DMHF Rules Matrix 1-20-22

Rule Summary	Bulletin Publication	Effective
R414-1 Utah Medicaid Program (Five-Year Review); The Department will continue this rule because it sets forth services and eligibility for the Medicaid program, specifies provider and member policy, specifies the role of certain entities within the Medicaid program, specifies the availability of program manuals and policies, and serves as the basis for all other rules in the Medicaid program.	**1-1-22**	**12-13-21**
R414-10A Transplant Services Standards (Five-Year Review); The Department will continue this rule because it defines important terms and provisions, sets forth eligibility and access requirements, specifies service coverage and prior authorization, clarifies covered and non-covered services for stem cell transplantation, and lists criteria for requests of non-covered services.	**1-1-22**	**12-13-21**
R414-21 Physical Therapy and Occupational Therapy (Five-Year Review); The Department will continue this rule because it implements physical therapy and occupational therapy for Medicaid members, and implements reimbursement to service providers.	**1-1-22**	**12-13-21**
R414-38 Personal Care Services; (Five-Year Review); The Department will continue this rule because it implements personal care services for Medicaid members and reimbursement for personal care providers, by referencing the Personal Care Utah Medicaid Provider Manual and the Medicaid State Plan.	**1-1-22**	**12-13-21**

The public may access proposed rules published in the State Bulletin at https://rules.utah.gov/publications/utah-state-bull/

State of Utah
Administrative Rule Analysis
Revised November 2021

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
	Title No. - Rule No.	
Utah Admin. Code Ref (R no.):	**R414-1**	**Filing ID: (Office Use Only)**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health	
Agency:	Division of Medicaid and Health Financing	
Room no.:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84114-3101	
Mailing address:	PO Box 143101	
City, state and zip:	Salt Lake City, UT 84114-3101	
Contact person(s):		
Name:	**Phone:**	**Email:**
Craig Devashrayee	801-538-6641	cdevashrayee@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule catchline:
Utah Medicaid Program
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
Section 26-18-3 requires the Department to implement Medicaid policy through administrative rules, which allow the Department to administer the Medicaid program. Additionally, Section 26-1-5 authorizes the Department to adopt rules that provide services and eligibility for Medicaid members.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it sets forth services and eligibility for the Medicaid program, specifies provider and member policy, specifies the role of certain entities within the Medicaid program, specifies the availability of program manuals and policies, and serves as the basis for all other rules in the Medicaid program.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.			
Agency head or designee, and title:	Nate Checketts	**Date** (mm/dd/yyyy)**:**	12/12/2021
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or nonsubstantive change.			

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-1. Utah Medicaid Program.
R414-1-1. Introduction and Authority.

(1) This rule generally characterizes the scope of the Medicaid Program in Utah, and defines all of the provisions necessary to administer the program.

(2) The rule is authorized by Title XIX of the Social Security Act, and Sections 26-1-5, 26-18-2.1, 26-18-2.3, UCA.

R414-1-2. Definitions.

The following definitions are used throughout the rules of the Division:

(1) "Act" means the federal Social Security Act.

(2) "Applicant" means any person who requests assistance under the medical programs available through the Division.

(3) "Categorically needy" means aged, blind or disabled individuals or families and children:

(a) who are otherwise eligible for Medicaid; and

(i) who meet the financial eligibility requirements for AFDC as in effect in the Utah State Plan on July 16, 1996; or

(ii) who meet the financial eligibility requirements for SSI or an optional State supplement, or are considered under section 1619(b) of the federal Social Security Act to be SSI recipients; or

(iii) who is a pregnant woman whose household income does not exceed 133% of the federal poverty guideline; or

(iv) is under age six and whose household income does not exceed 133% of the federal poverty guideline; or

(v) who is a child under age one born to a woman who was receiving Medicaid on the date of the child's birth and the child remains with the mother; or

(vi) who is least age six but not yet age 18, or is at least age six but not yet age 19 and was born after September 30, 1983, and whose household income does not exceed 100% of the federal poverty guideline; or

(vii) who is aged or disabled and whose household income does not exceed 100% of the federal poverty guideline; or

(viii) who is a child for whom an adoption assistance agreement with the state is in effect.

(b) whose categorical eligibility is protected by statute.

(4) "Code of Federal Regulations" (CFR) means the publication by the Office of the Federal Register, specifically Title 42, used to govern the administration of the Medicaid Program.

(5) "Client" means a person the Division or its duly constituted agent has determined to be eligible for assistance under the Medicaid program.

(6) "CMS" means The Centers for Medicare and Medicaid Services, a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, and the State Children's Health Insurance Program.

(7) "Department" means the Department of Health.

(8) "Director" means the director of the Division.

(9) "Division" means the Division of Health Care Financing within the Department.

(10) "Emergency medical condition" means a medical condition showing acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

(a) placing the patient's health in serious jeopardy;

(b) serious impairment to bodily functions;

(c) serious dysfunction of any bodily organ or part; or

(d) death.

(11) "Emergency service" means immediate medical attention and service performed to treat an emergency medical condition. Immediate medical attention is treatment rendered within 24 hours of the onset of symptoms or within 24 hours of diagnosis.

(12) "Emergency Services Only Program" means a health program designed to cover a specific range of emergency services.

(13) "Executive Director" means the executive director of the Department.

(14) "InterQual" means the McKesson Criteria for Inpatient Reviews, a comprehensive, clinically based, patient focused medical review criteria and system developed by McKesson Corporation.

(15) "Medicaid agency" means the Department of Health.

(16) "Medical assistance program" or "Medicaid program" means 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.

(17) "Medical or hospital assistance" means services furnished or payments made to or on behalf of recipients under medical programs available through the Division.

(18) "Medically necessary service" means that:

(a) 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

(b) 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.

