STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

The following ambulatory services are provided:

Outpatient Hospital Services
Rural Health Clinics
Laboratory and X-ray Service
Child Health Evaluation and Care (Formerly EPSDT)
Family Planning Services
Physician Services
Home Health Service

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

. 1. Inpatient hospital services other than those provided in an institution for mental diseases

X Provided ___No limitations X With limitations*

2. a. Outpatient hospital services

X Provided ___No limitations X With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the plan)

X Provided X No limitations ____With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub 45-4)

X Provided X No limitations ____With limitations*

3. Other laboratory and X-ray services

X Provided: X No limitations ____With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals under 21 years of age or older

X Provided X No limitations ____With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found*

X Provided

c. Family planning services and supplies for individuals of child-bearing age

X Provided ___No limitations X With limitations*

d. Tobacco Cessation Counseling Services for Pregnant Women

(1) Face-to-Face Tobacco Cessation Counseling Services provided:

X (i) By or under supervision of a physician;

X (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services.

(2) Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women:

Provided ___No limitations X With limitations*

Tobacco cessation counseling services for pregnant women are limited to one face-to-face visit without prior authorization along with a referral to the telephone quitline which has no limits

*Description provided on attachment

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

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5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

   Provided: ___No limitations _X_ With limitations*

   b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

   Provided: ___ No limitations _X_ With limitations*

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

   a. Podiatrists' services

      X Provided: __ No limitations X With limitations*

   b. Optometrists' services.

      X Provided: __ No limitations X With limitations*

   c. Chiropractors' services.

      __ Provided: __ No limitations __ With limitations*
      X Not provided:

   d. Other practitioners' services - Psychologists:

      __ Provided: X Not provided

7. Home health services.

   a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

      X Provided: __ No limitations X With limitations*

   b. Home health aide services provided by a home health agency.

      X Provided: __ No limitations X With limitations*

   c. Medical supplies, equipment, and appliances suitable for use in the home.

      X Provided: __ No limitations X With limitations*

   d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

      X Provided: __ No limitations X With limitations*

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

8. Private Duty Nursing Services.

X Provided: ___ No limitations X With limitations*

9. Clinic services.

X Provided: ___ No limitations X With limitations*

10. Dental services.

X Provided: ___ No limitations X With limitations*

11. Physical therapy and related services.

a. Physical therapy.

X Provided: ___ No limitations X With limitations*

b. Occupational therapy.

X Provided: ___ No limitations X With limitations*

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

X Provided: ___ No limitations X With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed Drug:

X Provided: ___ No limitations X With limitations*

b. Dentures:

X Provided: ___ No limitations X With limitations*

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

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c. Prosthetic devices.

X Provided: ___ No limitations X With limitations*

d. Eyeglasses.

__ Provided: ___ No limitations __ With limitations*
X Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

X Provided: X No limitations __ With limitations*

b. Screening services.

X Provided: ___ No limitations X With limitations*

c. Preventive services.

X Provided: ___ No limitations X With limitations*

d. Rehabilitative services.

X Provided: ___ No limitations X With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

X Provided: ___ No limitations X With limitations*

b. Skilled nursing facility services.

X Provided: ___ No limitations X With limitations*

*Description provided on attachment.

State/Territory UTAH

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE CATEGORICALLY NEEDY

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15. a. 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 Act, to be in need of such care.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

16. Inpatient psychiatric facility services for individuals under 22 years of age. [X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

17. Nurse-midwife services

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

18. Hospice care (in accordance with section 1905(o) of the Act).

[X] Provided [X] No limitation [X] Provided in accordance with section 2302 of the Affordable Care Act

[ ] With limitations* [ ] Not Provided:

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

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19. Case management services and Tuberculosis related services

    a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

    X Provided: ___ No limitations ___ With limitations
    ___ Not provided.

    b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

    X Provided: X With limitations*
    ___ Not provided.

20. Extended services for pregnant women

    a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

    ___ Additional coverage **

    b. Services for any other medical conditions that may complicate pregnancy.

    X Additional coverage **

21. Certified pediatric or family nurse practitioners' services

    X Provided: X No limitations ___ With limitations*

    ___ Not provided.

*Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

**Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

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22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act.

    ___ Provided: ___ No limitations ___ With limitations*

    _X_ Not provided.

23. Certified pediatric or family nurse practitioners' services.

    a. Transportation.

    _X_ Provided: ___ No limitations _X_ With limitations*

    ___ Not provided.

    b. Services provided in Religious Non-medical Health Care Institutions.

    ___ Provided: ___ No limitations ___ With limitations*

    _X_ Not provided.

    c. Reserved

    d. Nursing facility services for patients under 21 years of age.

    _X_ Provided: ___ No limitations _X_ With limitations*

    ___ Not provided.

    e. Emergency hospital services.

    _X_ Provided: _X_ No limitations ___ With limitations*

    ___ Not provided.

    f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

    _X_ Provided: ___ No limitations _X_ With limitations*

    ___ Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

24. Certified pediatric or family nurse practitioner services as defined in Section 1905(a)(21) of the Act (added by Section 6405 of 'OBRA 89):

X Provided ___ No limitations X With limitations*

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

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25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

    __ Provided _X_ Not provided

INPATIENT HOSPITAL SERVICES

DEFINITION

Inpatient Hospital Services means services provided in a hospital licensed by the Utah Department of Health. General services are defined under Subsection 26-21-2(11) of the Utah Code and in the Utah Administrative Code under *Rule R432-100 General Hospital Standards*. Specialty services are defined under Subsection 26-21-2(21) of the Utah Code and in the Utah Administrative Code under *Rules R432-103 Specialty Hospital - Rehabilitation* and *R414-515 Long Term Acute Care*.

LIMITATIONS

1. *The lower of the Western Region Professional Activities Study at the 50th percentile or the State of Utah's 50th percentile will be established as the upper limit of length of stay as a utilization control for the most frequent single cause of admission. These criteria will be used to evaluate the length of stay in hospitals that are not under the DRG payment system.*

2. Need for an extension of length of stay must be justified by a physician, and reauthorization must be obtained from the Medicaid Agency for hospitals that are not under the DRG payment system.

3. Inpatient hospital psychiatric counseling services provided under personal supervision, rather than directly by the physician, are not provided in all hospitals in the state, and therefore, are non-covered services.

4. Inpatient hospital care for treatment of alcoholism and/or drug dependency is not a service provided in all hospitals in the state, and therefore, the service is limited to acute care for detoxification only.

5. Procedures determined to be cosmetic, experimental, or of unproven medical value, are non-covered services.

6. Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in ATTACHMENT 3.1-E.

7. Abortion services, except as covered under ATTACHMENT 3.1-A, (Attachment #5a).

8. Selected medical and surgical procedures are limited by federal regulation and require review, special consent, and approval. A list will be maintained in the Medicaid Inpatient Hospital Provider Manual.

9. Except for item 7 above, the Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
   a. that the proposed services are medically appropriate; and
   b. that the proposed services are more cost effective than alternative services.

