2023 Medicaid Statewide Provider Training

Managed Care & Specialties

Utah Department of Health & Human Services

Agenda

- Overview of Managed Care
  - Appeals/grievances/hearings
  - Billing
  - Plans
- Medicaid Dental Services
  - Dental Policy Updates
- Durable Medical Equipment (DME)
- Behavioral Health Services
- Electronic Visit Verification (EVV)

Managed care

Managed care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid and CHIP managed care provides for the delivery of health benefits and additional services through contracted arrangements between the Department of Health and Human Services (DHHS) and Managed Care Entities (MCE).

Medicaid managed care programs:

- ACO - Accountable Care Organizations (physical health)
- UMIC - Utah Medicaid Integrated Care (physical health and behavioral health)
  - Only in five counties: Weber, Davis, Salt Lake, Utah, and Washington counties
- HOME - Healthy Outcomes, Medical Excellence (physical health and behavioral health)
- Dental
- PMHP - Prepaid Mental Health Plans (behavioral health)

CHIP managed care programs:

- MCO - Managed Care Organizations (physical health and behavioral health)
- Dental

For more information and latest managed care information, please visit
https://medicaid.utah.gov/managed-care/

Appeals, grievances, and fair hearings for managed care plans

Through appeals, grievances and fair hearings, members and providers have various mechanisms and pathways to pursue reviews on adverse benefit determinations and express dissatisfaction about matters involving managed care plans.

Each will be reviewed on subsequent slides.

Managed care plan appeals

- Upon an adverse benefit determination (e.g. claim denial), the provider or member may submit an appeal directly to the managed care plan for a review of the adverse action
- The appeal request must be submitted within 60 calendar days from the date on the Notice of Adverse Benefit Determination (e.g. claim denial)
- The managed care plan will provide information about how to file an appeal on the notice adverse benefit determination
- The managed care plan should complete the appeal review and provide notice of the outcome within 30 calendar days
- If the results of the appeal uphold the adverse benefit, details on requesting a State Fair Hearing will be provided by the managed care plan
- Providers and members can request an expedited appeal through the managed care plan for urgent needs

State Fair Hearing

- Members or providers are able to file a State Fair Hearing request when the appeals process with the managed care plan are exhausted
- The managed care plan will include details on how to file a State Fair Hearing on the final appeal resolution notice
- The State Fair Hearing involves participation from parties, including an Administrative Law Judge (ALJ), representatives from the managed care plan, representatives from the member or provider and representatives from DHHS
    - This can also include legal representation, but is not a requirement
- Each party will be able to present evidence, documentation, and testimony regarding the situation
- If the parties are unable to come to a resolution, the ALJ will make a decision based on the facts of the case

Managed care plan grievances

- Medicaid members may file a grievance with the managed care plan
- Grievances are a method to express dissatisfaction about any matter other than an adverse benefit determination
- The managed care plan has 90-days to respond to/resolve the grievance
- Managed care plans accept grievances either in writing or orally

Billing a managed care plan

- Providers must contract as a network provider or be enrolled as a paneled provider in each managed care plan prior to rendering services to a member enrolled in a managed care plan
- Providers must ensure that any prior authorizations or criteria required by the managed care plan are followed
- Providers should utilize the Eligibility Lookup Tool prior to rendering services to know if a member is enrolled in a managed care plan on the date of service
    - The tool can be found at https://medicaid.utah.gov/eligibility/
- Providers must contact the member's managed care plan for billing and claims questions

Managed care entity contact information

Managed Care Plan Name	Plan Type	Phone	Website
Health Choice	ACO/Integration	1-877-358-8797	www.healthchoiceutah.com
Healthy U	ACO/Integration	1-888-271-5870	www.uhealthplan.utah.edu/medicaid
Molina Healthcare of Utah	ACO/Integration/CHIP	1-888-483-0760	www.molinahealthcare.com
SelectHealth Community Care	ACO/Integration/CHIP	1-800-538-5038	www.selecthealth.org/plans/medicaid
HOME Program	HOME	1-800-824-2073	healthcare.utah.edu/uni/programs/home/
MCNA Dental	Dental	1-844-904-6262	www.MCNAUT.net
Premier Access Dental	Dental/CHIP Dental	1-877-541-5415	www.premierlife.com/utmedicaid