(19) "Medically needy" means aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid, who are not categorically needy, and whose income and resources are within limits set under the Medicaid State Plan.

(20) "Medical standards," as applied in this rule, means that an individual may receive reasonable and necessary medical services up until the time a physician makes an official determination of death.

(21) "Prior authorization" means the required approval for provision of a service that the provider must obtain from the Department before providing the service. Details for obtaining prior authorization are found in Section I of the Utah Medicaid Provider Manual.

(22) "Provider" means any person, individual or corporation, institution or organization that provides medical, behavioral or dental care services under the Medicaid program and who has entered into a written contract with the Medicaid program.

(23) "Recipient" means a person who has received medical or hospital assistance under the Medicaid program, or has had a premium paid to a managed care entity.

(24) "Undocumented alien" means an alien who is not recognized by Immigration and Naturalization Services as being lawfully present in the United States.

(25) "Utilization review" means the Department provides for review and evaluation of the utilization of inpatient Medicaid services provided in acute care general hospitals to patients entitled to benefits under the Medicaid plan.

(26) "Utilization Control" means the Department has implemented a statewide program of surveillance and utilization control that safeguards against unnecessary or inappropriate use of Medicaid services, safeguards against excess payments, and assesses the quality of services available under the plan. The program meets the requirements of 42 CFR, Part 456.

R414-1-3. Single State Agency.

The Utah Department of Health is the Single State Agency designated to administer or supervise the administration of the Medicaid program under Title XIX of the federal Social Security Act.

R414-1-4. Medical Assistance Unit.

Within the Utah Department of Health, the Division of Health Care Financing has been designated as the medical assistance unit.

R414-1-5. Incorporations by Reference.

The Department incorporates the January 2018 versions of the following by reference:

(1) Utah Medicaid State Plan, including any approved amendments, under Title XIX of the Social Security Act Medical Assistance Program;

(2) Medical Supplies and Durable Medical Equipment Utah Medicaid Provider Manual, as applied in Rule R414-70, and the manual's attachment for Donor Human Milk Request Form;

(3) Hospital Services Utah Medicaid Provider Manual with its attachments;

(4) Home Health Agencies Utah Medicaid Provider Manual, and the manual's attachment for the Private Duty Nursing Acuity Grid;

(5) Speech-Language Pathology and Audiology Services Utah Medicaid Provider Manual;

(6) Hospice Care Utah Medicaid Provider Manual;

(7) Long Term Care Services in Nursing Facilities Utah Medicaid Provider Manual with its attachments;

(8) Personal Care Utah Medicaid Provider Manual;

(9) Utah Home and Community-Based Waiver Services for Individuals Age 65 or Older Utah Medicaid

Provider Manual;

(10) Utah Home and Community-Based Waiver Services for Individuals with an Acquired Brain Injury Utah Medicaid Provider Manual;

(11) Utah Community Supports Waiver for Individuals with Intellectual Disabilities or Other Related Conditions Utah Medicaid Provider Manual;

(12) Utah Home and Community-Based Services Waiver for Individuals with Physical Disabilities Utah Medicaid Provider Manual;

(13) Utah Home and Community-Based Waiver Services New Choices Waiver Utah Medicaid Provider Manual;

(14) Utah Home and Community-Based Services Waiver for Technology Dependent, Medically Fragile Individuals Utah Medicaid Provider Manual;

(15) Utah Home and Community-Based Waiver Services Medicaid Autism Waiver Utah Medicaid Provider Manual;

(16) Office of Inspector General Administrative Hearings Procedures Manual;

(17) Pharmacy Services Utah Medicaid Provider Manual with its attachments;

(18) Drug Criteria and Limits Policy;

(19) Coverage and Reimbursement Code Look-up Tool found at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php;

(20) CHEC Services Utah Medicaid Provider Manual with its attachments;

(21) Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual;

(22) General Attachments (All Providers) for the Utah Medicaid Provider Manual;

(23) Indian Health Utah Medicaid Provider Manual;

(24) Medical Transportation Utah Medicaid Provider Manual;

(25) Non-Traditional Medicaid Plan Utah Medicaid Provider Manual with attachment;

(26) Licensed Nurse Practitioner Utah Medicaid Provider Manual;

(27) Physical Therapy and Occupational Therapy Services Utah Medicaid Provider Manual, and the manual's attachment for Physical Therapy and Occupational Therapy Decision Tables;

(28) Physician Services Utah Medicaid Provider Manual with its attachments;

(29) Podiatric Services Utah Medicaid Provider Manual;

(30) Primary Care Network Utah Medicaid Provider Manual with its attachments;

(31) Rehabilitative Mental Health and Substance Use Disorder Services Utah Medicaid Provider Manual;

(32) Rural Health Clinics and Federally Qualified Health Centers Services Utah Medicaid Provider Manual;

(33) School-Based Skills Development Services Utah Medicaid Provider Manual;

(34) Section I: General Information Utah Medicaid Provider Manual;

(35) Targeted Case Management for Individuals with Serious Mental Illness Utah Medicaid Provider Manual;

(36) Targeted Case Management for Early Childhood (Ages 0-4) Utah Medicaid Provider Manual;

(37) Vision Care Services Utah Medicaid Provider Manual;

(38) Medically Complex Children's Waiver Utah Medicaid Provider Manual; and

(39) Autism Spectrum Disorder Related Services for EPSDT Eligible Individuals Utah Medicaid Provider Manual.

R414-1-6. Services Available.

