly documented in the child's targeted case management record;

7. Time spent traveling to the client's home or other location where a covered case management activity will occur is not reimbursable, nor is time spent transporting a client or a client's family members;

8. Providing services for or on behalf of other family members that do not directly assist the client to access needed services. For example, counseling the client's sibling or helping the client's parent obtain a mental health service are not reimbursable as targeted case management;

9. Recruitment activities in which the center or case manager attempts to contact potential members of service are not reimbursable as targeted case management;

10. Time spent assisting client to gather evidence for a hearing with DIH or participating in a hearing as a witness is not reimbursable as targeted case management;

11. Time spent coordinating between case management team members for a client is a non-reportable activity;

12. When there is a failed face-to-face or telephone contact, time spent leaving a note or message noting the failed attempt is not reimbursable as targeted case management; and

13. In accordance with Chapter 2-1, A., time spent by two or more treatment providers of an entity specified in Chapter 1-5, A., arranging or coordinating their treatment services, and indirect activities of the entity (i.e., supervision of treatment providers, and interdisciplinary team conferences for the development of rehabilitative treatment plans) may not be reported as targeted case management activities.

2-3 Limitations on reimbursable services

1. The agency may report the covered services and activities specified in Chapter 2-1, B. only if:
    a) The services and activities are identified in the targeted case management service plan;
    b) The time spent in the service or activity involves a face-to-face encounter, telephone or written communication with the client, family, caretaker, service provider, or other individual with a direct involvement in providing or assuring the client obtains the necessary services documented in the targeted case management service plan;
    c) There are no other third parties liable to pay for such services, including reimbursement under a medical, social, education, or other program;
    d) Activities are not an integral and inseparable component of another covered Medicaid service; and
    e) Activities do not constitute the direct delivery of underlying medical, education, social, or other services to which an eligible individual has been referred including foster care programs.

2. The agency may not report the covered services and activities specified in Chapter 2-1 if no payment liability is incurred. Reimbursement is not available for services provided free-of-charge to non-Medicaid members.

3. Payment for targeted case management services may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

4. Team case management
   Targeted case management services provided to a client by more than one targeted case manager employed by or under contract with the same entity are reimbursable only under the following conditions:

   a) All targeted case managers on the team meet the qualifications described in Chapter 1-5;

   b) All targeted case managers on the team coordinate with one another to ensure only necessary, appropriate, and unduplicated case management services are delivered by all team members;

   c) Time spent by two or more targeted case managers on the team in the same targeted case management activity may be reported by one case manager team member only; and

   d) The client is informed of and understands the roles of the team members.

3. Record keeping

3-1 General requirements

The case management record must be maintained on file in accordance with any federal or state law or state administrative rules, and made available for state or federal review, upon request.

3-2 Required documentation

The following documents must be contained in each client's case file:

1. A written individualized needs assessment which documents the client's need for targeted case management services;

2. A written, individualized targeted case management service plan that identifies the services (i.e., medical, social educational, and other services) the client is to receive, who will provide them, and a general description of the targeted case management activities needed to help the client obtain or maintain these services; and

3. A written review of the service plan, at a minimum every 180-days, summarizing the client's progress toward targeted case management service plan objectives. The service plan review must be completed within the month due, or more frequently as required by the client's condition. If changes are required in the written service plan, a revised service plan must also be developed.

The case manager must develop and maintain sufficient written documentation for each unit of targeted case management services reported.

Record:
For each date of service, documentation must include:

1. Date, start and stop time and duration of each service;

2. Setting in which the service was rendered (when via telehealth, the provider setting and notation that the service was provided via telehealth);

3. At the end of the day, total number of minutes of targeted case management services based on the rules specified in the 'Unit' section below;

4. At a minimum, one note summarizing all of the targeted case management activities performed during the day, or a separate note summarizing each targeted case management activity. Notes must document how the activities relate to the targeted case management service plan and be sufficient to support the number of units reported; and

5. Signature and licensure or credentials of the individual who rendered the targeted case management service(s).

Unit:

T1017 - Targeted Case Management for Clients with Mental Health Disorders - per 15 minutes

H0006 - Targeted Case Management for Clients with Substance Use Disorders - per 15 minutes

1. When reporting these procedure codes, follow the rules specified below for converting the total duration of targeted case management services provided in a day to the specified unit.
2. The number of 15-minute units of service reported cannot exceed four units in an hour and cannot exceed total billings in a day, the number of hours the case manager worked (e.g., 8-hour workday).
3. If the total duration of targeted case management activities provided in a day total less than 15 minutes, then there must be a minimum of 8 minutes in order to reported one 15-minute unit.
4. If the total duration of targeted case management activities provided in a day are in excess of 60 minutes, divide the total number by 15 to determine the number of 15-minute units that can be reported. If there are minutes left over, apply the following rules:

   1-7 minutes equal 0 units; and
   8-15 minutes equals one 15-minute unit.

   For example, the targeted case manager performed five separate targeted case management activities for the client during the day for a total duration of 70 minutes. If divided by 15 this would result in 5 units of service.

5. A range of dates should not be reported on a single line of a claim (e.g., listing on the claim the 1st through the 30th or 31st as the service date). Each date of service should be reported on a separate line of the claim.

4. Procedure codes for targeted case management for the seriously mentally ill

For each date of service, enter the appropriate 5-digit procedure code as indicated below:

<table>
<tr><th>Procedure Code</th><th>Service and units</th><th>Limits per patient</th></tr>
<tr><td>T1017</td><td>Targeted Case Management – mental health - per 15 minutes</td><td rowspan="2">Available for up to 30 consecutive days of a covered stay in a medical institution</td></tr>
<tr><td>H0006</td><td>Targeted Case Management – alcohol and/or drug services; case management - per 15 minutes</td></tr>
</table>

Utah Medicaid Provider Manual

Medical Transportation Services

Division of Integrated Healthcare

Updated January 2024

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1 Non-emergency medical transportation services

Non-emergency medical transportation (NEMT) is only available to traditional Medicaid members for medically necessary appointments. NEMT is provided through the below sources.

1-1 Personal transportation

The member has access to a working, licensed personal vehicle that can be used for transportation to and from covered medical services. The member must contact their DWS eligibility worker for authorization and reimbursement of covered Medicaid services.

1-2 Utah Transit Authority (UTA)

Utah Transit Authority (UTA) services, including fixed bus routes, rapid transit, streetcar routes, TRAX, and Paratransit, may be available for members living in UTA service areas.

1-2.1 UTA Transit Card

Members qualify for a UTA Transit Card, allowing them to utilize UTA fixed bus routes, rapid transit, streetcar routes, and TRAX for NEMT if they:

1. Do not have regular access to a working, personal vehicle;
2. Are not currently residing in a long-term care facility; and
3. Live within UTA service areas.

Children (under the age of 19) also qualify for a UTA Transit Card when they are enrolled in Medicaid. Parents/guardians that assist eligible children 17 years old and younger will also be eligible for a card. Members who require assistance during transportation for medical reasons are eligible for an attendant to travel with them. They will have this designated on their UTA Transit card with the words "Attendant: Yes."

NOTE: Children five years old and younger do not need a Medicaid Transit Card to utilize UTA services. The exception is those who are disabled and require an attendant. Those children will need a UTA Transit Card to identify attendants that may not be parents/guardians.

To request a UTA Transit Card, members can go to their MyBenefits account https://mybenefits.utah.gov/ and follow the UTA Transit Card request instructions. If members do not have a MyBenefits account, they will need to contact a Health Program Representative (HPR) at 1-844-238-3091 and request a card. UTA Transit Cards will be mailed out Monday-Friday, excluding holidays. Cards requested on weekends will not be processed until the next business day.

1-2.2 Paratransit

Paratransit bus services are available for members who have a functional inability to use the regular UTA bus service, need curb-to-curb service, and live in Box Elder, Salt Lake, Weber, Davies, Tooele, or Utah counties. A member must complete a UTA evaluation to be deemed eligible to use their Paratransit service. To schedule an appointment at the UTA Mobility Center to determine functional inability to use buses and TRAX, members should call 801-287-7433 in Salt Lake and Davis Counties; Box Elder, Weber, Davis, and Toole counties call 877-882-7272.

Once a member has qualified for Paratransit services, they will need to call the Medicaid Operations Office at 801-538-6155 or 1-800-662-9651 to request monthly stickers.

1-3 Cedar Area Transportation Services (CATS)

Cedar Area Transportation Services (CATS) are available to members within that service area. These services include fixed bus routes and Dial-A-Ride. Members will need to provide their current Medicaid member ID to gain access to both of these services. Dial-A-Ride is available for those members who cannot use the CATS fixed bus routes, and these members must fill out an application found on the CATS website. To schedule a ride with Dial-A-Ride, members should call:

Weekdays, 7am-6pm (M-F): 435-865-4510
Saturday, 10am-5:15pm: 435-592-9117

1-4 Modivcare

Modivcare is the statewide NEMT broker meaning Modivcare contracts with local transportation entities to provide NEMT services.

Medicaid covers NEMT services through Modivcare for members who, through a primary care provider's statement, do not have regular access to a private vehicle or live outside of UTA/CATS service areas. Members may receive Modivcare services for up to four weeks while awaiting a primary care provider's statement. The contractor may use the most reasonable and economical mode of transportation available and appropriate to the member's medical condition that is safe and according to state and federal laws.

General Modivcare services are available from 7:30 am to 5:30 pm, Monday-Friday. Transportation for urgent care needs is available to free-standing urgent care facilities, doctor's offices, or after-hours clinics from 7:00 am to 11:00 pm every day of the week. Limited services are available on Saturdays and holidays for members requiring dialysis services.

Requests for Modivcare must be made three business days before the transportation is needed, however Modivcare cannot schedule appointments for members before approval from a DWS eligibility worker. Members should not schedule the transportation several days in advance if they are unsure they will be going to the appointment. Urgent scheduling can be done in less than three business days, but a primary care provider's note may be required.

Day of medical appointment:	**Schedule with Modivcare no later than the prior:**
Monday	Wednesday
Tuesday	Thursday
Wednesday	Friday
Thursday	Monday
Friday	Tuesday
Saturday*	Wednesday
*Saturday and holiday scheduled appointments are limited to accommodate members needing dialysis or have a condition that requires routine care.	

Members can schedule rides with Modivcare by phone at 1-855-563-4403 or through their website at https://www.mymodivcare.com/.