Managed care entity contact information

Prepaid Mental Health Plans (PMHP)

County	Inpatient & Outpatient Mental Health Services	Outpatient Substance Use Disorder Services
Box Elder, Cache, Rich	Bear River Mental Health 1-800-620-9949; 435-752-0750	Fee-for-Service Network (any Medicaid provider), including Bear River Health Department: 435-792-6500
Beaver, Garfield, Kane, Iron, Washington	Southwest Behavioral Health Center 1-800-574-6763; 435-634-5600 (hospital prior authorization: 435-705-1388)	Southwest Behavioral Health Center 1-800-574-6763; 435-634-5600
Carbon, Emery, Grand	Four Corners Community Behavioral Health 1-866-216-0017; 435-637-7200 (hospital prior authorization: 435-637-2358 & after hours: 435-637-0893)	Four Corners Community Behavioral Health 1-866-216-0017; 435-637-7200
Daggett, Duchesne, Uintah, San Juan	Northeastern Counseling Center 1-844-824-6776 435-789-6300 – Vernal 435-725-6300 – Roosevelt San Juan Counseling – San Juan County 1-888-833-2992; 435-678-2992	Northeastern Counseling Center 1-844-824-6776 435-789-6300 – Vernal 435-725-6300 – Roosevelt San Juan Counseling – San Juan County 1-888-833-2992; 435-678-2992
Davis	Davis Behavioral Health 1-844-305-4782; 801-773-7060	Davis Behavioral Health 1-844-305-4782; 801-773-7060
Piute, Juab, Wayne, Millard, Sanpete, Sevier	Central Utah Counseling Center 1-800-523-7412; 435-283-8400; 1-877-469-2822	Central Utah Counseling Center 1-800-523-7412; 435-283-8400; 1-877-469-2822
Salt Lake	Salt Lake County Division of Behavioral Health Services/Optum Salt Lake County: 385-468-4707; Optum: 1-877- 370-8953	Salt Lake County Division of Behavioral Health Services/Optum Salt Lake County: 385-468-4707; Optum: 1-877- 370-8953
Summit	Healthy U Behavioral 1-833-981-0212; 801-213-4104	Healthy U Behavioral 1-833-981-0212; 801-213-4104
Tooele	Optum Tooele County 1-800-640-5349	Optum Tooele County 1-800-640-5349
Utah	Wasatch Behavioral Health 1-866-366-7987; 801-373-4760 (prior approvals: 801-494-0880)	Wasatch Behavioral Health 1-844-773-7128; 385-268-5000
Wasatch	Fee-for-Service Network (any Medicaid provider), including Wasatch County Family Clinic/Wasatch Behavioral Health - 435-654-3003	Fee-for-Service Network (any Medicaid provider), including Wasatch County Family Clinic/Wasatch Behavioral Health, 435-654-3003
Weber, Morgan	Weber Human Services 1-844-625-3700; 801-625-3700; (after-hours hospital prior authorization: 801-513-9641)	Weber Human Services 1-844-625-3700; 801-625-3700

Medicaid dental services

Who receives comprehensive dental services?