(1) Medical or hospital services available under the Medical Assistance Program are generally limited by federal guidelines as set forth under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

(2) The following services provided in the Utah Medicaid State Plan are available to both the categorically needy and medically needy:

(a) inpatient hospital services, with the exception of those services provided in an institution for mental diseases;

(b) outpatient hospital services and rural health clinic services;

(c) other laboratory and x-ray services;

(d) skilled nursing facility services, other than services in an institution for mental diseases, for individuals 21 years of age or older;

(e) early and periodic screening and diagnoses of individuals under 21 years of age, and treatment of conditions found, are provided in accordance with federal requirements;

(f) family planning services and supplies for individuals of child-bearing age;

(g) physician services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere;

(h) podiatrist services;

(i) optometrist services;

(j) psychologist services;

(k) interpreter services;

(l) home health services:

(i) intermittent or part-time nursing services provided by a home health agency;

(ii) home health aide services by a home health agency;

(iii) medical supplies, equipment, and appliances;

(m) private duty nursing services for children under 21 years of age;

(n) clinic services;

(o) dental services;

(p) physical therapy and related services;

(q) services for individuals with speech, hearing, and language disorders furnished by or under the supervision of a speech pathologist or audiologist;

(r) prescribed drugs, dentures, and prosthetic devices and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist;

(s) other diagnostic, screening, preventive, and rehabilitative services other than those provided elsewhere in the Utah Medicaid State Plan;

(t) services for individuals 65 years of age or older in institutions for mental diseases:

(i) inpatient hospital services for individuals 65 years of age or older in institutions for mental diseases;

(ii) skilled nursing services for individuals 65 years of age or older in institutions for mental diseases; and

(iii) intermediate care facility services for individuals 65 years of age or older in institutions for mental diseases.

(u) intermediate care facility services, other than services in an institution for mental diseases. These services are for individuals determined, in accordance with Subsection 1902(a)(31)(A) of the Social Security Act, to be in need of this care, including those services furnished in a public institution for the mentally retarded or for individuals with related conditions;

(v) inpatient psychiatric facility services for individuals under 22 years of age;

(w) nurse-midwife services;

(x) family or pediatric nurse practitioner services;

(y) physician assistant services;

(z) hospice care in accordance with Subsection 1905(o) of the Social Security Act;

(aa) case management services in accordance with Subsection 1905(a)(19) or Subsection 1915(g) of the Social Security Act;

(bb) extended services to pregnant women, pregnancy-related services, postpartum services for 60 days, and additional services for any other medical conditions that may complicate pregnancy;

(cc) 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; and

(dd) 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 440.170, including:

(i) medical or remedial services provided by licensed practitioners, other than physician services, within the scope of practice as defined by state law;

(ii) transportation services;

(iii) skilled nursing facility services for patients under 21 years of age;

(iv) emergency hospital services;

(v) personal care services in the recipient's home, prescribed in a plan of treatment and provided by a qualified person, under the supervision of a registered nurse; and

(ee) other medical care, medical supplies, and medical equipment not otherwise a Medicaid service if the Division determines that it meets both of the following criteria:

(i) it is medically necessary and more appropriate than any Medicaid-covered service; and

(ii) it is more cost effective than any Medicaid-covered service.

R414-1-7. Aliens.

Certain qualified aliens described in Title IV of Pub. L. No. 104 193, 110 Stat. 2105, may be eligible for the Medicaid program. All other aliens are prohibited from receiving non-emergency services as described in Section 1903(v) of the Social Security Act.

R414-1-8. Statewide Basis.

The medical assistance program is state-administered and operates on a statewide basis in accordance with 42 CFR 431.50.

R414-1-9. Medical Care Advisory Committee.

There is a Medical Care Advisory Committee that advises the Medicaid agency director on health and medical care services. The committee is established in accordance with 42 CFR 431.12.

R414-1-10. Discrimination Prohibited.

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subjected to discrimination under the plan on the grounds of race, color, gender, national origin, or handicap.

R414-1-11. Administrative Hearings.

The Department has a system of administrative hearings for medical providers and dissatisfied applicants, clients, and recipients that meets all the requirements of 42 CFR, Part 431, Subpart E.

R414-1-12. Utilization Review.

(1) The Department shall conduct hospital utilization reviews as outlined in the Hospital Services Utah Medicaid Provider Manual. The Department shall use the Hospital Services Utah Medicaid Provider Manual in effect at the time the service is rendered.

(2) The Department shall determine medical necessity and appropriateness of inpatient admissions through utilization reviews. Utilization reviews shall use an evidence-based criteria tool determined by the Department through the state's procurement process.

(3) The Department shall seek a contract implemented through a competitive solicitation process in accordance with Title 63G, Chapter 6a, Utah Procurement Code.

(4) The standards in the evidence-based criteria may not apply to services in which a determination has been made to utilize the following criteria:

(a) criteria customized by the Department;

(b) criteria excluded as a Medicaid benefit by rule or contract; or

(c) criteria for organ transplant services as described in Rule R414-10A.

(5) The Department shall approve or deny services based upon administrative rules or its own criteria set forth in the Medicaid provider manuals when the exceptions in Subsection R414-1-12(4) exist.

R414-1-13. Provider and Client Agreements.

(1) To meet the requirements of 42 CFR 431.107, the Department contracts with each provider who furnishes services under the Utah Medicaid Program.

(2) By signing a provider agreement with the Department, the provider agrees to follow the terms incorporated into the provider agreements, including policies and procedures, provider manuals, Medicaid Information Bulletins, and provider letters.

(3) By signing an application for Medicaid coverage, the client agrees that the Department's obligation to reimburse for services is governed by contract between the Department and the provider.

R414-1-14. Utilization Control.

(1) In order to control utilization, and in accordance with 42 CFR 440, Subpart B, services, equipment, or supplies not specifically identified by the Department as covered services under the Medicaid program are not a covered benefit. In addition, the Department will also use prior authorization for utilization control. All necessary and appropriate medical record documentation for prior approvals must be submitted with the request. If the provider has not obtained prior authorization for a service as outlined in the Medicaid provider manual, the Department shall deny coverage of the service.