When requesting a ride, a member must provide the following:

1. Member's name, birth date, and Medicaid ID
2. Address and phone number of the place where a pickup will occur
3. Name, address, and phone number of the Medicaid provider being seen
4. Date and time of the appointment and general reason for the appointment

If a member is not prepared with the required information, Modivcare may not schedule the ride. The member may be asked to call back Modivcare with the required missing information. At the end of the call, Modivcare will give a confirmation number for the ride and tell the member when the ride will pick them up.

In certain circumstances, Modivcare may deny a member service. In this instance, Modivcare will tell a member they have been denied during the phone call for a request for a ride. If services are denied, Modivcare sends a notice within five business days. The denial states the reason for the denial of services and will include a form explaining how to file a grievance or appeal. The member has 30 days from the postmark to file a written appeal.

Grievances may be filed directly with Modivcare at 1-855-563-4404 or on their website at https://wecare.logisticare.com/.

Please note that members may travel with a service animal or authorized attendant with advanced notice. No family member, other than a parent or guardian, may accompany a minor child.

1-5 American Indians

American Indians residing in their tribal service area are provided NEMT through their respective Tribal NEMT Grants for the Navajo, Confederated Tribes of Goshutes, and Paiute Indian Tribe of Central Utah.

1-6 General pathway for securing non-emergency transportation services

The available options for NEMT services are based on the member's needs and include UTA, Paratransit, Modivcare, ambulance, and payment for personal car mileage. To maintain cost effectiveness while providing necessary services to Traditional Medicaid members, utilization is based on where the member lives and what services are available.

Note: A Medicaid member needs to discuss their medical transportation needs with a DWS eligibility worker as they can assist the member in finding the most effective way to get to/from appointments.

Hierarchy of NEMT:

1. Members who live within UTA or Cedar Area Transportation Services (CATS) boundaries should utilize "fixed bus route" services or UTA's TRAX light rail for NEMT. "Fixed bus route" refers to buses that operate on a predetermined route according to a predetermined schedule.
    a) UTA and CATS buses can only support members with an aggregate weight (member and wheelchair combined) of 800 lbs.
2. If a member cannot use the UTA/CATS fixed bus services or TRAX and they live within the established boundaries, they can apply for UTA Paratransit transportation or the CATS Dial-A-Ride service
    a) UTA Paratransit Services
        i. Members must complete the application process and be certified as eligible before scheduling any Paratransit rides
        ii. UTA's base level of Paratransit service is Curb-to-Curb service
            - For Curb-to-Curb service, members are responsible for getting to and from the curb at the pickup and drop-off locations by themselves
        iii. Beyond-the-Curb service is available as a reasonable modification for customers who, without such assistance, are unable to access Paratransit service
            - Assistance is available from the vehicle to the first exterior door at the rider's pick up or drop off location

- Be aware that UTA may determine that this type of service may not always be feasible or safe to provide
- Requests should be made ahead of time to allow UTA to assess any safety risks that would prevent its drivers from providing beyond-the-curb service
- The driver may grant requests on a case-by-case basis

iv. Paratransit service vehicles can only support members with an aggregate weight (member and wheelchair combined) of 800 lbs.

b) CATS Dial-A-Ride

i. Services are available by appointment only and require a 24-hour minimum notice

ii. Curb-to-Curb service is available

iii. Service vehicles can only support members with an aggregate weight (member and wheelchair combined) of 800 lbs.

3. Members who live outside the boundaries of the UTA/CATS service areas or who are unable to use the previously mentioned services for medical reasons can utilize the contracted NEMT broker, Modivcare, for transportation services

   a) Modivcare

   i. Vehicles can only support members with an aggregate weight (member and wheelchair combined) of 600lbs.

4. If the member exceeds the weight limits and cannot obtain or use a manual wheelchair, then NEMT ambulance services are available for their use

   a) Members may obtain a manual wheelchair for transportation purposes. Please refer to Section II: Medical Supplies and Durable Medical Equipment, Chapter 8-14, Wheelchairs, for more information.

5. Members may receive round-trip mileage reimbursement when using personal transportation for medical appointments. Please refer to the Medicaid Eligibility Policy Manual for more information.

2 Provider participation and requirements

Refer to Section I: General Information, Chapter 3, Provider participation and requirements.

3 Member eligibility

Refer to Section I: General Information, Chapter 6, Member eligibility, for information about how to verify a member's eligibility, third party liability, ancillary providers, and member identity protection requirements.

4 Transportation to the nearest provider

All NEMT must be to the nearest appropriate Medicaid provider or facility that can provide the service.

5 Cost-effective transportation

Medicaid will authorize the most cost-effective transportation. Medicaid retains the right to determine the most appropriate means of transportation based on the information provided.

6 Resident of nursing facility

Medicaid covers emergency transportation for a nursing facility resident (nursing home). However, the facility must provide non-emergency or routine transportation.

7 Hospital to hospital transfers

Transfers between hospitals for Medicaid-eligible members must be medically necessary.

8 Coverage and reimbursement

For coverage and reimbursement information for specific procedure codes, see the Coverage and Reimbursement Code Lookup.

9 Billing Medicaid

Refer to Section I: General Information, Chapter 11, Billing Medicaid, for more information about billing instructions.

10 Non-emergency transportation procedure code modifiers

All claims billed to Medicaid for NEMT must have a two-letter modifier. The modifier may be any combination of the single letter codes listed below, with the first indicating the origin of transportation and the second letter indicating transportation destination.

Code	Location
D	Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential, domiciliary, custodial facility
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of an accident or acute event
X	(Destination code only) intermediate stop at the physician's office on the way to the hospital

11 Ambulance transportation

Ambulance services (ground, air, or water) are covered in the following circumstances:

1. The life of the member is in immediate danger
2. Life support equipment or medical care is required during travel
3. Other means of transportation would endanger the member's health or be medically contraindicated

Medicaid will reimburse for first aid calls when the member is not transported.

All claims billed to Medicaid for emergency transportation by ambulance must have a two-letter modifier. The modifier may be any combination of the single letter codes listed below, with the first indicating the origin of transportation and the second letter indicating transportation destination.

Code	Location
D	Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential, domiciliary, custodial facility
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of an accident or acute event
X	(Destination code only) intermediate stop at the physician's office on the way to the hospital

11-1 Reimbursement for ground ambulance

Coverage is limited to base rate billed with the appropriate modifiers, mileage for the loaded ambulance only, oxygen and airway management, and, when necessary, waiting time. Charges for unloaded mileage are not reimbursable.

11-1.1 Non-covered ambulance transportation

Round-trip ambulance transportation from one hospital to another hospital or clinic to obtain necessary diagnostic or therapeutic services when the member remains registered as an inpatient at the originating facility is non-covered. It is the responsibility of the originating hospital to cover the transportation.

Rural hospitals and Long-Term Acute Care facilities (LTACs) are excluded from this policy. In this instance, Medicaid will reimburse an ambulance service provider for round-trip facility transportation from a rural hospital or LTAC facility.

11-2 Air ambulance

Air ambulance, whether fixed wing or helicopter, is covered in any of the following circumstances:

1. Member's condition warrants rapid transportation, and the location of the member is inaccessible by land vehicle
2. Member must be transported a great distance, and time is a factor
3. Member's condition, combined with other obstacles, justifies air (versus ground) ambulance
4. Cost combined with other factors makes air transport more cost-effective

11-3 Water ambulance

Water ambulance is covered in two circumstances:

1. Member's location is inaccessible by ground or air ambulance, or
2. Ground or air ambulance is unavailable

12 Out-of-state transportation

Out-of-state transportation includes transportation (ground, air, or water) from Utah to another state or from another state to Utah. Medicaid only covers out-of-state transportation when the transportation cannot be provided through the contracted NEMT broker, Modivcare, and must be for a medically necessary service following Utah Administrative Code R414-1-2(18). Modivcare provides NEMT services statewide, including up to 120 miles of one-way travel into out-of-state border

communities. Providers must first verify that Modivcare cannot provide out-of-state transportation services.

Coverage of out-of-state transportation requires meeting all criteria found throughout this manual, including prior authorization. The Out-of-State Transportation Prior Authorization Request Form must include:

1. A letter of medical necessity stating:
    a) The service requiring transportation is a Medicaid covered service, and
    b) The service is medically necessary, and
    c) The out-of-state provider and/or facility is/are the nearest that can perform the service, or
    d) It is the general practice for Medicaid members in a particular locality to use the medical resources in another State
2. A letter from the out-of-state provider and/or facility accepting the Medicaid member for treatment and confirming the provider and/or facility is/are Utah Medicaid enrolled or willing to become enrolled.

Medicaid will not cover out-of-state transportation strictly for convenience.

When a member who is already out-of-state acutely requires medical services, transportation for returning the member to Utah is covered only when all out-of-state transportation criteria are met. For example, a member that is injured out-of-state would not qualify for transportation to Utah unless medically necessary services could not be furnished in the out-of-state treating facility or if it was determined to be more cost-effective to return the member to an in-state facility.

Upon approval of out-of-state transportation requests, the out-of-state provider and/or facility must contact the Utah Medicaid reimbursement staff before rendering services in order to determine reimbursement. The Office of Coverage and Reimbursement may be contacted at 801-538-6094.

Out-of-state transportation travel expenses, upon prior approval, include the cost of transportation for the member to and from appointments. See Chapter 1 Non-emergency medical transportation services.

Subsidized out-of-state transportation travel expenses, upon prior approval, may include:

1. Cost of meals during the transportation period
2. Cost of lodging during the transportation period
3. Cost of an attendant to accompany the member when medically necessary
    a) Travel
    b) Meals
    c) Lodging
    d) Salary when the attendant is not related to the member

See Chapter 651-6, Rate and method of reimbursement, of the Medicaid Eligibility Policy Manual for further details regarding coverage of out-of-state travel expenses.

For out-of-state emergency transportation, see Chapter 11 Ambulance transportation.

12-1 Managed care entities

When a Managed Care Entity (MCE) elects or arranges to have a member receive services from an out-of-state provider or facility, the MCE is responsible for the applicable out-of-state and return-to-state transportation and related costs for the member and, if necessary, for a parent, guardian, and/or attendant.

The MCE shall follow the out-of-state transportation criteria and related costs, including food and lodging, as outlined in this manual.

The MCE is not responsible for transportation expenses for a member who has a medical condition that occurs while out-of-state and must return to the state for treatment or services. These services are considered carved-out. See chapter 2-6, MCE carve-out services, of the Section I: General Information provider manual for additional information regarding requests for carve-out services.

13 Non-covered services

NEMT is non-covered when transportation is requested to obtain non-covered medical services, including:

1. Daycare
2. School or educational service
3. Non-Medicaid providers
4. Transportation for transplant or triage teams is not covered

Utah Medicaid Provider Manual

Vision Care Services

Division of Integrated Healthcare

Updated November 2024

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1 General information

This manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as Section I: General Information and the Physician Services manual.