INPATIENT HOSPITAL SERVICES (Continued)

Deleted 12-1-17

OUTPATIENT HOSPITAL SERVICES

DEFINITION

Outpatient Hospital means a facility that is in, or physically connected to, a hospital licensed by the Utah Department of Health as a hospital - general, as defined by Utah Code Annotated, Section 26-21-2(8), 1990, as amended; and by Utah Administrative Code, R432-100-1 and 432-100.101, 1992, as amended.

LIMITATIONS

1. Procedures determined to be cosmetic, experimental, or of unproven medical value, are not a benefit of the program.

2. Abortion services, except as covered under ATTACHMENT 3.1-A, (Attachment #5a).

3. Except for item 2 above, the Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
   a. that the proposed services are medically appropriate; and
   b. that the proposed services are more cost effective than alternative services.

SKILLED NURSING FACILITY SERVICES

LIMITATIONS

1. In accordance with section 1919(f)(7) of the Act, Residents may be charged for the following personal hygiene items and services:
   a. Cosmetic and grooming items and services in excess of those included in the basic service;
   b. Private room, unless medically necessary;
   c. Specially prepared food, beyond that generally prepared by the facility;
   d. Telephone, television, radio;
   e. Personal comfort items including tobacco products and confections;
   f. Personal clothing;
   g. Personal reading materials;
   h. Gifts purchased on behalf of a resident;
   i. Flowers and plants;
   j. Social events and activities beyond the activity program; and
   k. Special care services not included in the facility's Medicaid payment.

2. In accordance with ATTACHMENT 4.19-D, Nursing Home Reimbursement, each nursing facility must provide the following personal hygiene items and services (and residents may not be charged for):
   a. Nursing and related services;
   b. Specialized rehabilitative services (treatment and services required by residents with mental illness or intellectual disability, not provided or arranged for by the State);
   c. Pharmaceutical services (with assurance of accurate acquiring, receiving, dispensing, and administering of drugs and biologicals);
   d. Dietary services individualized to the needs of each resident;
   e. Professionally directed program of activities to meet the interests and needs for well-being of each resident;
   f. Emergency dental services (and routine dental services to the extent covered under the State Plan);
   g. Room and bed maintenance services; and
   h. Routine personal hygiene items and services.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
   a. the proposed services are medically appropriate; and
   b. the proposed services are more cost effective than alternative services.

MEDICALLY NECESSARY SERVICES

DEFINITION

Medically necessary services not otherwise provided under the State Plan but available to EPSDT (CHEC) eligibles.

LIMITATIONS

Other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by EPSDT (CHEC) screening services will be provided when medically necessary to EPSDT eligibles. Services not provided under the plan but now available to EPSDT eligibles if medically necessary are:

1. Occupational therapy
2. Orthodontia
3. Medical or other remedial care provided by licensed practitioners:
    a. Chiropractic services

MEDICALLY NECESSARY SERVICES (Continued)

Medically necessary services not otherwise provided under the State Plan but available to EPSDT (CHEC) Eligibles (Continued)

Diagnostic, Preventive, Rehabilitative Services (42 CFR 440.130)

A. Early intervention services are diagnostic and treatment services to prevent further disability and improve the functioning of infants and toddlers up to age four with disabilities.

   1. Individual or group therapeutic interventions to ameliorate motor impairment, sensory loss, or communication deficits; and
   2. Information and skills training to the family to enable them to enhance the health and development of the child.

B. Skills development services are medically necessary diagnostic and treatment services provided to children between the ages of 2 and 22 to improve and enhance their health and functional abilities and prevent further deterioration. Services include:

   1. Individual or group therapeutic interventions to ameliorate motor impairment, sensory loss, communication deficits, or psycho social impairments; and
   2. Information and skills training to the family to enable them to enhance the health and development of the child.

Services may be provided at the early intervention site, day care site, in the child's home, at the child's school as needed in accordance with the Individualized Family Service Plan (IFSP) or the Individualized Educational Plan (IEP). Children between the ages of 2 and 4 will be served in the setting that best meets their needs in accordance with the IFSP or IEP. All services are prescribed in accordance with state law.

Early intervention and skills development services are provided by or under the supervision of:

a. A licensed physician, registered nurse, dietician, clinical social worker, psychologist, audiologist, speech and language pathologist, occupational therapist, physical therapist, practicing within the scope of their license in accordance with Title 58, Occupational and Professional Licensing (Utah Code Annotated, as amended 1953); or
b. An early childhood special educator certified under Section 53A-1-402 of the Utah Code Annotated, as amended in 1953); or
c. Qualified mental retardation professional (QMRP) as defined in 42 CFR 483.430.

Qualified providers include entities operated by or under contract with the state Maternal and Child Health Title V Grantee agency responsible for Part H of the Individual with Disabilities Education Act (PL 102-119) to provide early intervention services; or school districts that provide special education and related services under Part B of the Individuals with Disabilities Education Act.

MEDICALLY NECESSARY SERVICES (Continued)

Other Diagnostic, Screening, Preventive, and Rehabilitative Services

LIMITATIONS

Diagnostic, Preventive, and Rehabilitative Services for EPSDT Participants [42 CFR 440.130(a)(c) and (d)].

Diagnostic, preventive, and rehabilitative health services for EPSDT participants provided by or through a Maternal and Child Health (Title V grantee). Clinic are covered benefits. Such services may be provided in other settings as appropriate.

Services are recommended by a physician and delivered according to a plan of care that is reviewed periodically by the physician. Services, including early intervention services, are provided by a licensed practitioner, including a licensed physician, registered nurse, dietician, clinical social worker, psychologist, audiologist, speech and language pathologist, occupational therapist, or physical therapist practicing within the scope of their license in accordance with Title 58, Occupational and Professional Licensing, of the Utah Code Annotated 1953, as amended.

SERVICES PROVIDED BY LICENSED PRACTITIONERS - PSYCHOLOGISTS

Deleted July 1, 2013

FAMILY PLANNING SERVICES AND SUPPLIES

DEFINITION

Family planning services means diagnostic, treatment, drugs, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy. Family planning services are provided by or under the supervision of a physician for individuals of childbearing age, including minors who are sexually active.

LIMITATIONS

The following services are excluded from coverage as family planning services:

1. Experimental or unproven medical procedures, practices, or medication.

2. Surgical procedures for the reversal of previous elective sterilization, both male and female.

3. In-vitro fertilization.

4. Artificial insemination.

5. Surrogate motherhood, including all services, tests, and related charges.

6. Abortion services, except as covered under ATTACHMENT 3.1-a, (Attachment #5a).

7. Except for item 6 above, the Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

PHYSICIAN SERVICES

LIMITATIONS

1. Supervision by a Physician - Physician services must be personally rendered by a physician licensed under state law to practice medicine or osteopathy, or by a non-physician practitioner licensed to serve the health care needs of a practice population within their scope of practice.

2. Abortion services may only be covered in accordance with ATTACHMENT 3.1-A, (Attachment #5a).

3. Admission to a general hospital for psychiatric care by a physician is limited to those cases determined by established criteria and utilization review standards to be of a severity and intensity that appropriate service cannot be provided in any alternative setting.

4. Inpatient hospital care for the treatment of alcoholism, drug dependency or both will be limited to acute care for detoxification only.