(2) The Department may request records that support provider claims for payment under programs funded through the Department. These requests must be in writing and identify the records to be reviewed. Responses to requests must be returned within 30 days of the date of the request. Responses 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, the Department will close the record and will evaluate the payment based on the records available.

(3)(a) If the Department pays for a service which is later determined not to be a benefit of the Utah Medicaid program or does not comply with state or federal policies and regulations, the provider shall refund the payment upon written request from the Department.

(b) If services cannot be properly verified or when a provider refuses to provide or grant access to records, the provider shall refund to the Department all funds for services rendered. Otherwise, the Department may deduct an equal amount from future reimbursements.

(c) Unless appealed, the refund must be made to Medicaid within 30 days of written notification. An appeal of this determination must be filed within 30 days of written notification as specified in Rule R410-14.

(d) A provider shall reimburse the Department for all overpayments regardless of the reason for the overpayment.

(e) Provider appeals of action for recovery or withholding of money initiated by the Office of Inspector General of Medicaid Services (OIG) shall be governed by the OIG Administrative Hearings Procedures Manual incorporated by reference in Section R414-1-5.

R414-1-15. Medicaid Fraud.

The Department has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 for prevention and control of program fraud and abuse.

R414-1-16. Confidentiality.

State statute, Title 63G, Chapter 2, and Section 26-1-17.5, impose legal sanctions and provide safeguards that restrict the use or disclosure of information concerning applicants, clients, and recipients to purposes directly connected with the administration of the plan.

All other requirements of 42 CFR Part 431, Subpart F are met.

R414-1-17. Eligibility Determinations.

Determinations of eligibility for Medicaid under the plan are made by the Division of Health Care Financing, the Utah Department of Workforce Services, and the Utah Department of Human Services. There is a written agreement among the Utah Department of Health, the Utah Department of Workforce Services, and the Utah Department of Human Services. The agreement defines the relationships and respective responsibilities of the agencies.

R414-1-18. Professional Standards Review Organization.

All other provisions of the State Plan shall be administered by the Medicaid agency or its agents according to written contract, except for those functions for which final authority has been granted to a Professional Standards

Review Organization under Title XI of the Act.

R414-1-19. Timeliness in Eligibility Determinations.

The Medicaid agency shall adhere to all timeliness requirements of 42 CFR 435.911, for processing applications, determining eligibility, and approving Medicaid requests. If these requirements are not completed within the defined time limits, clients may notify the Division of Health Care Financing at 288 North, 1460 West, Salt Lake City, UT 84114-2906.

R414-1-20. Residency.

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403.

R414-1-21. Out-of-state Services.

Medicaid services shall be made available to eligible residents of the state who are temporarily in another state. Reimbursement for out-of-state services shall be provided in accordance with 42 CFR 431.52.

R414-1-22. Retroactive Coverage.

Individuals are entitled to Medicaid services under the plan during the 90 days preceding the month of application if they were, or would have been, eligible at that time.

R414-1-23. Freedom of Choice of Provider.

Unless an exception under 42 CFR 431.55 applies, any individual eligible under the plan may obtain Medicaid services from any institution, pharmacy, person, or organization that is qualified to perform the services and has entered into a Medicaid provider contract, including an organization that provides these services or arranges for their availability on a prepayment basis.

R414-1-24. Availability of Program Manuals and Policy Issuances.

In accordance with 42 CFR 431.18, the state office, local offices, and all district offices of the Department maintain program manuals and other policy issuances that affect recipients, providers, and the public. These offices also maintain the Medicaid agency's rules governing eligibility, need, amount of assistance, recipient rights and responsibilities, and services. These manuals, policy issuances, and rules are available for examination and, upon request, are available to individuals for review, study, or reproduction.

R414-1-25. Billing Codes.

In submitting claims to the Department, every provider shall use billing codes compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements as found in 45 CFR Part 162.

R414-1-26. General Rule Format.

The following format is used generally throughout the rules of the Division. Section headings as indicated and the following general definitions are for guidance only. The section headings are not part of the rule content itself. In certain instances, this format may not be appropriate and will not be implemented due to the nature of the subject matter of a specific rule.

(1) Introduction and Authority. A concise statement as to what Medicaid service is covered by the rule, and a listing of specific federal statutes and regulations and state statutes that authorize or require the rule.

(2) Definitions. Definitions that have special meaning to the particular rule.

(3) Client Eligibility. Categories of Medicaid clients eligible for the service covered by the rule: Categorically Needy or Medically Needy or both. Conditions precedent to the client's obtaining coverage such as age limitations or otherwise.

(4) Program Access Requirements. Conditions precedent external to the client's obtaining service, such as type of certification needed from attending physician, whether available only in an inpatient setting or otherwise.

(5) Service Coverage. Detail of specific services available under the rule, including limitations, such as number of procedures in a given period of time or otherwise.

(6) Prior Authorization. As necessary, a description of the procedures for obtaining prior authorization for

services available under the particular rule. However, prior authorization must not be used as a substitute for regulatory practice that should be in rule.

(7) Other Sections. As necessary under the particular rule, additional sections may be indicated. Other sections include regulatory language that does not fit into sections (1) through (5).

R414-1-27. Determination of Death.

(1) In accordance with the provisions of Section 26-34-2, the fiduciary responsibility for medically necessary care on behalf of the client ceases upon the determination of death.

(2) Reimbursement for the determination of death by acceptable medical standards must be in accordance with Medicaid coverage and billing policies that are in place on the date the physician renders services.

R414-1-28. Provider-Preventable Conditions.