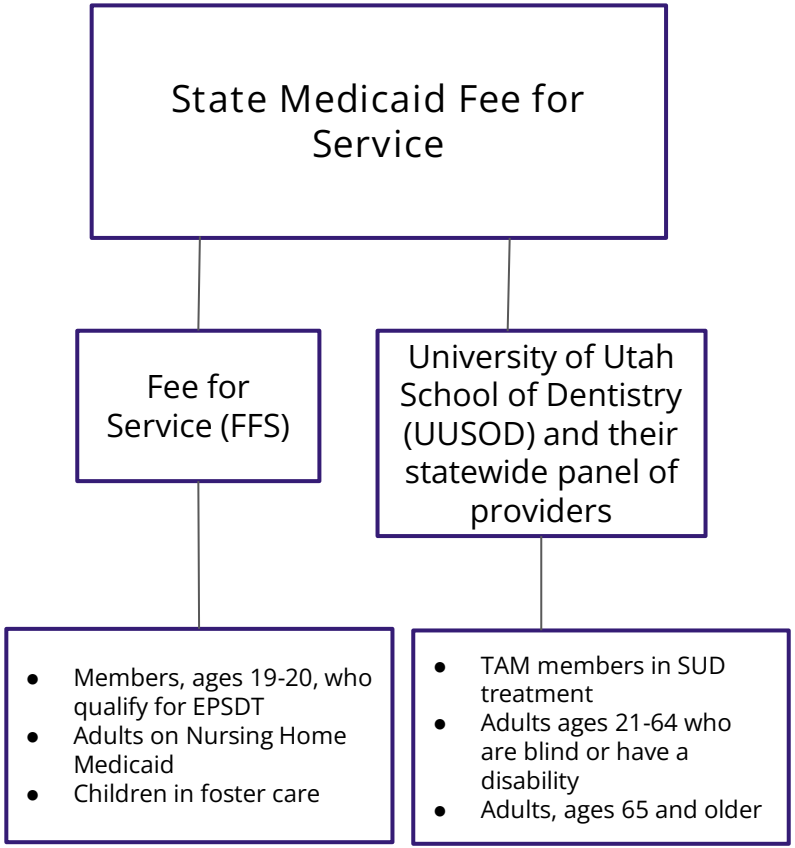
The following Medicaid populations receive full comprehensive dental services:

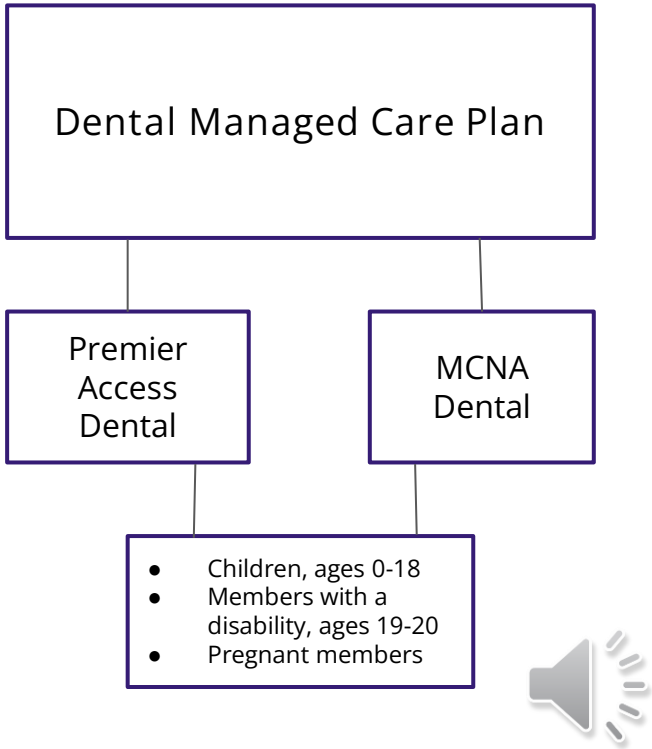
- Children, ages 0-20
- Pregnant members
- Individuals with a disability
- Seniors (age 65 and older)
- Members enrolled in Targeted Adult Medicaid (TAM), ages 21-64 who are enrolled in a substance use treatment program

Utah Medicaid dental delivery networks

- Member's are assigned to a delivery network based on their Medicaid eligibility
- The three Medicaid dental networks are:
  - Fee for Service
  - Managed Care Dental
  - University of Utah School of Dentistry (UUSOD)
- Utah Medicaid contracts with two Dental Managed Care Plans to provide dental services statewide:
  - Premier Access
  - MCNA Dental
- Members who are assigned to a Dental Managed Care Plan must see a dental provider listed in their dental plan network
- Once they choose a Dental Managed Care Plan member's have 60-days to make a different selection and after that they must wait until the annual open enrollment if they want to change their plan
- Members assigned to the UUSOD must use dentists who are on their statewide panel of providers.

Dental delivery by model and population





Medicaid Dental Managed Care

Utah Medicaid contracts with two dental plans statewide to provide dental services to eligible Medicaid enrollees.

In the next few slides we will discuss:

- Services covered by dental managed care plans
- Services not covered by dental managed care plans
- Obtaining a prior authorization for members enrolled in a dental managed care plan
- Recent policy updates

Dental Managed Care Plan services

Dental managed Care plans are responsible to pay for covered dental services for their enrolled members.