5. Services not actually furnished to a client because the client failed to keep a scheduled appointment will not be covered by Medicaid.

6. Procedures determined to be cosmetic, experimental, or of unproven medical value are non-covered services.

7. Organ transplant services will be limited to those procedures for which selection criteria have been approved and documented in ATTACHMENT 3.1-E.

8. Physicians may bill for pain management services using the appropriate evaluation and management codes.

   a. A physician may complete a consultation and provide a treatment plan to the primary care provider or continue as the patient's pain management physician.

9. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. the proposed services are medically appropriate; and
   b. the proposed services are more cost effective than alternative services.

PHYSICIAN SERVICES (Continued)

LIMITATIONS (Continued)

Deleted July 1, 2017

PHYSICIAN SERVICES (Continued)

LIMITATIONS (Continued)

Deleted July 1, 2017

PHYSICIAN SERVICES (Continued)

LIMITATIONS (Continued)

Deleted July 1, 2017

ABORTION SERVICES

DEFINITION

Abortion means all procedures performed for the purpose of terminating a pregnancy. Abortion does not include removal of a dead unborn child.

LIMITATIONS

Abortions procedures are limited to:

1. Those where the pregnancy is the result of an act of rape or incest; or

2. A case with medical certification of necessity where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

MEDICAL OR SURGICAL SERVICES FURNISHED BY DENTISTS

LIMITATIONS

1. A list of approved procedure codes for dentists and oral maxillofacial surgeons will be maintained in the Medicaid Dental Provider Manual. Certain medical and surgical procedures not reimbursable to physicians shall neither be reimbursable to dentists or oral maxillofacial surgeons.

2. Only dentists having a permit from the Division of Occupational and Professional Licensing may administer general anesthesia. The dentist administering the anesthesia may not also render the procedure.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

PODIATRIC SERVICES

LIMITATIONS

1. A podiatrist is limited to the provision of podiatric services within the scope of professional licensure.

2. A person licensed to practice podiatry may not administer general anesthesia and may not amputate the foot.

3. Palliative care must include the specific service and must be billed by the specific service and not by using an evaluation and management (office call) procedure code.

4. Podiatry services for recipients residing in long term care facilities have the following limitations:

    a. Foot care performed by an employee of the facility is not covered.
    b. Visits are limited to one visit every 60 days.
    c. Debridement of mycotic toenails is limited to once every 60 days.
    d. Trimming corns, warts, calluses or nails is limited to once every 60 days.

5. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

    a. that the proposed services are medically appropriate; and
    b. that the proposed services are more cost effective than alternative services.

PODIATRIST SERVICES (Continued)

Deleted July 1, 2013

OPTOMETRY SERVICES

SERVICES

Optometry services include examination, evaluation, diagnosis, and treatment of eye disease or injury.

LIMITATIONS

The following services are excluded from coverage:

1. Vision training;
2. Pathology services, as specified in the optometry license;
3. Medications dispensed in an office;
4. Eyeglasses are addressed in Attachment #12d of ATTACHMENT 3.1-B;
5. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
   a. the proposed services are medically appropriate; and
   b. the proposed services are more cost effective than alternative services.

SERVICES PROVIDED BY LICENSED CHIROPRACTORS

Deleted 3-1-18

SERVICES PROVIDED BY LICENSED PRACTITIONERS - PSYCHOLOGISTS

Deleted January 1, 2016

SERVICES PROVIDED BY LICENSED NURSE PRACTITIONERS

1. Services provided by a registered nurse who is licensed and certified by the Utah State Board of Nursing as a nurse practitioner. A nurse practitioner includes, but is not limited to, a general nurse practitioner, nurse anesthetist, obstetrics-gynecology nurse practitioner, or a neonatal nurse practitioner. These services are limited to ambulatory, non-institutional services provided to the extent that the licensed and certified nurse practitioner is authorized to practice under state law.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

    a. the proposed services are medically appropriate; and

    b. the proposed services are more cost effective than alternative services.

HOME HEALTH SERVICES

DEFINITION

Home health services are part-time or intermittent medical and non-medical services ordered by an attending physician. These services are based on medical necessity for the diagnosis or treatment of illness, injury, or to improve the function of a malformed body member. A patient may receive home health services when the patient demonstrates the need and potential to restore or improve lost or impaired functions, and when the physician determines that the home is the most appropriate and cost effective setting that is consistent with the patient's medical needs.

Home health services include home health aide services, nursing services as defined in the State Nurse Practice Act, and medical supplies, equipment and appliances suitable for use in the home.

1. Skilled home health Services

   a. The expert application of nursing theory, practice and techniques by a registered nurse (RN) to meet patient needs in the home, through application of professional judgment, standardized procedures, medically delegated techniques, and by independently solving patient care problems.

   b. Home health aide services include assistance of the direct provision of routine care that does not require specialized nursing skill. The assistant works under written instruction and close supervision by the RN.

   c. IV therapy, enteral and parenteral nutrition therapies are provided as home health services in conjunction with skilled home health services, supportive maintenance home health services, or as a standalone service. Home Health Program requirements apply to the therapy policies outlined in the Medical Supplies Program.

   d. Physical therapy services are available and are arranged by the home health agency through a physician order, and must be provided by a qualified, licensed therapist in accordance with the written plan of care.

2. Supportive, Maintenance Home Health Care

   Supportive maintenance home health services are available for patients with stabilized medical conditions who require minimal assistance, observation, teaching, or follow-up. A certified home health agency may provide these services through an RN, a licensed practical nurse (LPN), or through a home health aide supervised by an RN under the direction of a physician.

HOME HEALTH SERVICES (Continued)

LIMITATIONS

The following services are excluded from coverage:

1. Services not ordered and directed by a physician and written in an approved plan of care. A written plan must be reviewed and signed at least every 60 days.

2. Home health services not provided by an RN, LPN, physician assistant, or home health aide, and not supervised by an RN who is employed by a home health agency.

3. Home health services provided to a patient capable of self-care.

4. Housekeeping or homemaking services.

5. Respite Care.

6. Medical supplies neither suitable for home use nor for providing home health care in accordance with physician orders and as part of the written plan of care.

   Medical supplies used during the initial visit to establish the plan of care do not require a prior authorization, but are limited to:

   a. supplies consistent with the plan of care; and

   b. non-durable medical equipment.

7. Occupational therapy.

8. Speech pathology services.

9. Physical therapy not included in the plan of care, and not provided by a qualified, licensed therapist.

10. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

    a. that the proposed services are medically appropriate; and

    b. that the proposed services are more cost effective than alternative services.

HOME HEALTH SERVICES - HOME HEALTH AIDE

LIMITATIONS

1. Home health aide services must be provided by a Home Health Agency through an established plan of care.

2. Home health aide services must be provided under specific written instruction and supervised by a registered nurse.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

HOME HEALTH SERVICES - MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES

LIMITATIONS

Supplies, equipment (durable or disposable), and appliances are provided to Medicaid recipients who reside at home. Services are provided in accordance with 42 CFR 440.70(b)(3) and with established Medicaid policy covering medical supplies.

The following items are excluded from coverage as benefits of the Medicaid program:

1. First aid supplies with the exception of supplies used for post- surgical need, accidents, decubitus treatment, and long-term dressing.