The information in this manual represents available services when medically necessary. Services may be more limited or may be expanded if the proposed services are medically appropriate and are more cost effective than alternative services.

1-1 General policy

For adult members, vision services include one annual examination and, when medically necessary, treatment of visual deficiency or removal of a foreign body.

Eyeglasses, including lenses and frames or other corrective lenses are covered for pregnant women and EPSDT eligible members. These are not covered for non-pregnant adults (age 21 and older).

1-2 Fee for service or managed care

This manual provides information regarding Medicaid policy and procedures for fee for service Medicaid members.

A Medicaid member enrolled in a Managed Care Plan (MCP) (health, behavioral health or dental plan) must receive services through that plan with some exceptions called “carve-out services,” which may be billed directly to Medicaid. An MCP may use this manual as a reference to find out what Medicaid covers.

Refer to the provider manual, Section I: General Information, for information regarding MCPs and how to verify if a Medicaid member is enrolled in an MCP. Medicaid members enrolled in MCPs are entitled to the same Medicaid benefits as fee for service members. However, plans may offer more benefits than the Medicaid scope of benefits explained in this section of the provider manual. Contact the Medicaid member services hotline at (844) 238-3091 for further information.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid member enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a member enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a member's enrollment in a managed care plan. However, it is the provider's responsibility to verify eligibility and plan enrollment for a member before providing services. Therefore, if a Medicaid member is enrolled in an MCP, a fee for service claim will not be paid unless the claim is for a carve-out service.

Eligibility and plan enrollment information for each member is available to providers using the Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility.

1-3 Definitions

Additional definitions of terms used in Medicaid programs are available in Section I: General Information. Definitions specific to the content of this manual are provided below.

Eyeglasses

Means lenses, including frames, contact lenses, and other aids to vision that are prescribed by a physician skilled in diseases of the eye or by an optometrist.

Ophthalmologist

A person specifically trained as a physician who specializes in anatomy, physiology, pathology, disorders and treatment of the eye. Ophthalmologists must be licensed to practice medicine in the state where the services are provided.

Optician

A person specifically trained to translate optical prescriptions, prepare lenses, and fit and dispense eyeglasses. Opticians are reimbursed as 'optical suppliers' who must be licensed by the appropriate governmental authority licensing businesses in the state where the services are provided.

Optometrist

A person specifically trained and licensed, in accordance with the Utah Optometry Practice Act and the State of Utah Administrative Rule, Optometry Practice Act Rule (r156-16a). Optometrists must be licensed in the state where the services are provided.

2 Provider participation requirements

2-1 Provider enrollment

Providers must be enrolled as a Utah Medicaid provider to be reimbursed for services. Refer to provider manual, Section I: General Information for provider enrollment information.

3 Member eligibility

A Medicaid member is required to present the Medicaid member card before each service, and every provider must verify each member's eligibility each time before services are rendered. For more information regarding verifying eligibility, refer to provider manual, Section I: General Information, Verifying Medicaid eligibility, and to the Eligibility Lookup Tool located at https://medicaid.utah.gov/eligibility.

4 Program coverage

Procedure codes

With some exceptions, procedure codes with accompanying criteria and limitations have been removed from the provider manual and are now found on the Medicaid website Coverage and Reimbursement Lookup Tool at:
http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

4-1 Covered services

4-1.1 Eye examination

The eye examination includes evaluation, diagnosis and treatment of visual deficiency and abnormalities of the eye and visual system. Examinations must be documented as medically necessary in the member record.

The examination fee includes the refraction (glasses prescription) and the office visit. Do not bill an office visit separately from the eye examination (See Chapter 6, Billing).

One routine eye examination per year is covered for Medicaid members with two exceptions.

1. An eye examination may be completed whenever there is a medical need. The Medicaid member must have symptomatic eye problems prior to the examination for which treatment is medically necessary and documented. Examining or screening members to determine if they have an eye problem is not covered. This specifically includes nursing homes and ICF's/ID annual visual screening services.
2. If necessary, an eye examination may be done when glasses are lost or broken (See Chapter 4-1.4, Repairs).

4-1.2 Corrective lenses

Medical necessity is required for corrective lens coverage. Medical necessity includes a change in prescription or replacement due to normal lens wear. Corrective lenses must be suitable for indoor or outdoor, day or night use.

Lenses covered include single vision, bifocal, trifocal, with or without slab-off prism, in clear glass or plastic. If the prescription changes, the same frame must be used if possible (See Chapter 4-1.3, Frames).

Separate charges for glasses fitting are not reimbursable. Fitting fees are included in the reimbursement rate for the provided items.

4-1.3 Frames

When medically necessary, Medicaid provides one standard frame, plastic or metal. Frames must be reusable and if the lens prescription changes, the same frame must be used when possible. Medicaid reimburses one pair of eyeglasses every 12-month period.

4-1.4 Repairs

Medicaid will reimburse for repair or replacement of a damaged lens or frame.

4-1.5 Eyeglasses replacement

Replacement eyeglasses are allowed for eligible members once every 12-month period. Prior authorization is required to replace frames sooner than 12 months; replacement lenses are covered and do not require prior authorization. If the lenses alone need replacing, the provider must use existing frames.

Prior authorization may be issued for a new pair of eyeglasses, even though 12 months have not passed since a member's last pair was dispensed when one or more of the following reasons for medical necessity are met:

1. There is a change in correction of 0.5 diopters or greater in either sphere or cylinder power in either eye.
2. A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary.
3. A change in the member's head size warrants a new pair of eyeglasses.
4. The member has had an allergic reaction to the previous pair of eyeglasses.
5. The original pair is lost, broken, or irreparably damaged; the dispensing provider must obtain a written statement explaining this from the member (or the member's caretaker) with the prior authorization request.

4-1.6 Contact lenses

Contact lenses require written prior authorization. Refer to 6-1, Prior authorization.

1. Contact lenses may be covered under the following circumstances:
   a) Visual acuity cannot be corrected to 20/70 in the better eye with glasses lenses.
   b) The refractive error is greater than +- 8D.
   c) An unusual eye disease or disorder exists which is not correctable with eyeglasses.

d) To correct aphakia, keratoconus, nystagmus, or severe corneal distortion.
e) Other special medical conditions which medically require a contact lens.

2. Fitting contact lenses includes determining correction measurements, writing the prescription, fitting and follow-up care necessary for proper wear of the contact lens. Medicaid will not reimburse any additional office visits for any of these services.
3. Soft contact lenses may be approved when medically necessary because of a condition described in “A” above and for either circumstance below:
   a) Prescribed by an ophthalmologist or optometrist as a “bandage” to treat eye disease or injury.
   b) Prescribed for a member who is unable to wear hard contacts due to the shape or surface of the eye and who is unable to obtain the necessary correction with glasses.
4. Gas permeable contact lenses may be approved when a specific medical need exists which precludes the use of glasses.
5. Contact lenses are not covered for moderate visual improvement and/or cosmetic purposes.

4-1.7 Medication

Medications may be prescribed to treat eye disease or injury. The treating optometrist must be certified under the Optometry Practice Act. Medications dispensed in an office are not reimbursable, they are part of the office visit.

4-1.8 Low vision aids

Low vision aids or materials may be covered. These items require prior authorization and manual pricing. See Chapter 6-1, Prior authorization.

4-1.9 Prostheses

Prostheses, such as an artificial eye, and associated services are covered when medically necessary.

4-1.10 Member chooses non-covered services or upgrades

With few exceptions, a provider may not bill a Medicaid member, as the Medicaid payment is considered payment in full. Exceptions may include a member request for service that is not medically necessary and therefore not covered. Examples of services considered not medically necessary: more expensive frames, tinted lenses, lenses of special design.

For a provider to bill the member the following conditions must be met. (See also Section I: General Information, Exceptions to prohibition on billing members).

1. The provider has an established policy for billing all Medicaid members for services not covered by a third party. (The charge cannot be billed only to Medicaid members).
2. The member is advised prior to receiving a non-covered service that Medicaid will not pay for the service.
3. The member agrees to be personally responsible for the payment.
4. The agreement is made in writing between the provider and the member which details the service and the amount to be paid by the member.

Unless all four conditions are met, the provider may not bill the member for the non-covered service. Further, the provider may not “hold” the member's Medicaid card as guarantee of payment, nor may any other restrictions be placed upon the member.

If providing upgraded services such as more expensive frames, tinted lenses, or lenses of special design, bill the covered code and charges on the first line. On the second line, bill the non-covered code, including the modifier “GX” (HCPCS “GX” modifier description: Notice of liability issued, voluntary under payer policy) and the charges on the second line. This indicates that the member has signed a memo of understanding of the payment responsibility for the upgrade(s). The code with the GX modifier will be non-payable. The memo of understanding must be kept in the provider’s medical record for the member.

The amount paid by the member is calculated by taking the difference between the usual and customary charge for the more expensive item and the usual and customary charge for the covered item. For example, if the usual and customary charge for the basic frame were $35 and the member wanted frames that were presently advertised for $50, the member would be responsible to pay an additional $15. Remember, because Medicaid pays $27.61 for the $35 basic frame, the provider accepts this as payment in full and cannot bill the member for the $7.39 difference.

5 Non-covered services and limitations

For additional non-covered services or limitations, refer to the Coverage and Reimbursement Lookup Tool at the Medicaid website at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

5-1 Non-covered services

The following services are NOT covered by Medicaid.

1. Additional glasses, such as reading glasses, safety glasses, distance glasses, or "spare glasses"
2. Extended wear contact lenses
3. Contact lenses for moderate visual improvement and/or cosmetic purposes
4. Sunglasses, tints, or any other mechanism such as light-sensitive lenses that "darken" or photo grey lenses
5. Oversized, exclusive, or specially designed lenses
6. Special cataract lenses, unless medically necessary. Only clinical cataract lenses are covered.
7. No-line bifocal lenses and no-line trifocal lenses
8. Replacement of glasses that are broken or lost due to abuse and neglect of the member (See Chapter 4-1.6, Eyeglasses replacement for more information).
9. Repairs due to member neglect or abuse
10. Medications dispensed in an office

11. Screening examination to determine if member has an eye problem
12. Corneal Topography
    a) With a non-covered service (e.g., radial keratomy, lasix eye surgery)
    b) As a screening examination
    c) Separate from evaluation & management ophthalmological services (i.e., 92002-92014)
    d) Optical Coherence Tomography (OCT) (An ultrasonic method to evaluate ocular structures which is considered investigational)
13. Biometry by ultrasound 76516 and 76519 are subject to correct coding initiative edits.
    a) If both studies (76511 or 76516 and 76519) are reported, the charges are combined and processed under code 76519. The global service for code 76519 includes a bilateral technical component and unilateral professional component. When the procedure is completed on the second eye, only the professional component should be billed.
    b) It is not considered medically reasonable or necessary to perform both an A-scan and optical coherence biometry (OCB). If biometry by partial coherence interferometry (92136) and an A-scan (76516, 76519) is completed, a mutually exclusive edit will post. The A-scan procedure (76516 or 76519) will be paid, and the code 92136 will be denied.