(1) In accordance with 42 CFR 447.26, October 1, 2011 ed., which is incorporated by reference, Medicaid will not reimburse providers or contractors for provider-preventable conditions as noted therein. Please see Utah Medicaid State Plan Attachments 4.19-A and 4.19-B for detail.

(2) Medicaid providers who treat Medicaid eligible patients must report all provider-preventable conditions whether or not reimbursement for the services is sought. Medicaid providers shall meet this requirement by complying with existing state reporting requirements (rules and legislation) of these events that include:

(a) Rule R380-200;

(b) Rule R380-210;

(c) Rule R386-705;

(d) Rule R428-10; and

(e) Section 26-6-31.

(3) Utilizing the reporting mechanism from one of the rules noted above shall not impact confidentiality and privacy protections for reporting entities as noted in Title 26, Chapter 25, Confidential Information Release.

R414-1-29. Medicaid Policy for Reconstructive and Cosmetic Procedures.

(1) Reconstructive or restorative services are medically necessary; and

(a) performed on abnormal structures of the body to improve and restore bodily function; or

(b) performed to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention.

(2) Medicaid does not cover cosmetic procedures performed with the primary intent to improve appearance, nor does it cover non-medically necessary procedures performed in the same episode as a covered procedure.

(3) Coverage for reconstructive breast procedures related to cancer includes:

(a) reconstruction of the breast on which the procedure is performed; and

(b) reconstruction of the breast on which the procedure is not performed to produce a symmetrical appearance and prostheses.

(4) Medicaid limits reconstructive breast surgeries to initial occurrences that may include multi-step procedures.

(5) Medicaid does not cover repeat reconstructive breast procedures.

R414-1-30. Face-to-Face Requirements for Home Health Services.

(1) Orders for home health services and certain durable medical equipment (DME) must be in accordance with 42 CFR 440.70.

(2) DME that requires face-to-face shall be the same as DME items required by Medicare.

(3) No home health agency or DME supplier may report services for reimbursement until they meet the face-to-face requirement.

R414-1-31. Withholding of Payments.

(1) In addition to other remedies allowed by law and unless specified otherwise, the Department may withhold payments to a provider or contractor if:

(a) the provider or contractor fails to provide the requested information within 30 calendar days from the date of a written request for information;

(b) the provider or contractor has an outstanding balance owing the Department for any reason; or

(c) the provider or contractor receives more than $5,000,000 in reimbursement annually from the Department and fails to comply with Section 6032 of the Deficit Reduction Act. The Department or the Utah Office of the Inspector General may determine a provider to be noncompliant if the provider cannot submit, upon request:

(i) an attestation of compliance with Section 6032 of the Deficit Reduction Act;

(ii) the provider's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(iii) an employee handbook containing a specific discussion of the rights of employees to be protected as whistleblowers and the provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

(2) The Department shall provide written notice before withholding payments.

(3) When the Department rescinds withholding of payments to a provider or contractor, it will, without notice, resume payments according to the regular claims payment cycle.

KEY: Medicaid
Date of Last Change: November 15, 2021
Notice of Continuation: February 15, 2017
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3; 26-34-2

State of Utah
Administrative Rule Analysis
Revised November 2021

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
	Title No. - Rule No.	
Utah Admin. Code Ref (R no.):	**R414-10A**	**Filing ID: (Office Use Only)**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health	
Agency:	Division of Medicaid and Health Financing	
Room no.:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84114-3101	
Mailing address:	PO Box 143101	
City, state and zip:	Salt Lake City, UT 84114-3101	
Contact person(s):		
Name:	**Phone:**	**Email:**
Craig Devashrayee	801-538-6641	cdevashrayee@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule catchline:
Transplant Services Standards
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
Section 26-18-3 requires the Department to implement Medicaid policy through administrative rules, which allow the Department to administer the Medicaid program. Additionally, Section 26-1-5 allows the Department to adopt rules that provide access to Medicaid services, and 42 CFR 482.68 sets forth special requirements for transplant programs.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it defines important terms and provisions, sets forth eligibility and access requirements, specifies service coverage and prior authorization, clarifies covered and non-covered services for stem cell transplantation, and lists criteria for requests of non-covered services.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.			
Agency head or designee, and title:	Nate Checketts	**Date** (mm/dd/yyyy)**:**	12/12/2021
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or nonsubstantive change.			

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-10A. Transplant Services Standards.
R414-10A-1. Introduction and Authority.

(1) This rule establishes standards and requirements for tissue and organ transplantation services for the State of Utah Medicaid Program.

(2) Title XIX of the Social Security Act allows coverage of transplantation services when there is no discrimination in the availability of services and high quality care is available to all eligible individuals.

(3) Section 26-18-2.3 grants the Department of Health discretion to fund transplantation services.

R414-10A-2. Definitions.

For purposes of Rule R414-10A:

(1) "Abstinence" means the documented non-use of any abusable substance by the patient.

(2) "Abusable substance" means any substance which is not appropriately prescribed and taken under the direction of a physician or is not medically indicated. This includes, but is not limited to, over-the-counter medicines, prescription medicines, alcohol, tobacco (including nicotine-bearing vapor products), cannabis, benzodiazepines, narcotics, methadone, cocaine, amphetamines, opiates, tricyclic antidepressants, barbiturates, and street drugs.

(3) "Active infection" means current presumptive evidence of invasion of tissue or body fluids by bacteria, viruses, fungi, rickettsiae, or parasites which is not demonstrated to be effectively controlled by the host, antibiotic or antimicrobial agents.

(4) "Active substance use" means the current use (within the most recent six months) of any abusable substance or substances that can adversely impact treatment outcomes or treatment plan adherence. This may include the personal admission of substance use with a positive drug screen.

(5) "Allogenic" means having a different genetic constitution but belonging to the same species.

(6) "Autologous" means the products or components of the same individual person.