2. Surgical stocking if ordered by a non-physician.

3. Syringes in excess of 100 per month.

4. Beds, when the recipient is not bed-confined.

5. Variable height beds.

6. Two oxygen systems unless the physician has specifically ordered portable oxygen for travel to practitioners.

7. Oxygen systems provided more frequently than monthly.

8. Spring-loaded traction equipment.

9. Wheelchairs, unless the recipient would be bed or chair confined without the equipment.

    a. Wheelchairs, attachments, and other adaptive equipment for addition to wheelchairs require prior authorization and review.

10. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

    a. that the proposed services are medically appropriate; and

    b. that the proposed services are more cost effective than alternative services.

HOME HEALTH SERVICES - PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH PATHOLOGY SERVICES

LIMITATIONS

1. Occupational therapy (OT) and speech pathology services in the home are not covered.

2. Physical therapy (PT) services must be prescribed by a physician and included in the plan of care.

3. PT services must be provided by a qualified, licensed therapist and must follow all regulations that govern these services.

4. PT services must follow a written plan of care, and include an expectation that the patient's medical condition under treatment, will improve in a predictable period.

5. PT services must be provided in accordance with 42 CFR 440.110.

6. All home health services require prior authorization.

7. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

HOME HEALTH SERVICES - SPEECH PATHOLOGY SERVICE

Deleted July 1, 2013

PRIVATE DUTY NURSING

LIMITATIONS

1. Private duty nursing services will be provided:

   a. to ventilator-dependent individuals who meet established criteria; and

   b. in the individual's home, in order to prevent prolonged institutionalization. The service will be based on physician order and a written plan of care specific to needs of the individual, reviewed and recertified every 60 days; and

   c. for a period of time essential to meet medically necessary care needs and develop confidence in family care givers. Private duty service needs are expected to decrease over time.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

CLINIC SERVICES

LIMITATIONS

1. End Stage Renal Dialysis

   Limited to medically accepted dialysis procedures, such as peritoneal dialysis (CAPO, CCPO and IPO) or hemodialysis for outpatients receiving services in free-standing State-licensed facilities, which are also approved under Title XVIII.

2. Ambulatory Surgical Centers

   Scope of service is limited to ambulatory surgical procedures which are scheduled for non-emergency conditions.

3. Alcohol and Drug Center

   Service limited to Methadone treatment at an approved center.

CLINIC SERVICES

LIMITATIONS (Continued)

5. Maternal and Child Health (Title V Grantee) Clinics

   a. Maternal and Child Health Clinic services are covered benefits for EPSDT eligibles.

   b. Qualified providers include clinics under the direction of a licensed physician and operated or administered by the Title V grantee agency.

   c. The clinic scope of benefits includes preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services, including early intervention services, provided by or under the direction of a licensed physician or dentist. Other providers of services include registered nurses, psychologists, dieticians, clinical social workers, audiologists, speech and language pathologists, occupational therapists, or physical therapists practicing within the scope of their license in accordance with Title 58, Occupational and Professional Licensing (Utah Code Annotated, as amended 1953).

   d. All clinic services are provided under the direction of a physician according to a written plan of care that is reviewed periodically by the directing physician.

6. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

DENTAL SERVICES

SERVICE

1. Dental services are not covered except as noted below.

2. The Agency may exceed the limitations on the aforementioned limitations, except to extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

PHYSICAL THERAPY SERVICES

SERVICES

Physical therapy services by independent provider, group practice, rehabilitation facility, outpatient facilities, and hospital include:

The examination, evaluation, diagnosis, prognosis, and intervention under the direct supervision of a physical therapist of a client to prevent, correct, alleviate and limit physical disability, bodily malfunction, pain from injury, disease and other physical or mental disabilities.

LIMITATIONS

1. Physical therapy requires a physician order.

2. Physical therapy requires the attending physician to certify the client's need for therapy services.

3. Physical therapy requires a written plan of care signed by the physician.

4. Physical therapy related to a stroke must be initiated within 60 days following the stroke and may continue only until the expected, reasonable level of function is restored.

5. Physical therapy is limited to 20 visits per calendar year.

6. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

OCCUPATIONAL THERAPY SERVICES

SERVICES

Outpatient occupational therapy services include:

Program planning, consultation, evaluation, and intervention under the direct supervision of an occupational therapist to provide the therapeutic use of everyday activities to promote health and wellness for clients at risk for developing illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction.

LIMITATIONS

1. Occupational therapy requires a physician order.

2. Occupational therapy requires the attending physician to certify the client's need for therapy services.

3. Occupational therapy requires a written plan of care signed by the physician.

4. Occupational therapy related to a stroke must be initiated within 90 days following the stroke and may continue only until the expected, reasonable level of function is restored.

5. Occupational therapy is limited to 20 visits per calendar year.

6. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

SPEECH PATHOLOGY SERVICES

SERVICES

1. Speech pathology services include evaluation, diagnosis and therapy services.

2. 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.

3. Speech pathology services and providers meet the federal requirements of 42 CFR 440.110.

LIMITATIONS

1. One speech evaluation per client per year is a covered service.

AUDIOLOGY SERVICES

SERVICES

1. Audiology services include preventive, screening, evaluation, and diagnostic services.
2. Audiology services are provided by or under the direction of an audiologist.
3. Audiology services and providers meet the federal requirements of 42 CFR 440.110.

NON-COVERED SERVICES

1. Hearing aids

PRESCRIBED DRUG SERVICES

LIMITATIONS

1. Outpatient drugs covered under Medicare Prescription Drug Benefit Part D for full-benefit dual eligible beneficiaries who are defined as individuals who have Medicare and full Medicaid coverage, will not be covered under Medicaid in accordance with SSA 1935(a).

2. Drugs excluded under Medicare Part D are not covered for dual eligible recipients, except for certain limited drugs which are provided, in accordance with SSA, Section 1927(d)(2), to other Medicaid recipients including those who are full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit Part D. These drugs are limited to include:
   a. selected legend cough and cold agents used for symptomatic relief, as listed in the Utah Medicaid Pharmacy Services Provider manual,
   b. selected over-the-counter drugs from the following categories:

      Antacid liquids and tablets
      Anti-diarrheal preparations
      Anti-fungal preparations
      Antihistamines
      Contraceptive Drugs
      Fever reducers and pain relievers (ASA, APAP and NSAIDs)
      Hydrocortisone
      Laxatives
      Anti-Lice preparations
      Stomach acid reducers

PRESCRIBED DRUG SERVICES

LIMITATIONS

3. Drug Efficacy Study Implementation Project Drugs (DESI Drugs) as determined by the FDA to be less-than-effective are not a benefit of the Medicaid program.

4. Other drugs and/or categories of drugs as determined by the Utah State Division of Health Care Financing and listed in the Pharmacy Provider Manual are not a benefit of the Medicaid program.

5. In accordance with Utah Law 58-17b-606(4), when a multi-source legend drug is available in the generic form, reimbursement for the generic form of the drug will be made unless the treating physician demonstrates a medical necessity for dispensing the non-generic, brand-name legend drug. However, the Department of Health pharmacists may override the generic mandate provisions if a financial benefit will accrue to the state (See Utah Code 58-17b-606).