6 Billing

Vision care services may be billed electronically or on paper, using the CMS-1500 (08/05) claim format. Refer to the provider manual, Section I: General Information, for detailed billing instructions.

If a member chooses non-covered services or upgrades, refer to 4-1.11 Member chooses non-covered services or upgrades for billing information.

6-1 Prior authorization

Prior authorization may be required for certain services. Failure to obtain prior authorization can result in payment denial by Medicaid. Providers must determine if

prior authorization is necessary and obtain authorization before providing services. Exceptions may be made, with appropriate documentation, if the service provided is emergent or the member is retro-eligible for the dates of service requested.

Prior authorization (PA) information is provided in the provider manual, Section I: General Information. Code specific coverage and prior authorization requirements are provided on the Medicaid website, Coverage and Reimbursement Lookup Tool at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

When requesting prior authorization, complete the requirements found in Section I: General Information include documentation supporting the diagnosis.
Examples of information to include in the prior authorization request.

1. Results of refraction in each eye.
2. Statement concerning presence of aphakia, keratoconus, or nystagmus.
3. If the diagnosis is corneal distortion include test results.
4. If post cataract removal, date of surgery.
5. If soft or gas permeable lenses are being requested, evidence of a physical problem precluding the use of hard contacts.

7 References

1. Utah Code 26-18-3
2. Utah Optometry Practice Act, Title 58, Chapter 16a
3. 42 CFR 441.30, Optometric services
4. 42 CFR 440.120 (d), Prescribed drugs, dentures, prosthetic devices, and eyeglasses

COORDINATION OF BENEFITS

Before submitting a claim to Medicaid, a provider must submit and secure payment from all other liable parties such as Medicare Part A and B. (For more information, refer to the Medicaid General Information Section, 11-5.1). Claims denied from Medicare as non-covered services should be submitted to Medicaid Fee-For-Service, not to Crossovers.

If the primary payer made line level payments on the claim, please report line level data, in addition to the claim level data, to Medicaid. Do not include co-payments received from the patient in the TPL reporting. Only send an explanation of benefits (EOB) when indicated by the table below for electronically billing secondary claims.

For Healthy U, Health Choice Utah, or Molina TPL claims, contact that health plan for specific billing instructions.

INSTRUCTIONS FOR ELECTRONIC CLAIMS

When submitting COB information in an electronic format, be sure to include payer payment amount, patient liability, and reason codes with amounts for contractual write-offs. The Mail Boxes (Trading Partner Numbers) for claim submission are:

HT000004-001 Medicaid Fee-For-Service
HT000004-005 Utah Medicaid Crossovers (NOT when Medicare denies as non-covered)

To electronically bill secondary claims to Utah Medicaid * * * Do not fax paper claims * * *				
Enter third party payment and the patient responsibility and then transmit to the appropriate Medicaid Trading Partner Number (TPN)				
If Primary payer	When Primary Payer is	Transmit Electronic Claim to	Will Deny	Additional action to take
Pays	Medicare	HT000004-005		None
	Commercial	HT000004-001		None
Pays Zero	Medicare	HT000004-005		None
	Commercial	HT000004-001	X	Fax Medicaid remittance w/denial & EOBs to ORS (801) 536-8513
Denies	Medicare	HT000004-001	X	Fax Medicaid remittance w/denial & EOBs to Medicaid (801) 536-0481
	Commercial	HT000004-001	X	Fax Medicaid remittance w/denial and EOBs to ORS (801) 536-8513

NOTE: Please fill out a *Documentation Submission Form* when sending a copy of the EOB via fax or mail. If the identifiable information is not submitted, the request may not be fulfilled.

INSTRUCTIONS FOR PAPER CLAIMS

Third Party Liability (TPL) payments must be reported in the positions listed below. When reporting multiple payers on a CMS-1500 (02/12), or dental claim, indicate the combined total payments and the final remaining patient responsibility. To identify a crossover claim check both the Medicare and Medicaid boxes in Box 1.

CMS-1500 (02/12)	
Box	**Instructions**
28	Total Claim Charge.
29	Amount Paid by other payer(s). Contractual adjustments should not be reported. The contractual amount will be calculated by Medicaid (Total claim charge - Amount Paid by other Payer - Patient Responsibility = Contractual Adjustment).
30	Balance due.
19	If amount in Box 30 is different than the claim level patient responsibility as reported by the other payer(s), report patient responsibility in Box 19 by using PR01 and then the amount (example: PR01:13)
24 Shaded	Required for crossover when Medicare reports Patient Responsibility at the line level, optional for Fee for Service. Each line of service must contain the following information: (1) Indicator of “T” to identify a third party payment, and amount paid by other payer(s). (2) Indicator of “PR” to identify patient responsibility, reason code reported by other payer(s) related to the PR, and patient responsibility amount. If no reason code is available from other payer(s) to identify the patient responsibility, use “01". (3) All reason codes as reported by other payer(s) and amounts (contractual obligation or write-offs). Codes should contain a qualifier of either CO or CR and then a number. If no reason codes given by the payer, report all contractual obligations using “CO45". Report the amount of the contractual obligation. There may be multiple reason codes and amounts per line.

EXAMPLE:

24A Date(s) of Service From MM	**DD**	**YY**	**To MM**	**DD**	**YY**	**B. Place of Service**	**C. EMG**	**D. Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT/CPT/HCPCS Modifier**					**E. Diagnosis Pointer**	**F. Charges**
T: 40:35 PR01:10 CO45:9.65														
03	**11**	**06**	**03**	**11**	**06**	**11**		**99213**					**1**	**60.00**

Provider Instructions for Emergency Services Program for Non-Citizens Dialysis Coverage

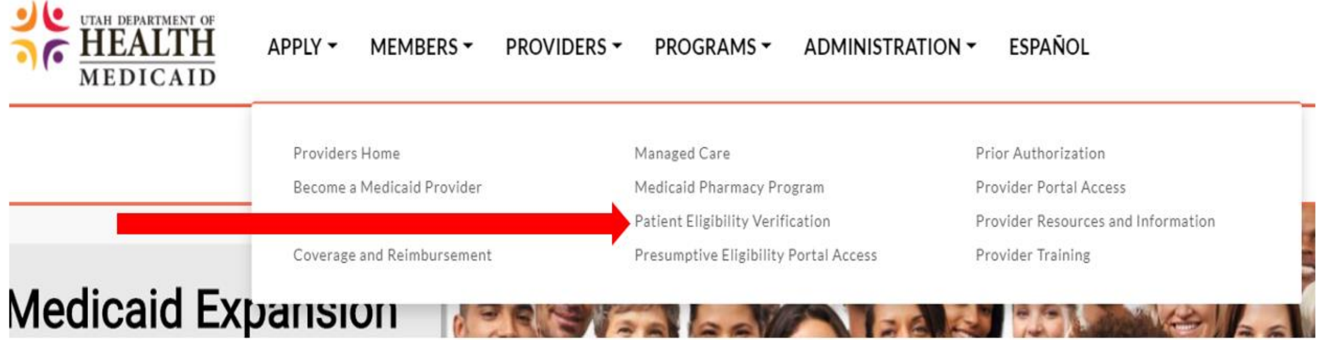
Eligible individuals for the Emergency Services Program for Non-Citizens (otherwise known as the Emergency Only Program or EOP) can receive outpatient hemodialysis services when diagnosed with End-Stage Renal Disease (ESRD), after experiencing a qualifying Emergency Department (ED) event identified by Medicaid. Not all those who are "financially" eligible for EOP are "clinically" eligible to receive outpatient hemodialysis. By following the instructions below, providers can verify an individual's eligibility to receive coverage for outpatient hemodialysis.

Step 1:

Go to the Medicaid website at https://medicaid.utah.gov/

Step 2:

Under the PROVIDERS drop down tab, click the "Patient Eligibility Verification" link.



Step 3:

Click on the "Eligibility Lookup Tool" link.

Patient Eligibility Verification

The Eligibility Lookup Tool is a website that allows a provider to electronically view a member's Medicaid eligibility and plan enrollment information. The Eligibility Lookup Tool will also tell you if the patient is restricted to a specific provider and if the patient is responsible for co-pays.

To verify your patient's eligibility on the portal you will need the information off of the Medicaid card which includes member's name, Medicaid ID and date of birth. A provider must also have a Provider ID (NPI or API) known to Medicaid.