(7) "Department" means the Utah Department of Health.

(8) "Drug screen" means testing to identify the presence of one or more drugs or substances as stated in Subsection R414-10A-2(2), which can adversely impact treatment outcomes or treatment plan adherence.

(9) "Emergency transplantation" means any transplantation which for reasons of medical necessity requires that a transplant be performed less than five days after determination of the need for the procedure.

(10) "Hematopoietic stem cell transplantation and bone marrow transplantation" means transplantation of cells from the bone marrow stem cells, peripheral blood stem cells, or cord blood stem cells to supplant the patient's bone marrow.

(11) "Intestine transplantation" means transplantation of the small bowel or both the small bowel and colon.

(12) "Medical necessity", for purposes of this rule, means a patient's medical condition that meets all the requirements and none of the contraindications for the type of transplantation requested.

(13) "Multi-organ transplantations" means, except for corneas, the transplantation of more than one tissue or organ during the same operative procedure.

(14) "Medicare-approved transplant center" means a center that meets Medicare's conditions of participation for transplant hospitals or, for purposes of this rule, is an approved National Marrow Donor Program (NMDP) bone marrow transplant center.

(15) "Patient" means an individual eligible to receive covered Medicaid services from an enrolled Medicaid provider and is receiving covered professional services provided or directed by a licensed practitioner of the healing arts enrolled as a Medicaid provider.

(16) "Remission" means the lack of any evidence of the cancer on physical examination and hematological evaluation, including normocellular bone marrow with less than five percent blast cells, and peripheral blood counts within normal values, except for patients who are receiving maintenance chemotherapy.

(17) "Services" means the type of medical assistance specified in Subsections 1905(a)(1) through (24) of the Social Security Act and interpreted in 42 CFR 440, Subpart A.

(18) "Substance use treatment program" means a treatment program developed and conducted by an inpatient or outpatient facility that, at a minimum, meets the standards of organization and staff of a chemical dependency and substance use disorder specialty facility specified in Section R432-101-4 and Rule R501-21.

(19) "Transplantation" means the transfer of a human organ or tissue from one person to another or from one site to another in the same individual, excluding skin, tendon, and bone.

R414-10A-3. Patient Eligibility Requirements for Coverage of Transplantation Services.

Transplantation services are available to categorically eligible and medically needy individuals who are Title XIX eligible and meet the requirements in this rule at the time the transplantation service is provided.

R414-10A-4. Program Access Requirements.

(1) Transplantation services may be provided only for eligible patients who meet the requirements in this rule and only for services covered under the Utah Medicaid program.

(2) Transplantation services may be provided only in a Medicare-approved transplant center.

(3) Transplantation services may be provided out-of-state in a Medicare-approved facility only when the service is not available in an approved facility in the state of Utah.

(4) All Utah transplant requirements and policies are applicable to in-state and out-of-state transplant services and facilities.

R414-10A-5. Service Coverage.

(1) Transplantation services are covered by the Utah Medicaid program only when requirements in this rule are met.

(2) Multi-organ transplantation services may be provided only when the requirements for each individual transplant are met.

(3) Repeat transplantations of the same tissues or organs may be covered only under Departmental review and approval based on requirements in this rule.

(4) The following transplants are covered when requirements in this rule are met:

(a) Cornea, heart, lung, kidney, liver, pancreas, intestine, bone marrow, hematopoietic stem cell.

(b) Some combinations of the above may also qualify.

(5) Emergency transplantations may be covered if all requirements are met.

R414-10A-6. Prior Authorization.

(1) Prior authorization (PA) may be required for any transplantation service.

(a) To determine if PA is required, refer to the Utah Medicaid Coverage and Reimbursement Code Lookup tool.

(2) The Department's evidence-based criteria may be used, when available, as part of the PA process.

(3) If PA is required, the request must include documentation that the patient meets the organ specific requirements in this rule.

(4) The PA request for transplantation services must include:

(a) A description of condition needing transplantation;

(b) Transplantation treatment alternatives utilized previous to the transplant request;

(c) Transplantation treatment alternatives considered and discarded, including rationale for discarding;

(d) A comprehensive examination, evaluation and recommendation completed by a Board-Certified or Board-Eligible specialist and medical and surgical specialists in the field directly related to the patient's condition, which demonstrates the need for a transplant. The patient must also demonstrate the ability to tolerate the proposed transplant and subsequent treatment regimen;

(e) A comprehensive psycho-social evaluation of the patient that includes:

i. motivation for transplant;

ii. willingness and ability to follow a long-term treatment and follow-up regimen; and

iii. history of active substance use.

(f) If the patient is less than 18 years of age, a comprehensive psycho-social evaluation of the patient's parent or guardian that includes:

i. motivation for transplant;

ii. willingness and ability to follow a long-term treatment and follow-up regimen; and

iii. history of active substance use.

(g) A comprehensive psychiatric evaluation, if the patient has a history of mental illness.

(h) Documentation of a successfully completed treatment program or abstinence, if the patient has a history of substance use.

(i) Treatment program success and abstinence are supported by negative drug screens for a minimum of six months, with two negative drug screens in the most recent three months. The timing of the drug screens is in relation to the PA request date.

(j) If the history of substance use involves drugs other than those listed in this rule under Section R414-10A-2, then the drug screens must include the other substance upon drug testing availability.

(k) The patient may not be an active substance user as defined under Section R414-10A-2.

(l) Comprehensive infectious disease evaluation for a patient with a recent or current suspected infectious episode.

(m) All applicable hospital and clinic records.

(n) Completed cancer screening tests.

(o) All relevant laboratory and imaging studies.

(p) Documentation that the patient meets the eligibility and selection criteria for the transplant facility where the transplant will be performed.