In addition to paying for dental services, Dental Managed Care Plans can help:

- Coordinate dental care for members with special health care needs
- Arrange for and provide interpretive services
    - Members must use an interpreter contracted with their dental plan
    - Providers can and should refer Medicaid patients to their dental plan to arrange for an interpreter if needed.
- Provide case management for members who need to see a specialist
- Help providers and members find dental specialists on their network
- Resolve billing and third party liability (TPL) problems
    - Provider's and members should contact their dental plan if they have questions about a bill or an unpaid claim.

Services not covered by the Dental Managed Care Plan

There are some services that are not covered by the dental managed care plan but may be covered by the medical plan or FFS. These are called “Carved Out” services.

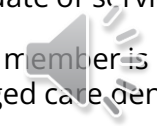
Some carved out services from the Dental Managed Care Plan are:

- The facility fees for dental anesthesia in a hospital or ambulatory surgical center
- Transportation services, both emergent and non emergent
- Dental services related to the correction of oral maxillofacial anomalies

Prior authorizations (PA) for managed care dental plans

When a PA is required for a service and the member is enrolled in a dental managed care plan:

- The dental plan's provider manual should be referred to for information about prior authorization requirments.
- All PA requests and records are submitted to the member's dental plan listed on the Eligibility Lookup Tool (ELT)
- The dental plans will only honor a PA from Fee for Service or another Medicaid dental plan if the member was enrolled in FFS or another dental plan when the PA was issued
    - They will honor the PA for 90 days
    - Orthodontia may have the PA honored for more than 90 days for the continuation of care during the orthodontic treatment period.
- Always verify the member's eligibility at the time authorization is requested AND on the date of service.
    - The PA will only be honored if the member is eligible and enrolled in the managed care dental plan on the service date



Updates in Medicaid Dental Policies

Dental hygienists

- Beginning January 1, 2023, dental hygienists may be reimbursed for services performed independently in a public health setting
- As of 7/1/23 dental hygienists are no longer required to work under a written agreement or general supervision of a dentist
- Covered services available to the dental hygienist provider type are limited
    - Refer to the Coverage and Reimbursement Lookup Tool for information regarding code coverage

Endodontics

Rate Increase

An increased reimbursement rate for endodontic services was applied for CDT codes D3310, D3320, D3330 and D3410, effective August 1, 2022. These new rates are applied to Fee for Service and managed care dental providers who pay equal to or greater than the new rates. The increased rates are as follows:

Code	Previous Rate	8/1/22 Rate
D3310 - Anterior Root Canal	$232.86	$330.00
D3320 - Bicuspid Root Canal	$294.94	$394.00
D3330 - Molar Root Canal	$349.28	$487.00
D3410 - Anterior Apicoectomy	$176.97	$281.00

Resin-based composite restoration

Coverage

- Effective July 1, 2022, Medicaid now covers posterior resin-based composite restorations for EPSDT and pregnant members

- The dental managed care plans will pay for these services for all enrolled members

Durable medical equipment/supplies

Automatic blood pressure monitor

Coverage

- Medicaid covers the purchase of an automatic blood pressure monitor when medically necessary
    - Reported under HCPCS code A4670 - automatic blood pressure monitor
- The monitor must be ordered by a qualified practitioner
- In-home monitoring of blood pressure readings must be required as part of a comprehensive treatment plan
- A unit limit of one every three years applies
- Refer to the Coverage and Reimbursement Lookup Tool for more information

Nutritional services

- The Medical Supplies and Durable Medical Equipment Services manual was updated as of July 1, 2022 to reflect the current coverage of medical foods and enteral formulas, including:
    - Clarification for providers concerning coverage of medical foods and enteral formulas for members with dual eligibility for Medicaid and the Utah Women, Infants, and Children (WIC) nutrition program
        - Medicaid is the primary payor for for dual eligible members
            - Formula must meets medical necessity criteria
            - Must meet policy criteria for coverage
- Clarification provided concerning coverage of medical foods and enteral formulas for the treatment of inborn errors of metabolism