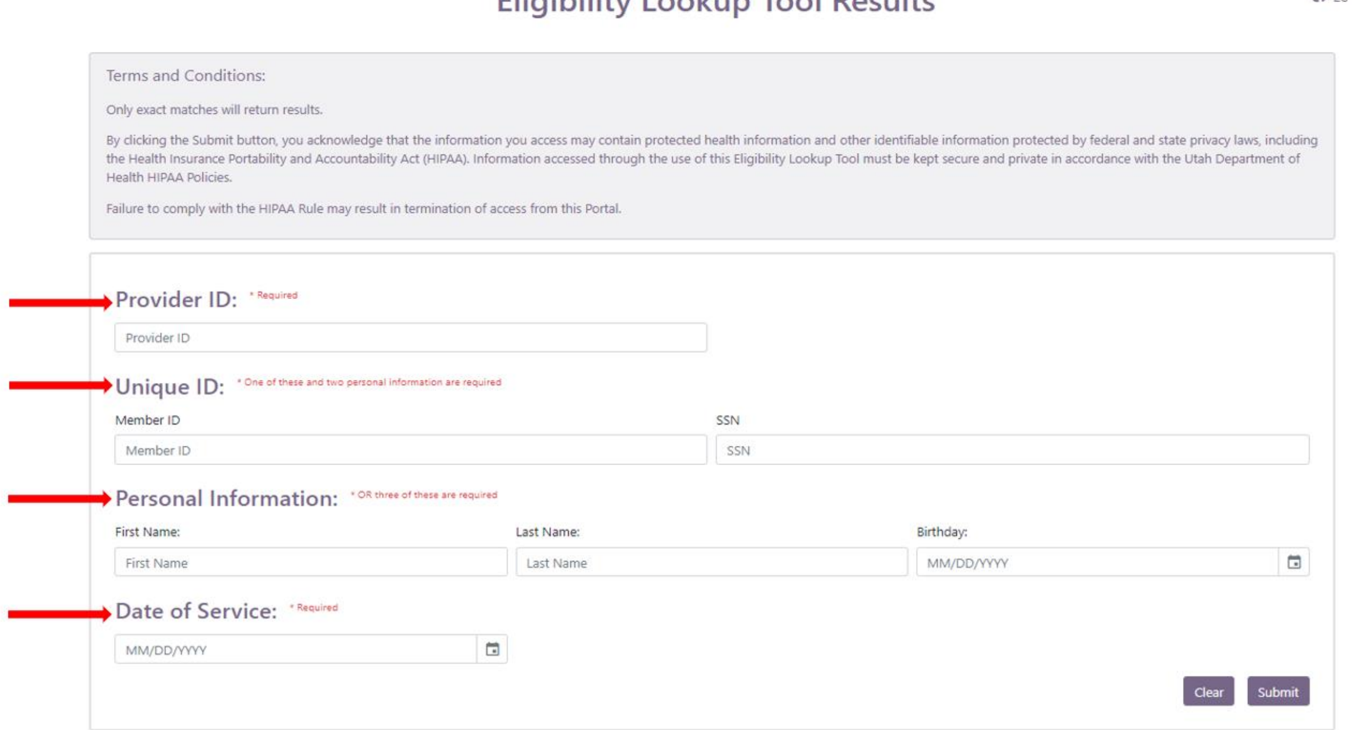
In order to be in compliance with HIPAA, we must assure that only those that have the right to this information have access. A provider will have to register with the State of Utah by creating a Utah-ID account. If not currently logged in, you will be redirected and prompted to log in. If you have a Utah-ID and password, simply login to access the Eligibility Lookup Tool. Due to security, there is a 20-minute inactivity timeout feature on the Eligibility Lookup Tool.

Click here for more information and instructions if you have not previously created a Utah-ID account.

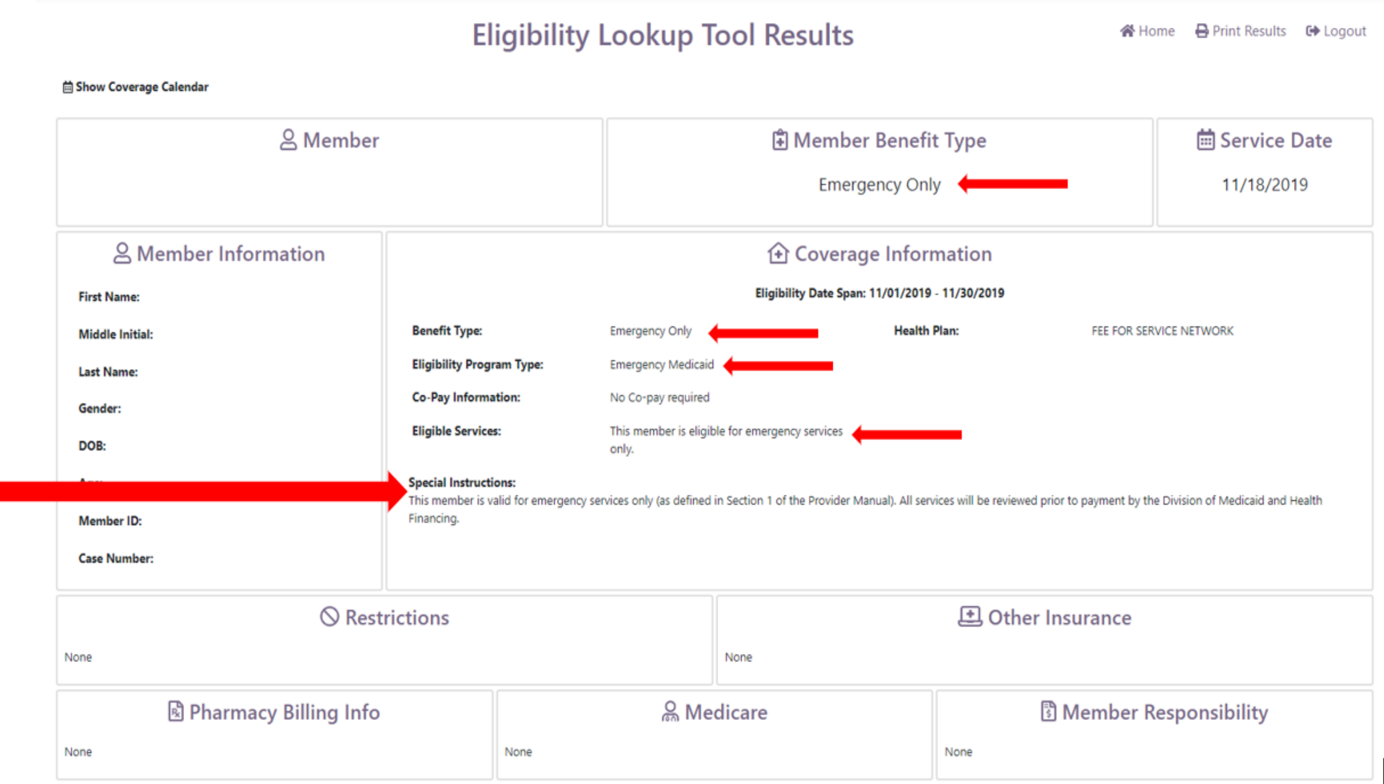
Eligibility Lookup Tool

Step 4:

Enter the indicated "provider" and "personal information" into the required fields as indicated below.



Step 5: Financial eligibility will be listed in the "Coverage Information" area of the "Eligibility Lookup Tool Results." Clinical eligibility will be indicated in the "Special Instructions" in the "Coverage Information" area.



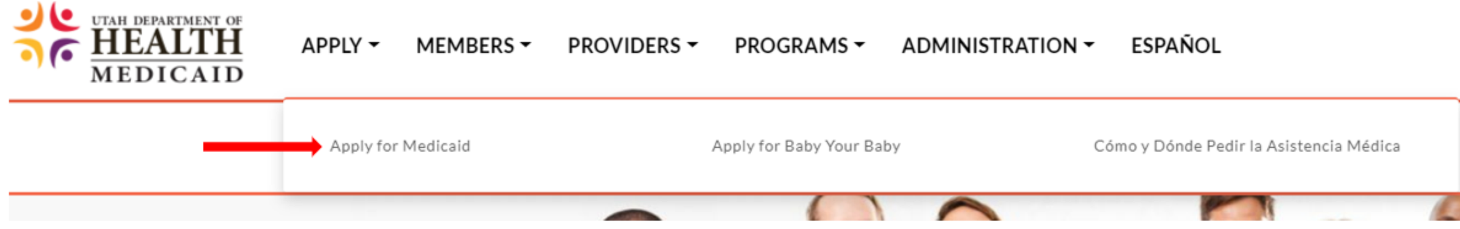
After the individual has been verified as financially and clinically eligible, the provider may then schedule outpatient hemodialysis. Providers must continue to check eligibility requirements prior to rendering services as outlined in Chapter 6 “Member Eligibility” of the Section I: General Information Provider Manual.

Additional Instructions to Hospital Providers

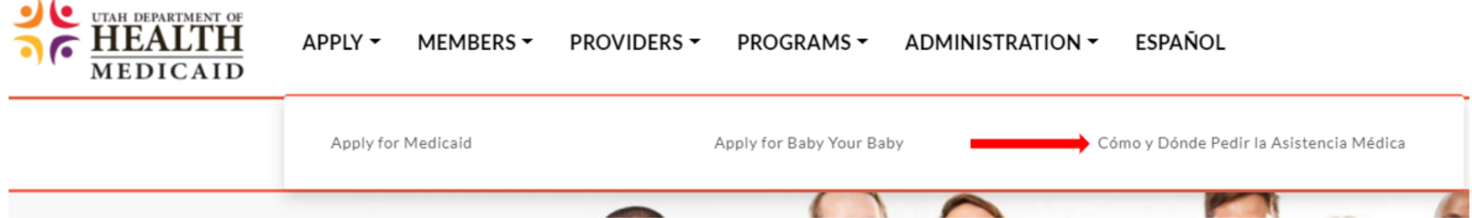
Newly Presenting Individuals with ESRD

1. When a non-citizen with ESRD presents to the ED for the first time, if the person is not already enrolled in EOP at the time services were provided, the services may not be covered until both financial and clinical eligibility have been determined.
    a. Providers may help facilitate the enrollment of individuals into EOP by going to the Medicaid website and following these steps.

Go to the “APPLY” drop down and click the “Apply for Medicaid” link. Follow the instructions found on the link.



If the non-citizen is applying for themselves, and are non-English speaking, go to the “APPLY” drop down and click “Cómo y Dónde Pedir la Asistencia Médica” link. Follow the instructions found on the link.



2. In the interim of applying for financial eligibility for EOP, providers can determine if an individual meets the clinical eligibility requirements for coverage of outpatient hemodialysis by completing the following steps:
    a. Fax substantiating clinical documentation to eop_dialysis@utah.gov or 801-237-0776.
        i. This process allows for an expedited review and waives the 60-day waiting period Medicaid requires for all other EOP claims review.
        ii. Providers must contact Medicaid by calling 801-538-6094 after documentation has been submitted.
            1. Request to speak with an EOP Nurse Reviewer, who will review the documentation to determine clinical eligibility.
                a. This process may take up to two business days.

Please Note:

Establishing clinical eligibility does not guarantee financial eligibility. Submission of clinical documentation provides the opportunity to establish clinical eligibility only.

Providers that begin outpatient hemodialysis, prior to the establishment of both financial and clinical eligibility, do so at their own risk, and understand that services provided may not be covered by Medicaid.

Additional Instructions to Dialysis Centers

Individuals enrolled in EOP generally require substantiating documentation supporting the treatment of emergency medical conditions. When Medicaid has identified clinically eligible EOP individuals who receive outpatient hemodialysis, the submission of documentation is not required. This only applies to outpatient hemodialysis performed in a dialysis center.

Due to programming surrounding EOP, the Medicaid system will automatically send out remittance advice denying claims that are submitted without documentation. Medicaid requests, in this instance, that these denials for documentation be disregarded. Medicaid will manually review these EOP claims identifying financial and clinical eligibility of each individual. If an individual has been treated who is not financially eligible, the claim will be denied.