(q) Any other documentation requested by PA or the Department's physician consultants.

(5) If incomplete documentation is received by the Department, the patient's case is pended until the requested documentation has been received.

(6) If a transplant requiring PA is performed without PA, reimbursement may be denied for all services related to the transplant up to the outlier threshold days for the specific type of transplant.

(7) Refer to the Section I: General Information Provider Manual for retroactive authorization for emergency transplant services.

R414-10A-7. Solid Organ Transplantation, Covered Services and Requirements.

(1) The following solid organ transplant services are covered. Minimum requirements for specific transplant services are shown. As required by 42 CFR 482, Subpart E, each transplant center must also have written selection criteria.

(2) All patients must be free of active infection. Liver transplants are excepted as noted.

(3) Liver.

(a) The patient must:

(i) have progressive, irreversible liver disease requiring transplant;

(ii) be free from active infection outside the hepatobiliary system;

(iii) not have acute, severe hemodynamic compromise at the time of transplantation if this compromises non-hepatic end-organs;

(iv) be free from significant pulmonary disease;

(v) be free from any significant cardiovascular disease; and

(vi) not have stage IV hepatic coma.

(4) Cornea.

(a) The patient must be free of other associated disease that may preclude visual improvement with transplant.

(5) Cardiac.

(a) The patient must:

(i) have irreversible and progressive cardiac disease with a life expectancy of one year or less without transplant or progressive pulmonary hypertension without other treatment options; and

(ii) be free from significant pulmonary disease, except pulmonary hypertension.

(6) Intestine.

(a) The patient must:

(i) have short bowel syndrome or irreversible and progressive small bowel disease requiring daily hyperalimentation without reasonable alternatives;

(ii) be free from significant pulmonary disease; and

(iii) be free from significant cardiovascular disease.

(7) Kidney.

(a) The patient must:

(i) have irreversible, progressive end-stage renal disease;

(ii) not have acute, severe hemodynamic compromise at the time of transplantation if this compromises non-renal end-organs;

(iii) be free from significant pulmonary disease; and

(iv) be free from any significant cardiovascular disease.

(8) Lung.

(a) The patient must:

(i) not have acute, severe hemodynamic compromise at the time of the transplantation if this compromises non-pulmonary end-organs;

(ii) be free from significant cardiovascular disease; and

(iii) demonstrate abstinence from tobacco use within the last 6 months.

(9) Pancreas.

(a) The patient must:

(i) have type I diabetes mellitus;

(ii) not have acute, severe hemodynamic compromise at the time of the transplantation if this compromises end-organs;

(iii) not have active peptic ulcer disease;

(iv) be free from significant cardiovascular disease; and

(v) be free from significant pulmonary disease.

(10) Multi-organ transplants.

(a) Kidney/pancreas, liver/kidney, cardiac/lung, intestine/liver, and other multi-organ transplants may be considered;

(i) each case is reviewed individually as to medical necessity and appropriateness; and

(ii) complete documentation, including justification and outcomes, must be provided.

R414-10A-8. Solid Organ Transplantation, Non-Covered Services.

(1) Transplants requiring prior authorization performed without prior authorization. (Refer to the Section I: General Information Provider Manual for request for retroactive authorization for emergency transplant services.)

(2) Transplant for patients who did not qualify for Medicaid benefits at the time of transplantation. (Retroactive Medicaid qualification may be an exception.)

(3) Transplants which are experimental or investigational in nature.

(4) Transplant of beta cells or other pancreas cells not part of a pancreatic organ transplantation.

(5) Transplant of cells or tissues into the coronary arteries, myocardium, central nervous system, or spinal cord.

(6) "Bridge-to-transplant" devices for heart transplant:

(a) Temporary or implanted ventricular assist devices with the exception of intra-aortic balloon assist devices;

(b) Temporary or implanted biventricular assist devices; or

(c) Temporary or implanted mechanical heart.

(7) Transplants to patients with:

(a) Malignant neoplasm with a high risk for reoccurrence and non-curable malignancy (excluding localized skin cancer).

(b) Chronic illness with one year or less life expectancy.

(c) Limited, irreversible rehabilitation potential.

(8) All other conditions not specifically listed as covered in the rule.

R414-10A-9. Hematopoietic Stem Cell Transplantation (HSCT), Covered Services and Requirements.

(1) Allogeneic and syngeneic hematopoietic stem cell transplantation may be approved only when the patient has a suitable HLA-matched donor and one of the covered conditions is present.

(a) A search of related family members, unrelated persons, or both to find a suitable donor is a covered service.

(2) Patient must have adequate marrow and lack of marrow involvement of primary malignancy if autologous transplant.

(3) Patient must be free from any active infection.

(4) Allogeneic Hematopoietic Stem Cell Transplantation (ASCT) is covered for:

(a) Leukemia, leukemia in remission, or aplastic anemia; or

(b) Severe Combined Immunodeficiency Disease (SCID) and for the treatment of Wiskott-Aldrich syndrome.

(5) Autologous Hematopoietic Stem Cell Transplantation (AuSCT) is covered for:

(a) Acute leukemia in remission with a high probability of relapse and has no Human Leucocyte Antigens

(HLA)-matched;

(b) Resistant non-Hodgkin's lymphomas or those presenting with poor prognostic features following an initial response;

(c) Recurrent or refractory neuroblastoma; and

(d) Advanced Hodgkin's disease with failed conventional therapy and has no HLA-matched donor.

(e) Single AuSCT is only covered for Durie-Salmon Stage II or III that fit the following requirements:

(i) Newly diagnosed or responsive multiple myeloma. This includes those patients with previously untreated disease, those with at least a partial response to prior chemotherapy (defined as a 50 percent decrease either in measurable paraprotein (serum, urine or both) or in bone marrow infiltration, sustained for at least one month), and those in responsive relapse; and

(ii) adequate cardiac, renal, pulmonary, and hepatic function.