6. The Division maintains a preferred drug list for selected therapeutic drug classes. The therapeutic classes will be selected and a preferred drug or drugs for each therapeutic class implemented at the discretion of the Division.

PRESCRIBED DRUG SERVICES

LIMITATIONS

7. The State is in compliance with Section 1927 of the Social Security Act. The State will cover drugs of manufacturers participating in the federal rebate program. The State is in compliance with reporting requirements for utilization and restriction to coverage based on the requirements for Section 1927 of the Act. The State has the following policies for the supplemental rebate program for the Medicaid population:

a. The State maintains, and updates periodically, a version of the rebate entitled 'Supplemental Rebate Agreement between the State and the drug manufacturer for drugs provided to the Medicaid population and the Sovereign States Drug Consortium Addendum to Member States Agreements'.

b. Pursuant to 42 USC 1396r-8, the State has established a preferred drug list (PDL) with non-preferred drugs identified. The PDL program shall negotiate drug discounts, rebates, or benefits for the Medicaid program.

PRESCRIBED DRUG SERVICES

LIMITATIONS

8. CMS has authorized the State of Utah to enter into "The Sovereign States Drug consortium (SSDC)." The SSDC serves as a vehicle that allows the State to pool its data, lives, and resources with other State Medicaid programs desiring supplemental rebates, but the Consortium does not itself contract with the manufacturers. Utah's supplemental rebate agreement will be the version authorized by CMS and as updated periodically.

   Participation in the SSDC multi-state rebate agreement will not limit the State's ability to negotiate state-specific supplemental agreements. Utah will contract directly with each manufacturer.

9. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

10. The prior authorization process for covered outpatient drugs conforms to section 1927(d)(5)(B) of the Act.

DENTURE SERVICES

SERVICE

1. Denture services are covered and include the fabrication and placement of a complete or partial denture in either arch.

2. Initial placement includes the relining to assure the desired fit.

3. Denture services are available only to clients who are pregnant women or who are individuals eligible under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

LIMITATIONS to services are detailed in the Utah Medicaid Dental Provider Manual which may be found at http://health.utah.gov/medicaid/manuals/directory.php.

PROSTHETIC DEVICES

Prosthetic devices mean replacement, corrective or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law to:

1. Artificially replace a missing portion of the body;

2. Prevent or correct physical deformity or malfunctions (including promotion of adaptive functioning); or

3. Support a weak or deformed portion of the body.

LIMITATIONS

The following services are excluded from coverage as a benefit of the Medicaid program:

1. Shoes, orthopedic shoes or other supportive devices for the feet, except when shoes are integral parts of leg braces or a prosthesis.

2. Shoe repair except as it relates to external modification of an existing shoe to meet a medical need, e.g., leg length discrepancy requiring a shoe “build-up” of one inch or more.

3. Personal comfort items and services. Comfort items include, but are not limited to, arch supports, foot pads, “cookies” or accessories, shoes for comfort, or athletic shoes.

4. Manufacture, dispensing, or services related to orthotics of the feet.

5. Internal modifications of a shoe, except when supported by documentation of medical necessity.

6. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

PROSTHETIC AND ORTHOTIC SERVICES
(BRACES, ARTIFICIAL LIMBS, AND/OR PARENTERAL/ENTERAL SUPPLIES)

Prosthetic devices" means replacement, corrective or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to:

1. Artificially replace a missing portion of the body;

2. Prevent or correct physical deformity or malfunctions (including promotion of adaptive functioning); or

3. Support a weak or deformed portion of the body.

LIMITATIONS

The following items are excluded from coverage as benefits of the Medicaid program:

1. Any support items that could be classified as a corset, even those that have metal or wire supports;

2. "Test" equipment;

3. Any item provided to nursing home recipients which have been specifically restricted in the index in the Medical Supplies Provider Manual;

4. The provision of two monaural hearing aids instead on one binaural aid;

5. Rental of a hearing aid in excess of three months;

6. Nutrients used as food supplements. They are a Medicaid benefit only as total nutrition;

7. Baby formula such as Similac, Enfamil, or Mull-Soy.

8. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

EYEGLASSES SERVICES

Deleted 3-1-18

REHABILITATIVE SERVICES

LIMITATIONS

Rehabilitative Mental Health Services

Rehabilitative mental health and substance use disorder services (hereinafter referred to as mental health services) are medically necessary services designed to promote the patient's mental health and restore the patient to the highest possible level of functioning. Services must be provided to or directed exclusively toward the treatment of the Medicaid individual.

Services and required supervision are provided in accordance with State law governing the applicable profession and in accordance with the profession's administrative rules as set forth by the Utah Department of Commerce and found at the Department of Administrative Services, Division of Administrative Rules: www.Rules.utah.gov/publicat/code.htm.

Services do not include room and board, services to residents of institutions for mental diseases, services covered elsewhere in the State Medicaid plan, educational, vocational and job training services, recreational and social activities, habilitation services and services provided to inmates of public institutions.

Psychiatric Diagnostic Evaluation

Psychiatric diagnostic evaluations are conducted face-to-face with the patient for the purpose of identifying the patient's need for mental health services. In accordance with the HCPCS/Current Procedural Terminology (CPT) definition for psychiatric diagnostic evaluations, the evaluation is an integrated biopsychosocial assessment, and includes history, mental status and recommendations. Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies. In certain circumstances one or more other informants (family members, guardians, or significant others) may be seen in lieu of the patient. The service includes assessments and reassessments if required. The service is coded in accordance with CPT coding for psychiatric diagnostic evaluation. If it is determined mental health services are medically necessary, a provider qualified to perform this service is responsible for the development of an individualized treatment plan. The qualified provider is also responsible to conduct reassessments/treatment plan reviews with the patient as clinically indicated to ensure the patient's treatment plan is current and accurately reflects the patient's rehabilitative goals and needed mental health services.

Qualified providers are: (1) licensed mental health therapists under State law: physicians and surgeons or osteopathic physicians engaged in the practice of mental health therapy; psychologists qualified to engage in the practice of mental health therapy; certified psychology residents qualifying to engage in the practice of mental health therapy; clinical social workers; certified social workers and certified social worker interns; advanced practice registered nurses (APRNs) licensed either as a nurse specialist or a nurse practitioner with psychiatric mental health nursing specialty certification (and any other licensed advanced nursing categories as approved by the State's licensing division when practicing within the scope of their practice act and competency); marriage and family therapists; associate marriage and family therapists; clinical mental health counselors; and associate clinical mental health counselors; (2) individuals working within

LIMITATIONS (Continued)

Rehabilitative Mental Health Services

the scope of their certificate or license in accordance with State law: licensed APRNs formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours; and licensed APRN interns formally working toward psychiatric mental health specialty certification and accruing the required clinical hours for the specialty nursing certification (and any other licensed advanced nursing categories as approved by the State's licensing division when practicing within the scope of their practice act and competency); and (3) individuals exempted from licensure as a mental health therapist in accordance with State law: students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the State's licensing division under the supervision of qualified faculty, staff, or designee, and individuals 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 have maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of their official duties for that agency or political subdivision.