Medicaid FAX Numbers

Document Control: (801) 536-0476
Warrant tracers

Customer Service: (801) 536-0463
Manual review

Customer Service: (801) 237-0745
Sterilization consent

Customer Service: (801) 323-1584
Medicare EOB

Customer Service: (801) 536-0481
Other documentation including invoices

Pharmacy: (801) 536-0464
Pharmacy claim corrections

Nursing Home (Attn: Betsy)/Long Term Care/Transportation: (801) 536-0474
Claim corrections

Emergency Only Program: (801) 536-0475
Medical documentation

Hospital: (801) 536-0974
Provider Preventable Conditions

Filing Deadline Issues: (801) 536-0164
Timely Filing Affidavit and documentation

Provider Enrollment: (801) 536-0471
Provider Enrollment applications, EFT, provider information updates including change of address, etc.

Provider Enrollment: (801) 323-1574
Provider Enrollment - Mental Health applications

Electronic Data Interchange: (801) 536-0498
EDI transactions and Remittance Advice (RA)

Agency Conference and/or Formal Hearing: (801) 538-6478

TPL Documentation, EOBs: (801) 536-8513
Office of Recovery Services (ORS)

Prior Authorization (PA) fax number, refer to the prior authorization request form.

FORM TO REQUEST A STATE FAIR HEARING

Are you asking for a State fair hearing because of a decision made by the Medicaid agency or by a managed care plan?
*Check one: ☐ **Medicaid Agency** ☐ **Managed Care Plan - Name of Plan:** ______________________________
(A managed care plan can be a Medicaid physical health plan, Medicaid prepaid mental health plan, Medicaid dental plan, CHIP dental plan, or CHIP physical and mental health plan.)

This form must be submitted by the deadlines shown on the next page.

Please enclose a copy of the Medicaid Agency's denial notice or the Managed Care Plan's notice of its appeal decision or we cannot proceed with this hearing request.

If waiting for a decision about this hearing request could endanger the member's life, health, or ability to attain, maintain, or regain maximum function, call Administrative Hearings (801-538-6576) to request an expedited hearing.

*1. Name of person requesting hearing: ______________________________ *Phone #: __________________

*Street Address: ____

Email Address: ____ Fax #: __________________________

*2. Member's name: ________________________ *Medicaid ID #: _______________ Date of birth: __________

3. Provider's name: __________________________________ Provider's NPI: ________________________

4. Reason for hearing request: ____

____

5. Service(s) or procedure code(s): _________________________ Date(s) of service(s): ____________________

Providers: Submit any medical records that support your position, otherwise the hearing may be delayed.

You may represent yourself or have another person represent you. If an attorney represents you, the attorney must file a Notice of Appearance to the address below. *Will an attorney represent you? ☐ Yes ☐ No

Name of representative or attorney: ____________________________________ Phone #: ________________

Address: ____ State: __________ Zip: ___________

*Signature of person requesting hearing: ____________________________________ Date: ______________

Name and address of additional person(s) you would like to be notified of your hearing request:

____

____

All asterisked (*) items above must be completed to proceed with this hearing request.

SEND THIS FORM TO:

Via U.S. Post Office	**Via UPS or FedEx**	**Email or Fax**
Office of Administrative Hearings Division of Integrated Healthcare PO Box 143105 Salt Lake City, UT 84114-3105	Office of Administrative Hearings Division of Integrated Health Care 195 North 1950 West Salt Lake City, UT 84116	Email: utmedicaidhearings@utah.gov Fax: 801-536-0143

Administrative Hearings Telephone #: 801-538-6576

Deadlines for Submitting the Form to Request a State Fair Hearing

Box 1

If you checked **Medicaid Agency** at the top of the Form to Request a State Fair Hearing, you must send the form **within 30 days** from the date the Medicaid Agency sent a denial notice.

If you checked **Managed Care Plan (Plan)** at the top of the Request a State Fair Hearing, you must send the form **no later than 120 calendar days** from the date of the Plan's notice of its appeal decision.

Box 2

The deadlines in this box only apply if the member wants services continued during the State fair hearing.

If the member is getting service(s) related to this hearing request, does the member want the service(s) continued during the hearing? Yes ☐ No ☐ If "no" follow the instructions in Box 1 above. If "yes" follow the instructions below:

If you checked **Medicaid Agency** at the top of the Form to Request a State Fair Hearing, then the following deadline applies:

- The form **and** the member's signed request to have services continued must be sent **within 10 calendar days** of the date the Medicaid Agency's notice was sent. If the hearing decision is the same as the Medicaid Agency's decision, the member may have to pay for the services.

If you checked **Managed Care Plan (Plan)** at the top of the Form to Request a State Fair Hearing, then the following deadline applies:

- The form **and** the member's signed request to have services continued must be sent **within 10 calendar days** after the Plan sent the notice of its appeal decision. If the hearing decision is the same as the Plan's decision, the member may have to pay for the services.

FORMULARIO PARA SOLICITAR UNA AUDIENCIA IMPARCIAL ESTATAL

¿Está solicitando una audiencia imparcial ante el estado debido a una decisión tomada por la agencia de Medicaid o por un plan de atención administrado?

*Marque uno: ☐ **Agencia de Medicaid** ☐ **Plan de Atención Administrado - Nombre del Plan:** ________________
(Un plan de atención administrado puede ser un plan de salud física de Medicaid, un plan de salud mental prepagado de Medicaid, un plan dental de Medicaid, un plan dental de CHIP o un plan de salud física y mental de CHIP.)

Este formulario debe ser enviado dentro de las fechas que se muestran en la página siguiente.

Por favor envié una copia del aviso de negación de la Agencia de Medicaid o el aviso del Plan de Atención Administrado de su decisión de apelación o no podemos continuar con esta solicitud de audiencia.

Si esperar por una decisión sobre esta petición de audiencia podría poner en peligro la vida, la salud o la capacidad del miembro para alcanzar, mantener o recupera la función máxima, llame a la Audiencia Administrativa (801-538-6576) para solicitar una audiencia rápida.

*1. Nombre de la persona que solicita la audiencia: ______________________________ *Teléfono #: ____________

*Dirección: ____

Correo electrónico (email): ____ Fax #: ____________________

*2. Nombre del miembro: ____________________________ *Medicaid ID #: _________________ Edad: ______

3. Nombre del proveedor: ___________________________________ NPI del proveedor: ____________________

4. Razón que solicita audiencia: ____

____

5. Servicios(s) o código de procedimiento(s): _______________________ Fecha(s) de servicio(s): ________________

Proveedores: Envié cualquier registro médico que respalde su posición, de lo contrario, la audiencia podría atrasarse.

Usted puede representarse a sí mismo o hacer que otra persona lo represente. Sí un abogado lo representa, debe presentar un Aviso de Apariencia en la dirección que está a continuación. *Le representara un abogado? ☐ Sí ☐ No

Nombre del representante o abogado: ______________________________________ Teléfono #: ______________

Dirección: ____ Estado: ________ Código Postal: _________

____ ____________________

*Firma de la persona que solicita la audiencia Fecha

Nombre y la dirección de la(s) persona(s) adicional(es) a las que le gustaría que le notifiquen de su solicitud de audiencia:

____

____

Todas las secciones con asterisco (*) deben completarse para continuar con esta solicitud de audiencia.

MANDE ESTE FORMULARIO:

Vía U.S. Post Office	**Vía UPS o FedEx**	**Email o Fax**
Director's Office/Administrative Hearings Division of Medicaid and Health Financing PO Box 143105 Salt Lake City, UT 84114-3105	Director's Office/Administrative Hearings Division of Medicaid and Health Financing 288 North 1460 West Salt Lake City, UT 84116-3231	Email: administrativehearings@utah.gov Fax: 801-536-0143

Audiencias Administrativas Número de Teléfono: 801-538-6576

Fechas para enviar el formulario para solicitar una audiencia imparcial estatal

Caja 1

Sí marcó **Agencia de Medicaid** en la parte anterior del formulario para solicitar una audiencia imparcial estatal, debe enviar el formulario **dentro de los 30 días** posteriores a la fecha en que la Agencia de Medicaid envió un aviso de negación.

Sí usted marcó **Plan de Atención Administrado** en la parte anterior del formulario de audiencia imparcial estatal, debe enviar el formulario **no más tardar de los 120 días de calendario** a partir de le fecha de la notificación de apelación del plan.

Caja 2

Las fechas en esta caja solo se aplican sí el miembro desea servicios continuados durante la audiencia imparcial del estado.

Sí el miembro recibe servicio(s) relacionado con esta solicitud de audiencia, ¿desea el miembro que el servicio continúe durante la audiencia? Sí ☐ No ☐ Sí responde "no", siga las instrucciones de la Caja 1 anterior. Sí la respuesta es "Sí", siga las instrucciones a continuación:

Sí marcó la **Agencia de Medicaid** en la parte anterior del formulario para solicitar una audiencia imparcial estatal, se aplica las siguientes fechas:

- El formulario y la solicitud firmada por el miembro deben enviarse dentro **de los 10 días de calendario** a partir de la fecha en que se envió la notificación de la Agencia de Medicaid para que continúe los servicios. Sí la decisión de la audiencia es la misma qué la decisión de la Agencia de Medicaid, es posible que el miembro deba pagar por los servicios.

Sí marcó el **Plan de Atención Administrado (Plan)** en la parte anterior del formulario para solicitar una audiencia imparcial estatal, se aplica las siguientes fechas:

- El formulario **y** la solicitud firmada por el miembro deben enviarse **dentro de los 10 días de calendario** posteriores a la fecha en que el Plan envió la notificación de su decisión de apelación para que continúen los servicios. Sí la decisión de la audiencia es la misma que la decisión del Plan, es posible que el miembro deba pagar por los servicios.

Guide to Medical Interpretive Services

- Follow the steps below to obtain medical interpretive services paid by Medicaid for a qualified member.
- The box on the left is a "QUICK GUIDE" with keywords.
- The column on the right side of the box has information about each step.
- For more information, refer to the Utah Medicaid Provider Manual, Section I: General Information the chapters on: Applying for Medicaid, Medicaid Services, and Medical Interpretive Services.
- Online at: https://medicaid.utah.gov

QUICK GUIDE

Medical Interpretive Services for Medicaid, CHIP, PCN, and services authorized on a State Medical Services Reimbursement Agreement Form (MI-706).
Both member and service must qualify for Medicaid to pay for an interpreter.

❶ Member eligible for health care service?

YES - Go to step 2.

NO - Member NOT ELIGIBLE for interpretive service.

❷ Member in ACO, Prepaid Mental Health Plan, and/or Dental Plan??

YES - Go to step 3.

NO - Go to step 4.

❸ Service covered by ACO, Prepaid Mental Health Plan, and/or Dental Plan?