(f) When recognized clinical risk factors are employed to select patients for transplantation, High Dose Melphalan (HDM) together with AuSCT is medically reasonable and necessary for any age group with primary Amyloid Light (AL) chain amyloidosis who meet the following criteria:

(i) Amyloid deposition in two or fewer organs; and

(ii) Cardiac left ventricular Ejection Fraction (EF) greater than 45 percent.

R414-10A-10. HSCT Transplantation, Non-Covered Services.

(1) HSCT is not covered as treatment for multiple myeloma.

(2) AuSCT is not covered for:

(a) Acute leukemia not in remission;

(b) Chronic granulocytic leukemia;

(c) Solid tumors (other than neuroblastoma);

(d) Tandem transplantation (multiple rounds of AuSCT) for patients with multiple myeloma;

(e) Non-primary AL amyloidosis; or

(f) Primary AL amyloidosis for patients who are at least 64 years of age.

(3) All other conditions not specifically listed as covered in this rule.

R414-10A-11. Requests for Non-Covered Transplantation Services.

Requests for non-covered services are considered based on evidence submitted as to the efficacy of the requested services. These requests are reviewed on a case-by-case basis and require Medicaid Director or designee approval. Evidence types may include, but are not limited to:

(1) Evidence published in peer-reviewed medical journals listed on the Centers for Medicare and Medicaid Services (CMS) website.

(2) Evidence of acceptable survival rates with the proposed protocol in groups with similar clinical characteristics to the patient:

(a) The current survival rate threshold is at least 75 percent one-year survival and at least 55 percent three-year survival; or

(b) Similar characteristics include age, tumor type, tumor size, resection status, presence of metastases, etc.

(3) Study size with sufficient number of individuals for statistical analysis; or

(4) Evidence that the proposed protocol is a less costly alternative to other potential treatment protocols.

KEY: Medicaid
Date of Enactment or Last Substantive Amendment: December 15, 2016
Notice of Continuation: January 6, 2017
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3

State of Utah
Administrative Rule Analysis
Revised November 2021

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
	Title No. - Rule No.	
Utah Admin. Code Ref (R no.):	**R414-21**	**Filing ID: (Office Use Only)**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health	
Agency:	Division of Medicaid and Health Financing	
Room no.:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84114-3101	
Mailing address:	PO Box 143101	
City, state and zip:	Salt Lake City, UT 84114-3101	
Contact person(s):		
Name:	**Phone:**	**Email:**
Craig Devashrayee	801-538-6641	cdevashrayee@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule catchline:
Physical Therapy and Occupational Therapy
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
Section 26-18-3 requires the Department to implement Medicaid policy through administrative rules, which allow the Department to administer the Medicaid program. Additionally, Section 26-1-5 authorizes the Department to adopt rules that provide access to Medicaid services, and 42 CFR 440.110 authorizes qualified therapists to provide or supervise physical therapy and occupational therapy services.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it implements physical therapy and occupational therapy for Medicaid members, and implements reimbursement to service providers.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.			
Agency head or designee, and title:	Nate Checketts	**Date** (mm/dd/yyyy)**:**	12/12/2021
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or nonsubstantive change.			

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-21. Physical Therapy and Occupational Therapy.
R414-21. Introduction.

The Physical Therapy and Occupational Therapy programs provide a scope of services for Medicaid recipients in accordance with the Physical Therapy and Occupational Therapy Services Utah Medicaid Provider Manual and Attachment 4.19-B of the Medicaid State Plan, as incorporated into Section R414-1-5.

KEY: Medicaid

Date of Enactment or Last Substantive Amendment: January 10, 2014
Notice of Continuation: January 6, 2017
Authorizing, and Implemented or Interpreted Law: 26-1-4.1; 26-1-5; 26-18-3

State of Utah
Administrative Rule Analysis
Revised November 2021

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
	Title No. - Rule No.	
Utah Admin. Code Ref (R no.):	**R414-38**	**Filing ID: (Office Use Only)**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health	
Agency:	Division of Medicaid and Health Financing	
Room no.:		
Building:	Cannon Health Building	
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City, state and zip:	Salt Lake City, UT 84114-3101	
Mailing address:	PO Box 143101	
City, state and zip:	Salt Lake City, UT 84114-3101	
Contact person(s):		
Name:	**Phone:**	**Email:**
Craig Devashrayee	801-538-6641	cdevashrayee@utah.gov
Please address questions regarding information on this notice to the agency.		

General Information

2. Rule catchline:
Personal Care Services
3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:
Section 26-18-3 requires the Department to implement Medicaid policy through administrative rules, which allow the Department to administer the Medicaid program. Additionally, Section 26-1-5 authorizes the Department to adopt rules that provide services and eligibility for Medicaid members.
4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:
The Department did not receive any written comments regarding this rule.
5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:
The Department will continue this rule because it implements personal care services for Medicaid members and reimbursement for personal care providers, by referencing the Personal Care Utah Medicaid Provider Manual and the Medicaid State Plan.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.			
Agency head or designee, and title:	Nate Checketts	**Date** (mm/dd/yyyy)**:**	12/12/2021
Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or nonsubstantive change.			

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-38. Personal Care Services.
R414-38-1. Introduction.

The Personal Care Services program provides a scope of services for Medicaid recipients in accordance with the Personal Care Utah Medicaid Provider Manual and Attachment 4.19-B of the Medicaid State Plan, as incorporated into Section R414-1-5.

KEY: Medicaid

Date of Enactment or Last Substantive Amendment: April 7, 2015
Notice of Continuation: February 17, 2017
Authorizing, and Implemented or Interpreted Law: 26-1-5; 26-18-3