Nutritional services

- Effective September 1, 2022, prior authorization requirements were removed from enteral formula products for members enrolled in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. This includes products reported under the following HCPCS codes:
    - B4149—EF blenderized foods
    - B4150—EF complete w/intact nutrient
    - B4152—EF calorie dense>/=1.5Kcal
    - B4153—EF hydrolyzed/amino acids
    - B4154—EF spec metabolic non-inherit
    - B4155—EF incomplete/modular
    - B4157—EF special metabolic inherit
    - B4158—EF ped complete intact nut
    - B4159—EF ped complete soy based
    - B4160—EF ped caloric dense>/=0.7kc
    - B4161—EF ped hydrolyzed/amino acid
    - B4162—EF ped spec metabolic inherit

Behavioral Health Services

Autism spectrum disorder services

Manual Update

- The Autism Spectrum Disorder (ASD) Services Provider Manual was updated on January 1, 2023. Changes to the manual include:
  - The style of the manual was changed to meet the style guidelines used for Utah Medicaid provider manuals
  - Unnecessary and redundant information was removed from the manual
  - Medicaid now accepts any standardized assessment tool used to diagnose the presence of ASD according to current DSM criteria
  - The PA requirement was removed for CPT 97151 - *Behavior identification assessment*
    - There continues to be limitations on the number of units a provider may report
  - HCPCS code H0032 has been opened for reporting of indirect case supervision services
    - Direct case supervision services will continue to be reported using CPT code 97155

Autism spectrum disorder services

Manual Update continued…

Direct and indirect supervision services require the use of a modifier that indicates the credentials of the clinician performing supervision responsibilities

- Restrictions placed on services that may be performed by qualified clinicians have been changed to correspond with the licensing requirements detailed in applicable practice act rule
- Parent training reported using CPT 97156 may be performed with or without the child present
- Providers may request alternative service hour combinations
    - That equal less than 30 hours/week for ABA services performed by a behavior technician
    - That equal less than 29 hours every six month authorization period for behavior therapist services
- Progress data for ongoing ABA services previously reported in graphical format or utilizing specific assessment tools is no longer required
- Supervision and parent training may be performed by a behavior therapist via telehealth regardless of geographic location

Autism spectrum disorder services

Applied Behavior Analysis Services for Adults

- Effective July 1, 2023, applied behavior analysis (ABA) services will be a covered benefit for all eligible members with a diagnosis of autism spectrum disorder (ASD), regardless of age
    - The Autism Spectrum Disorder Services Provider Manual has been updated to remove references to these services being limited to EPSDT eligible members only

Behavioral health groups

As of November 2022, if the patient-to-provider ratio exceeds the limit established in the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual then the group may not be reported for any of the Medicaid members attending the group.

See the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual for more details.

Electronic Visit Verification (EVV)

What is Electronic Visit Verification (EVV)?

- EVV is a system that includes multiple point-of-care verification technologies, such as telephonic, mobile, and web-based verification inputs
- The system electronically verifies the occurrence of home or community based service visits, identifying the precise time that service provision begins and ends to ensure accurate claims disbursement
- All personal care services (PCS) and home health services (HHS) are required to capture and submit an Electronic Visit Verification record
- Providers may choose the EVV system that best meets their needs as long as the system meets federal and state requirements

EVV record submission FAQs

Question: Which providers need to capture and submit EVV records?

Answer: All providers that provide personal care services or home health services. A list of applicable service codes can be found in the EVV Provider Training.

Question: When do I submit EVV records?

Answer: EVV Records should be submitted within three months of submitting the claim for payment.

Question: How do I submit EVV records?

Answer: EVV records can be submitted via API or CSV. Refer to medicaid.utah.gov/evv for detailed instructions on how to structure the submitted files.

Question: What if I don't submit EVV records?

Answer: Each provider will be audited annually. Financial penalties are assessed for non-compliance.

Contact the EVV team by email at: dmhf_evv@utah.gov

Contact us

For additional questions, please email:

Dental Managed Care
Jennifer Wiser: jwiser@utah.gov

ACO and HOME plans
Trevor Smith: trevorsmith@utah.gov

Prepaid Mental Health Plans (PMHP)
medicaidbh@utah.gov

Policy Questions
dmhfmedicalpolicy@utah.gov