YES - Call plan for interpreter.

NO - Go to step 4.

❹ Health care service covered by fee-for-service medical program for which the member is eligible?

NO - Member NOT ELIGIBLE for interpretive service.

YES - Call Interpretive Service Contractor for interpreter.

❺ Give required information to contractor.

Reference: Utah Medicaid Provider Manual
Section I: General Information, Medical Interpretive Services

❶ Determine if member is eligible for health care service.
Verify the member is eligible for a federal or state medical assistance program. Programs include Medicaid, CHIP, PCN, and services authorized on a State Medical Services Reimbursement Agreement Form (MI-706).

To verify member eligibility use the Eligibility Lookup Tool (https://medicaid.utah.gov/medicaid-online), or call Medicaid Information at (801) 538-6155 or 1-800-662-9651 or ANSI 270 and ANSI 271.

If not eligible, the member is NOT ELIGIBLE for interpretive service.

❷ Determine if member is in managed care.
Is the member enrolled in an ACO, Prepaid Mental Health Plan, and/or Dental Plan?

YES - Member is enrolled in a plan, go to step 3.

NO - Member is not enrolled in a plan, go to step 4. The member is fee-for-service.

❸ Service covered by an ACO, Prepaid Mental Health Plan, and/or Dental Plan?

YES – ACO, Prepaid Mental Health Plan and Dental Plans must also cover interpretive services. Contact the plan directly for more information.

NO- Limited services, referred to as 'carve out' services, may be covered by Medicaid. (For more information on carve out service, refer to the Utah Medicaid Provider Manual, SECTION 1, Fee for Service Medicaid.) If service qualifies as a carve out service, go to step 4.

❹ Service covered by fee-for-service medical program for which the member is eligible?
To determine CPT coverage, refer to the online Coverage and Reimbursement Lookup Tool available on the Medicaid website at: https://health.utah.gov/stplan/lookup/CoverageLookup.php

YES -The service is covered, interpretive service is also covered.

NO - The service is NOT covered, the member does not qualify for interpretive service.

❺ When both the member and the service qualify, call one of the contractors listed on page 2. Give the required information below.

1. Member's first and last name spelled exactly as on the Medicaid Member Card.
2. Member date of birth: six digits only (mm/dd/yy).
3. Member's Medicaid ID number.
4. Your NPI number.
5. Language requested.
6. Time and date an interpreter is needed, whether in-person or telephone.

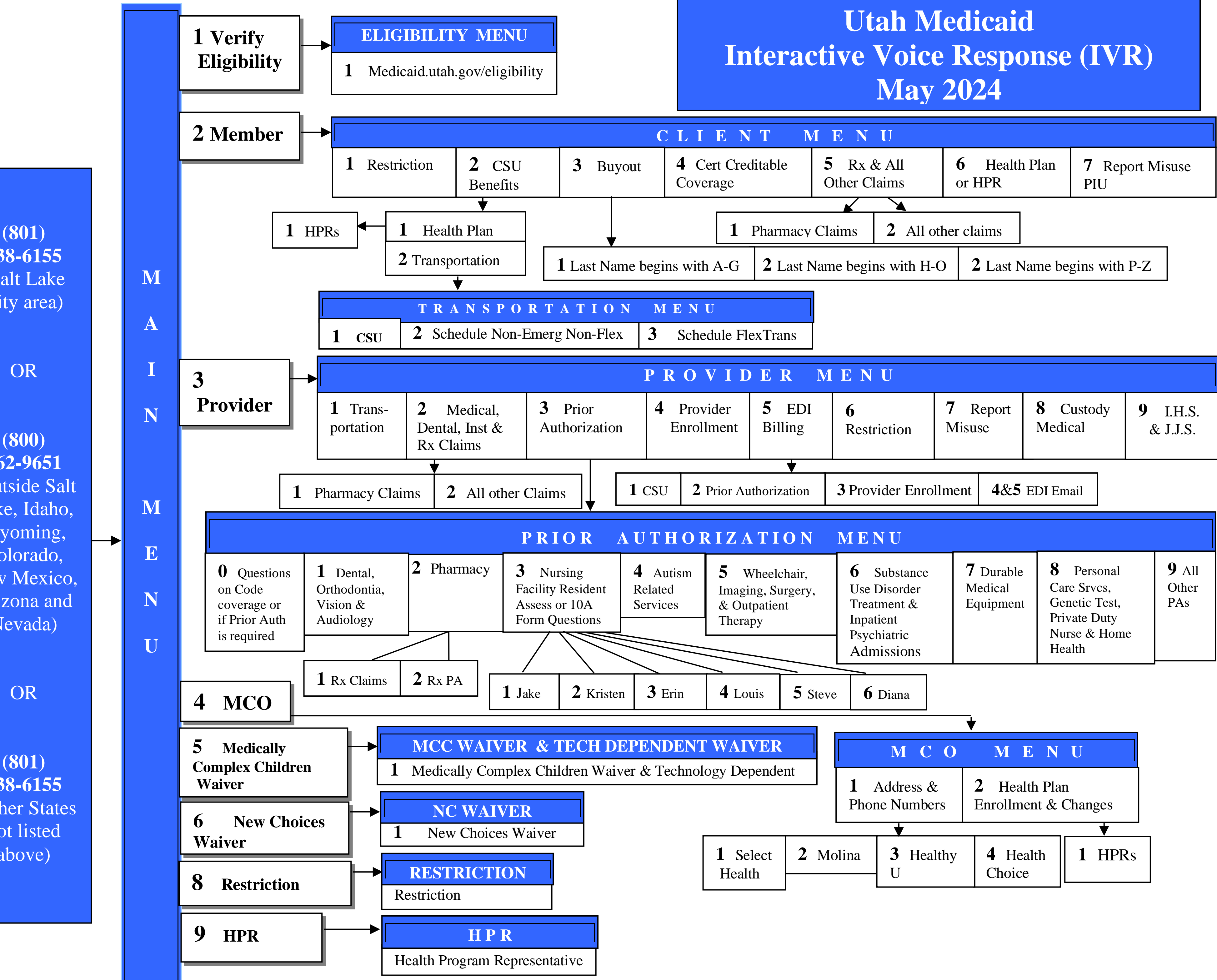
Medical Interpretive Service
State Cooperative Contractors

Contractor	Services
InSync Interpreters, LLC (801)838-8100 State Contract # MA2253	Face to Face and Written Translation
Linguistica International (801)262-4550 State Contract # MA2084	Face to Face, Telephonic and Written Translation
Linguistica International -Telephonic (866)908-5744 State Contract #MA2238	Telephonic Interpreting
CommGap International (801) 944-4049 State Contract # MA1841	Fact to Face, Telephonic, and Written Translation
Asian Association of Utah (801)990-9498 or State Contract # MA2255 **(801)990-9500**	Face to Face and Written Translation
Interwest Interpreting Inc. (801)224-7683 State Contract # MA1070	American Sign Language Interpreting
American Sign Language Communications (801)403-6606 or State Contract # MA880 **(702)610-4722**	American Sign Language Interpreting

Effective August 1, 2015, Medicaid recipients and providers must use the State contracted vendors for interpretive services, including sign language interpreting.

To ensure payment of interpretive services by Medicaid, check eligibility of the member prior to contacting the interpreting vendor.

➔ To verify member eligibility use the Eligibility Lookup Tool (https://medicaid.utah.gov/medicaid-online), or call Medicaid Information at (801) 538-6155 or 1-800-662-9651 or ANSI 270 and ANSI 271.



Utah Medicaid
Interactive Voice Response (IVR)
May 2024
(801) 538-6155 (Salt Lake City area)
OR
(800) 662-9651 (Outside Salt Lake, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada)
OR
(801) 538-6155 (Other States not listed above)
MAIN MENU
1 Verify Eligibility
ELIGIBILITY MENU
1 Medicaid.utah.gov/eligibility
2 Member
CLIENT MENU
1 Restriction
2 CSU Benefits
3 Buyout
4 Cert Creditable Coverage
5 Rx & All Other Claims
6 Health Plan or HPR
7 Report Misuse PIU
1 HPRs
1 Health Plan
2 Transportation
1 Pharmacy Claims
2 All other claims
1 Last Name begins with A-G
2 Last Name begins with H-O
2 Last Name begins with P-Z
TRANSPORTATION MENU
1 CSU
2 Schedule Non-Emerg Non-Flex
3 Schedule FlexTrans
3 Provider
PROVIDER MENU
1 Trans-portation
2 Medical, Dental, Inst & Rx Claims
3 Prior Authorization
4 Provider Enrollment
5 EDI Billing
6 Restriction
7 Report Misuse
8 Custody Medical
9 I.H.S. & J.J.S.
1 Pharmacy Claims
2 All other Claims
1 CSU
2 Prior Authorization
3 Provider Enrollment
4&5 EDI Email
PRIOR AUTHORIZATION MENU
0 Questions on Code coverage or if Prior Auth is required
1 Dental, Orthodontia, Vision & Audiology
2 Pharmacy
3 Nursing Facility Resident Assess or 10A Form Questions
4 Autism Related Services
5 Wheelchair, Imaging, Surgery, & Outpatient Therapy
6 Substance Use Disorder Treatment & Inpatient Psychiatric Admissions
7 Durable Medical Equipment
8 Personal Care Srvcs, Genetic Test, Private Duty Nurse & Home Health
9 All Other PAs
1 Rx Claims
2 Rx PA
1 Jake
2 Kristen
3 Erin
4 Louis
5 Steve
6 Diana
4 MCO
MCO MENU
1 Address & Phone Numbers
2 Health Plan Enrollment & Changes
1 Select Health
2 Molina
3 Healthy U
4 Health Choice
1 HPRs
5 Medically Complex Children Waiver
MCC WAIVER & TECH DEPENDENT WAIVER
1 Medically Complex Children Waiver & Technology Dependent
6 New Choices Waiver
NC WAIVER
1 New Choices Waiver
8 Restriction
RESTRICTION
Restriction
9 HPR
HPR
Health Program Representative

Payment Adjustment Process

A new electronic Payment Adjustment Request form for fee-for-service Medicaid claims is now available for issues regarding overpayment and credit balance. The form must accompany a payment in order to allow proper allocation of funds. To view the form, go to https://medicaid.utah.gov/utah-medicaid-forms. From the list choose the form named: **PaymentAdjustment.pdf**.

This form may be filled out on the computer before printing. One form is required per claim. The form must have all required fields appropriately filled out or it will be returned to the provider for corrections.