When evaluations are conducted for the purpose of determining need for medication prescription only, these evaluations may be conducted by licensed physicians and surgeons or osteopathic physicians regardless of specialty; licensed APRNs and licensed APRN interns regardless of specialty when practicing within the scope of their practice act and competency, (and any other licensed advanced nursing categories as approved by the State's licensing division when practicing within the scope of their practice act and competency); and other practitioners licensed under State law when acting within the scope of their practice, most commonly a physician assistant when practicing under the delegation of services agreement required by the profession's practice act.

Mental Health Assessment – Participating as part of a multi-disciplinary team, qualified providers of this service assist in the psychiatric diagnostic evaluation process defined under Psychiatric Diagnostic Evaluation by face-to-face contacts with the patient to: (1) gather psychosocial information including information on the patient's strengths, weaknesses and needs, and historical, social, functional, psychiatric, or other information and (2) assist the patient to identify treatment goals. The provider assists in the psychiatric diagnostic reassessment/treatment plan review process specified under Psychiatric Diagnostic Evaluation by gathering updated psychosocial information and updated information on treatment goals and by assisting the patient to identify additional treatment goals. Information also may be collected through in-person or telephonic interviews with family/guardians or other sources as necessary. The information obtained is provided to the qualified provider identified on page 1 or on page 2 above who will perform the psychiatric diagnostic evaluation assessment or reassessment.

REHABILITATIVE SERVICES

LIMITATIONS (Continued)

Rehabilitative Mental Health Services

Qualified providers are: licensed social service workers; licensed substance use disorder counselors; licensed registered nurses; licensed practical nurses; individuals working toward licensure as a social service worker under supervision of a licensed mental health therapist in accordance with State law; and registered nursing students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the State's licensing division and individuals enrolled in a qualified substance use disorder education program exempted from licensure and under the supervision of qualified faculty, staff, or designee in accordance with State law.

Although these providers may perform this service, under State law only individuals qualified to conduct psychiatric diagnostic evaluations may diagnose mental health disorders and prescribe rehabilitative mental health services.

Psychological Testing

Psychological testing is performed face-to-face with the patient using standardized psychological tests appropriate to the patient's needs, with interpretation and report. Psychological testing is coded in accordance with the CPT coding for psychological testing.

Qualified providers are: licensed physicians and surgeons or osteopathic physicians engaged in the practice of mental health therapy; licensed psychologists; certified psychology residents qualifying to engage in the practice of mental health therapy; and individuals exempted from licensure in accordance with State law: psychology students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the State's licensing division under the supervision of qualified faculty, staff, or designee, and individuals 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 have maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of their official duties for that agency or political subdivision.

Psychotherapy

In accordance with the CPT definition for psychotherapy, psychotherapy is the treatment of mental illness and behavioral disturbances in which the provider through definitive therapeutic communication, attempts to alleviate emotional disturbance, reverse or change maladaptive patterns of behavior and encourage personality growth and development so that the patient may be restored to his or her best possible functional level. Psychotherapy includes ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family and includes: psychotherapy with patient and/or family member, family psychotherapy with patient present, family psychotherapy without patient present, group psychotherapy and multiple-family group psychotherapy. Psychotherapy services are coded in accordance with CPT coding for psychotherapy services.

LIMITATIONS (Continued)

Rehabilitative Mental Health Services

Individual Psychotherapy

Individual psychotherapy means face-to-face interventions with the patient and/or family member and is coded in accordance with CPT coding for psychotherapy with patient and/or family member.

Family Psychotherapy with Patient Present

Family therapy with patient present means face-to-face interventions with family members and the identified patient with the goal of treating the patient's condition and improving the interaction between the patient and family members so that the patient and family may be restored to their best possible functional level. Family psychotherapy is coded in accordance with CPT coding for family psychotherapy with patient present.

Family Psychotherapy without Patient Present

Family therapy without patient present means face-to-face interventions with family members without the identified patient present with the goal of treating the patient's condition and improving the interaction between the patient and family members so that the patient and family may be restored to their best possible functional level. Family psychotherapy without patient present is performed in accordance with the CPT definition of psychotherapy and is coded in accordance with CPT coding for family psychotherapy without patient present.

Group Psychotherapy

Group psychotherapy means face-to-face interventions with two or more patients in a group setting where through interpersonal exchanges patients may be restored to their best possible functional level. Group psychotherapy is performed in accordance with the CPT definition of psychotherapy and is coded in accordance with CPT coding for group psychotherapy or multiple-family group psychotherapy.

Qualified providers of all psychotherapy services are: (1) licensed mental health therapists under State law: physicians and surgeons or osteopathic physicians engaged in the practice of mental health therapy; psychologists qualified to engage in the practice of mental health therapy; certified psychology residents qualifying to engage in the practice of mental health therapy; clinical social workers; certified social workers and certified social worker interns; advanced practice registered nurses (APRNs) licensed either as a nurse specialist or a nurse practitioner with psychiatric mental health nursing specialty certification (and any other licensed advanced nursing categories as approved by the State's licensing division when practicing within the scope of their practice act and competency); marriage and family therapists; associate marriage and family therapists; clinical mental health counselors; and associate clinical mental health counselors; (2) individuals working within the scope of their certificate or license in accordance with State law: licensed APRNs formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours; and licensed APRN interns formally working toward psychiatric mental health

LIMITATIONS (Continued)

Rehabilitative Mental Health Services

specialty certification and accruing the required clinical hours for the specialty nursing certification (and any other licensed advanced nursing categories as approved by the State's licensing division when practicing within the scope of their practice act and competency); and (3) individuals exempted from licensure as a mental health therapist in accordance with State law: students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the State's licensing division under the supervision of qualified faculty, staff, or designee, and individuals 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 have maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of their official duties for that agency or political subdivision.

Psychotherapy for Crisis

In accordance with the CPT definition for psychotherapy for crisis, this is a face-to-face service with the patient and/or family and includes an urgent assessment and history of a crisis state and disposition, psychotherapy to minimize the potential for psychological trauma, and 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 to a patient in high distress. Providers may use CPT coding for this service if the crisis and interventions qualify for this coding. Qualified providers are the same as those who may perform psychotherapy services.

Psychotherapy with Evaluation and Management Services

Psychotherapy with evaluation and management services means psychotherapy with the patient and/or family member when performed with an evaluation and management service on the same day by the same provider. The psychotherapy service is coded in accordance with CPT coding for psychotherapy with patient and/or family member and the evaluation and management service is performed and coded in accordance with the CPT definitions and coding for evaluation and management services.

Qualified providers are: licensed physicians and surgeons or osteopathic physicians engaged in the practice of mental health therapy; licensed APRNs with psychiatric mental health nursing specialty certification; licensed APRNs formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours and licensed APRN interns formally working toward psychiatric mental health specialty certification and accruing the required clinical hours for the specialty nursing certification (and any other licensed advanced nursing categories as approved by the State's licensing division when practicing within the scope of their practice act and competency).

LIMITATIONS (Continued)

Rehabilitative Mental Health Services

Pharmacologic Management

Pharmacologic management is provided face-to-face to a patient and/or family to address the patient's health issues and is provided and coded in accordance with the CPT definitions and coding for evaluation and management services.