Do not use this form for changes to a claim that is less than three years old. If a payment adjustment is required on a paid claim that is less than three years old, providers should submit a replacement claim through their practice management system or submit a claim adjustment in PRISM. Refer to your internal practice management policies on the procedure to submit a replacement claim. Additional information and training can be found here: https://medicaid.utah.gov/provider-training-0/.

Send checks for adjustments older than 3 years to:

Utah Office of Inspector General
PO BOX 143103
Salt Lake City, UT 84114-3103

Credit balances resulting from adjusting claims less than 3 years old will generally be satisfied by offsetting future claims until the credit balance reaches $0. If a provider elects to send in payment instead of allowing a credit balance to be offset completely by future claims, please include the Notice of Recovery letter that will be sent to you at the end of the week the claims are adjusted if there is still an outstanding balance. If the credit balance has already been reduced when the payment is received by Medicaid, the payment will be applied against the remaining credit balance. The remainder of the funds from that payment will be refunded to the provider.

Send checks for credit balances listed on the Notice of Recovery to:

Utah Department of Health and Human Services
Office of Financial Services
P. O. Box 143104
Salt Lake City, UT 84114-3104

Mail checks for Third Party Liability payments (excluding Medicare Crossover claim adjustments) to:

Office of Recovery Services Medicaid Section, Team 85
P. O. Box 45025
Salt Lake City, UT 84145-0025

For questions regarding payments sent to ORS, call (801) 741-7437
A **replacement claim** will correct units, charges including Third Party Liability (TPL) and client information. Check the **5010 Companion guide** for electronic claims submission requirements here: https://medicaid.utah.gov/hipaa/providers/#companion-guides.

Please do not send checks intended for a Medicaid Managed Care Entity (MCE) to the above listed addresses. To ensure proper reimbursement follow each MCE’s guideline for returning Payment Adjustments.

PAYMENT ADJUSTMENT REQUEST

Check all that apply:

☐ Additional information is attached

Make all Checks Payable to: Utah Office of Inspector General

If for a Third Party Liability adjustment an Explanation of Benefit (EOB) must be included.

Payment Adjustment type:

☐ Credit Balance:
Fill out: Boxes 1-9 and 30 & 31

☐ All other Payment Adjustments:
Fill out: Boxes 2-31

1. Credit Balance:	2. Date: MM/DD/YY

3. Provider Name:

4. Provider Address:	5. Provider City:	6. Provider State:	7. Provider Zipcode:

8. Provider Number (NPI):	9. PRISM ID:

10. Payment Adjustment:	11. Warrant Date:	12. Warrant Number:	13. Member ID Number:

14. Claim Number (TCN):	15. Member First Name:	16. Member Last Name:

Boxes 17-19 apply to TPL claims only	17. Third Party Liability Name:	18. Policy Holder Full Name:	19. Policy Number:

20. Explain Reason for Adjustment:

	21. Dates of Service: MM/DD/YY		22. Days or Units	23. Procedure or Revenue			24. Explanation of Change:	25. New Charges/ Line Level TPL	26. Original Charges:
	FROM	TO		CODE	MOD	MOD			
A									
B									
C									
D									
E									
F									
G									

Contact Information

30. Provider/Provider Representative:

31. Telephone Number:

27. Total Amount:		
28. TPL (Claim Level):		
29. Net Adjustment:		

FOR STATE USE ONLY:

Explanation of denial:

Denial Reason:	Clerk I.D.:	Date: MM/DD/YY

Payment Adjustment form for Pharmacy

Check#

Date:		Submitter Name:		Contact Phone:	
Provider NPI:		Store Name:		Page Total:	

Office Use Only

	Medicaid ID	Date of Service	TCN#	RX#	Amount	Reason for Return		
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36								
37								
38								
39								
40								
				Total				

rev. 07012016

Medicaid Information: Phone Menu Options

Providers and Medicaid members can access information efficiently by using the telephone menu options on the Medicaid Information Line.

Medicaid Information Line

From the Salt Lake area, call: **801-538-6155**

Outside Salt Lake City area, Idaho, Wyoming, Colorado, New Mexico, Arizona, and Nevada, call toll-free: **1-800-662-9651**

From any other states not listed above, please call: **1-801-538-6155**

There are nine options on the **Main Medicaid Information Menu.** These are listed in the column to the right.

Telephone Menu Options

Options marked with a ☎ in the list below are for Medicaid providers. Option 7 is strictly for Medicaid members use only.

☎	**1**	**Verify member eligibility**
☎	**2**	**Member**
☎	**3**	**Provider**
☎	**4**	**Health Plan Information**
☎	**5**	**Medically Complex Children Waiver**
☎	**6**	**New Choices Waiver**
	7	**Spanish (Member Menu only)**
☎	**8**	**Restriction**
☎	**9**	**Health Program Representative**

Medicaid Providers: Telephone Menu Options 1, 2 & 3 have nested menus. Each nested menu is described below:

☎ **1 Verify Member Eligibility**

- Press **1** For on-line Member Eligibility Verification – visit medicaid.utah.gov/eligibility
- Press **2** For a Member Eligibility Verification agent (during business hours)

☎ **2 Member**

- **Press 1** Restriction
- **Press 2** CSU – member benefits like transportation & health plan
- **Press 3** Buyout
- **Press 4** Certificate of Creditable Coverage
- **Press 5** All claims including Pharmacy
- **Press 6** Health Plan or HPR
- **Press 7** Report fraud or misuse of services

☎ **3 Health Care Provider**

- Press **1** Transportation Team for prior approval for non-emergency transportation.
- Press **2** Customer Service Representative
- Press **3** Prior Authorization Unit for prior authorization requests and approvals.
- Press **4** Provider Enrollment Team for enrollment questions on recertification, changes to billing address, or EFT (direct deposit).
- Press **5** EDI Billing Team for technical support with all electronic transactions including electronic claims submission, eligibility inquiry & electronic remittance advice.
- Press **6** Restriction Team for assistance with services for restricted members.
- Press **7** Program Integrity Team for reporting fraud or misuse of services.
- Press **8** Custody Medical Care
- Press **9** Indian Health Services and Juvenile Justice Services

☎ **4 Managed Care Organization**

- Press **1** Address & Phone Numbers
- Press **2** Health Plan Enrollment & Changes

☎ **5 Medically Complex Children Waiver (MCCW)**

☎ **6 New Choices Waiver (NCW)**

7 Spanish – Member Menu

☎ **8 Restriction**

☎ **9 Health Program Representative**

Hours of Operation

Medicaid Customer Service

Monday	8:00 A.M. – 5:00 P.M.
Tuesday	11:00 A.M. – 5:00 P.M.
Wednesday	8:00 A.M. – 5:00 P.M.
Thursday	8:00 A.M. – 5:00 P.M.
Friday	8:00 A.M. – 5:00 P.M.

HPR, Restriction, Rx Prior Auth

Monday	8:00 A.M. - 5:00 P.M.
Tuesday	8:00 A.M. - 5:00 P.M.
Wednesday	8:00 A.M. - 5:00 P.M.
Thursday	8:00 A.M. - 5:00 P.M
Friday	8:00 A.M. - 5:00 P.M.

Prior Authorization

Monday	8:00 A.M. - 5:00 P.M.
Tuesday	11:00 A.M. - 5:00 P.M.
Wednesday	8:00 A.M. - 5:00 P.M.
Thursday	8:00 A.M. - 5:00 P.M
Friday	8:00 A.M. - 5:00 P.M.

NOTE: Our office is closed on all State and Federal holidays.

Updated April 2024

UTAH MEDICAID
REMITTANCE ADVICE FORM REQUEST

A Remittance Advice is not to be requested prior to *30 days* from the date of payment. Please Allow 7-10 business days for processing. If the remittance advice was originally sent electronically, contact your clearinghouse or vendor to request the remittance.

REQUESTOR INFORMATION

Name (PRINT) (*Required*) ______________________

Title (*Required*) ______________________

Billing Company Name (if applicable) ______________________

Phone # (*Required* (________)______________________

E-mail Address (*Required*) ______________________

Attestation: I declare under penalty of perjury that I am an authorized agent of the provider listed below, and therefore am entitled to receive the Remittance Advice or Health Care Claim Payment/Advice (835) transaction covered under HIPAA Privacy rules and regulations pertaining to release of Personal Health Information/Personally Identifiable Information (PHI/PII) information.

Signature (*Required*) ______________________

Date (*Required*) ______________________

PROVIDER INFORMATION

Provider/Facility Name (*Required*) ______________________

NPI/Contract Number-Atypical (*Required*) ______________________

Tax ID Number *(Required)* ______________________

Contact Name *(Required)* ______________________

Phone Number *(Required)* (________)______________________

Address (*Required*) ______________________

Suite ______________________

City *(Required)* ______________________

State *(Required)* ______________________

ZIP Code *(Required)* ______________________

One Provider Per Worksheet
** If the Remittance Advice requested is being sent via US Mail and is over 25 pages, a charge of $0.12 will be assessed for each additional page. Payment must be received before the remittance is mailed out.

Run Date (*Required*)	Warrant Number *(Required)*	Amount

For Official Use Only:

Action Taken: ______________________

Name / Date ______________________

Return Document Request Form by mail or fax to:
Bureau of Medicaid Operations
PO Box 143106
Salt Lake City, UT 84114-3106
Fax: (801) 536-0498

UTAH MEDICAID WARRANT REQUEST FORM

REQUESTOR INFORMATION

Name (PRINT) (*Required*) | Title (*Required*)

Billing Company Name (if applicable) | ( ) Phone # (*Required*) | E-mail Address (*Required*)

Address (*Required*) | Suite

City (*Required*) | State (*Required*) | ZIP Code (*Required*)

SIGNATURE | Date (*Required*)

PROVIDER INFORMATION

Provider/Facility Name (*Required*) | NPI/Contract Number-Atypical (*Required*)

Tax ID Number (*Required*) | Contact Name (*Required*) | ( ) Phone Number (*Required*)

Address (*Required*) | Suite

City (*Required*) | State (*Required*) | ZIP Code (*Required*)

☐ **Warrant Tracer** (Paper Checks)

Warrant Date (Not Run Date)	Warrant # (*Required*)	Warrant Amount *Required)*
Warrant Date (Not Run Date)	Warrant # (*Required*)	Warrant Amount *Required)*
Warrant Date (Not Run Date)	Warrant # (*Required*)	Warrant Amount *Required)*
Warrant Date (Not Run Date)	Warrant # (*Required*)	Warrant Amount *Required)*

Return Warrant Request Form by mail or fax to:

Bureau of Medicaid Operations
PO Box 143106
Salt Lake City, UT 84114-3106
Fax: (801) 536-0476