Qualified providers are: licensed physicians and surgeons or osteopathic physicians regardless of specialty, licensed APRNs and licensed APRN interns regardless of specialty when practicing within the scope of their practice act and competency (and any other licensed advanced nursing categories as approved by the State's licensing division when practicing within the scope of their practice act and competency); and other practitioners licensed under State law who can perform the activities defined above when acting within the scope of his/her license, most commonly a licensed physician assistant when practicing under the delegation of services agreement required by their practice act.

Nurse Medication Management

Nurse medication management is provided face-to-face to a patient and/or family and includes reviewing/monitoring the patient's health issues, medication(s) and medication regimen, providing information, and administering medications as appropriate. The review of the patient's medications and medication regimen includes dosage, effect the medication(s) is having on the patient's symptoms, and side effects. The provision of appropriate information should address directions for proper and safe usage of medications.

Qualified providers are: licensed registered nurses; licensed practical nurses; and registered nursing students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the State's licensing division exempted from licensure and under the supervision of qualified faculty, staff, or designee in accordance with State law.

Therapeutic Behavioral Services

Therapeutic behavioral services are provided face-to-face to an individual or a group and is coded when the service provided does not fully meet the definition of psychotherapy. Instead providers use behavioral interventions to assist patients with a specific identified behavior problem. The service may be provided to an individual or group.

Qualified providers are: (1) licensed mental health therapists under State law: physicians and surgeons or osteopathic physicians engaged in the practice of mental health therapy; psychologists qualified to engage in the practice of mental health therapy; certified psychology residents qualifying to engage in the practice of mental health therapy; clinical social workers; certified social workers and certified social worker interns; advanced practice registered nurses (APRNs) licensed either as a nurse specialist or a nurse practitioner with psychiatric mental health nursing specialty certification (and any other licensed advanced nursing

LIMITATIONS (Continued)

Rehabilitative Mental Health Services

categories as approved by the State's licensing division when practicing within the scope of their practice act and competency); marriage and family therapists; associate marriage and family therapists; clinical mental health counselors; and associate clinical mental health counselors; (2) individuals working within the scope of their certificate or license in accordance with State law: licensed APRNs formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours; and licensed APRN interns formally working toward psychiatric mental health specialty certification and accruing the required clinical hours for the specialty nursing certification (and any other licensed advanced nursing categories as approved by the State's licensing division when practicing within the scope of their practice act and competency); and (3) individuals exempted from licensure as a mental health therapist in accordance with State law: students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the State's licensing division under the supervision of qualified faculty, staff, or designee, and individuals 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 have maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of their official duties for that agency or political subdivision. Licensed social service workers; licensed substance use disorder counselors; licensed registered nurses; individuals working toward licensure as a social service worker under supervision of a licensed mental health therapist in accordance with State law; and registered nursing students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the State's licensing division and individuals enrolled in a qualified substance use disorder education program exempted from licensure and under the supervision of qualified faculty, staff, or designee in accordance with State law, may also perform this service.

Psychosocial Rehabilitative Services

Psychosocial rehabilitative services are face-to-face services with an individual or a group and are designed to restore the patient to his or her maximum functional level through interventions such as cueing, modeling, and role-modeling of appropriate fundamental daily living and life skills. This service is aimed at maximizing the patient's basic daily living and life skills, increasing compliance with the patient's medication regimen as applicable, and reducing or eliminating symptomatology that interferes with the patient's functioning, in order to prevent the need for more restrictive levels of care such as inpatient hospitalization. Intensive psychosocial rehabilitative services may be coded when a ratio of no more than five patients per provider is maintained during a group service.

Qualified providers are: (1) licensed social service workers; (2) licensed substance use disorder counselors; (3) licensed registered nurses; (4) licensed practical nurses; (5) other trained individuals (but not including foster or proctor parents); and (6) individuals working toward licensure as a social service worker under supervision of a licensed mental health therapist in accordance with State law; and

LIMITATIONS (Continued)

Rehabilitative Mental Health Services

registered nursing students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the State's licensing division and individuals enrolled in a qualified substance use disorder education program exempted from licensure and under the supervision of qualified faculty, staff, or designee in accordance with State law. The individuals in (1)-(5) are the core service providers. The rate for this service is based on this core provider group.

Other trained individuals are under the supervision of a licensed mental health therapist identified in (1) on this page below or a psychologist identified in (3) on this page below; or a licensed substance use disorder counselor identified in (2) on page 2e above when the service is provided to patients with substance use disorders. Other trained Individuals receive training in areas including but not limited to administrative policies and procedures of the employing entity; emergency/crisis procedures, treatment planning, population(s) served, specific job responsibilities related to the patient population served, role and use of supervision, management of difficult behaviors, and medications and their role in treatment.

In addition, the following providers may also provide this service: (1) licensed mental health therapists under State law: physicians and surgeons or osteopathic physicians engaged in the practice of mental health therapy; psychologists qualified to engage in the practice of mental health therapy; certified psychology residents qualifying to engage in the practice of mental health therapy; clinical social workers; certified social workers and certified social worker interns; advanced practice registered nurses (APRNs) licensed either as a nurse specialist or a nurse practitioner with psychiatric mental health nursing specialty certification (and any other licensed advanced nursing categories as approved by the State's licensing division when practicing within the scope of their practice act and competency); and (3) individuals exempted from licensure as a mental health therapist in accordance with State law: students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the State's licensing division under the supervision of qualified faculty, staff, or designee, and individuals 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 have maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of their official duties for that agency or political subdivision. Licensed social service workers; licensed substance use disorder counselors; licensed registered nurses; individuals working toward licensure as a social service worker under supervision of a licensed mental health therapist in accordance with State law; and registered nursing students engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by the State's licensing division and individuals enrolled in a qualified substance use disorder education program exempted from licensure and under the supervision of qualified faculty, staff, or designee in accordance with State law, may also perform this service.

LIMITATIONS (Continued)

Rehabilitative Mental Health Services

Peer Support Services

Peer support services are provided for the primary purpose of assisting in the rehabilitation and recovery of individuals with mental health and/or substance use disorders. For children, peer support services are provided to their parents/legal guardians as appropriate to the child's age, and the services are directed exclusively toward the Medicaid-eligible child. Peer support services are provided face-to-face to an individual, a group of individuals or to parents/legal guardians. On occasion, it may be impossible to meet with the peer support specialist in which case a telephone contact with the client or his or her parent/legal guardian would be allowed.

Peer support groups are limited to a ratio of 1:8. Medicaid clients or parents/legal guardians of Medicaid-eligible children may participate in a maximum of four hours of peer support services a day.

Peer support services are designed to promote recovery. Peers offer a unique perspective that clients find credible; therefore, peer support specialists are in a position to build alliances and instill hope. Peer support specialists lend their unique insight into mental illness and what makes recovery possible.

Using their own recovery stories as a recovery tool, peer support specialists assist clients with creation of recovery goals and with goals in areas of employment, education, housing, community living, relationships and personal wellness. Peer support specialists also provide symptom monitoring, assist with symptom management, provide crisis prevention, and assist clients with recognition of health issues impacting them.

Peer support services must be recommended by an individual authorized under State law to perform psychiatric diagnostic evaluations and develop treatment plans. Peer support services are delivered in accordance with a written treatment/recovery plan. This plan is a comprehensive, holistic, individualized plan of care developed through a person-centered planning process. Patients lead and direct the design of their plans by identifying their own preferences and individualized measurable recovery goals. Treatment and recovery plans are reviewed by the patient and are updated to reflect the patient's progress and the patient's changing preferences, needs and goals.

To be eligible to qualify as a peer support services provider, individuals must be self-identified individuals at least 18 years of age. Individuals also are: (1) in recovery from a mental health and/or substance use disorder, (2) a parent of a child with a mental health and/or substance use disorder or (3) an adult who has or has had an ongoing and personal relationship with an individual with mental health and/or substance use disorder.

Qualified providers are certified peer support specialists. Qualified providers have successfully completed a peer support specialist training curriculum designed to give peer support specialists the competencies required to successfully perform peer support services. Curriculums are developed by the State of Utah, Department of Human Services, Division of Substance Abuse and Mental Health (DSAMH), in consultation with national

REHABILITATIVE SERVICES (Continued)

LIMITATIONS (Continued)

Rehabilitative Mental Health Services

experts in the field of peer support. Training is provided by DSAMH or a qualified individual or organization sanctioned by DSAMH. At the end of the training individuals must successfully pass a written examination. Successful individuals receive a written peer specialist certification from the DSAMH. Certified peer specialists also successfully complete any continuing education required by the DSAMH to maintain the certification.

The peer specialist training curriculum includes modules on stages or recovery, the role of peer support in the recovery process, using peers' recovery stories as a recovery tool; standards for peer support services; importance of beliefs that promote recovery; dynamics of change and the change process; how to facilitate recovery dialogue; effective active listening and questioning skills; dealing with crises, using dissatisfaction as an avenue for change; combating negative self-talk and facing fears; problem-solving; education on health issues impacting individual with mental illness; accomplishing recovery goals; peer specialist ethics and professional boundaries, including confidentiality and privacy; and documentation of services.

Certified peer specialists provide services under the supervision of one of the following: (1) a licensed mental health therapist under State law: a physician and surgeon or osteopathic physician engaged in the practice of mental health therapy; a psychologist qualified to engage in the practice of mental health therapy; a certified psychology resident; a clinical social worker; a certified social worker or certified social worker intern; an APRN licensed either as a nurse specialist or a nurse practitioner with psychiatric mental health nursing specialty certification (or any other licensed advanced nursing category as approved by the State's licensing division); a marriage and family therapist; an associate marriage and family therapist; a clinical mental health counselor; or an associate clinical mental health counselor; (2) an individual exempted from licensure as a mental health therapist in accordance with State law: an individual 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 or her official duties for that agency or political subdivision; or (3) when peer support services are provided to individuals with substance use disorders, licensed substance use disorder counselors may supervise peer support specialists. Supervisors provide ongoing weekly individual and/or group supervision.

OTHER DIAGNOSTIC, SCREENING, PREVENTIVE, AND REHABILITATIVE SERVICES

LIMITATIONS

Preventive services provided by the State Poison Control Center

1. Preventive services provided by the State Poison Control Center, through the Division of Family Health Services, are covered benefits for Medicaid recipients.

2. Services are provided by a physician or pharmacist practicing within the scope of their license in accordance with Title 58, Occupational and Professional Licensing, of the Utah Code Annotated 1953, as amended.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

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DIAGNOSTIC, SCREENING, PREVENTIVE, AND REHABILITATIVE SERVICES

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DIAGNOSTIC, SCREENING, PREVENTIVE, AND REHABILITATIVE SERVICES

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OTHER DIAGNOSTIC AND PREVENTIVE SERVICES

Diabetes Self-Management Training

Diabetes self-management training is an educational program that teaches individuals how to successfully manage and control diabetes. The training will increase the individual's understanding of disease progression and teach monitoring skills to prevent complications, disease progression and disability. As a result of the training the individual will be able to identify potential diabetes-related problems, establish achievable self-care goals and take responsibility for maintaining a healthy lifestyle that promotes quality mental and physical health. The program coordinator will be responsible for maintaining ongoing open communication with the patient's physician. The Coordinator will inform the physician of the patient's progress, compliance, or issues of concern identified while the patient's training is in progress. Evaluation of the patient training will occur with each session and at the conclusion of training. Also, the program coordinator will complete follow up with the patient several months after the training. Issues or concerns will be communicated directly to the physician.

LIMITATIONS

1. Diabetes self-management training is limited to a maximum of ten hours of outpatient service. Instructors eligible to provide diabetes self-management training will include registered nurses, registered pharmacists and certified dieticians licensed by the state who are eligible under their scope of practice to provide counseling for patients with diabetes and to monitor patient compliance with the plan of care. In order to be included as an instructor in the program, instructors must have at least a bachelor’s degree and a minimum of 24 hours of recent diabetes specific continuing education which includes pathophysiology, diabetes therapies and management, education principles and behavior change strategies. Instructors must acquire at least 6 hours of diabetes approved continuing education annually after completion of the initial 24 hours.

2. Diabetes self-management is limited to that certified by the physician, under a comprehensive plan, as essential to ensure successful diabetes management by the individual patient.

3. Diabetes self-management training is limited to the training presented in a certified program that meets all of the National Diabetes Advisory Board (NDAB) standards and is recognized by the American Diabetes Association (ADA) or is certified by the Utah Department of Health. For participation as a Diabetes Self-Management Training program within Medicaid, the program must have:
   a. each instructor within the program demonstrate proficiency in each of the 15 ADA core curriculum standards of practice guidelines.
   b. a designated program coordinator with education in the care of individuals with chronic diabetes and experience in program management to direct the planning, implementation and evaluation of the program.
   c. an oversight committee to advise the program in its direction, annual planning process, resource needs, cultural appropriateness, and program evaluation. The committee will include at least a physician, a certified diabetes educator, a registered nurse, a state licensed certified dietician, a registered pharmacist, the program coordinator, a community representative and a consumer.

OTHER DIAGNOSTIC AND PREVENTIVE SERVICES

Diabetes Self-Management Training (continued)

4. Diabetes self-management includes group sessions, but must allow for direct face-to-face interaction between the instructor and the patient to provide opportunity for questions and personal application of learned skills. Each nurse, pharmacist and dietician instructor will teach the 15 ADA core curriculum components which include:
   a. diabetes overview.
   b. stress and psycho-social adjustment.
   c. family involvement and social support.
   d. nutrition.
   e. exercise and activity.
   f. medications.
   g. monitoring and uses of results.
   h. interrelationship of nutrition, exercise, medication, and blood glucose level.
   i. prevention, detection and treatment of acute complications.
   j. prevention, detection and treatment of chronic complications.
   k. foot, skin and dental care.
   l. behavior change strategies, goal setting, risk factor reduction, and problem solving.
   m. benefits, risks and management options for improving glucose control.
   n. use of health care system and community resources.
   o. preconception care, pregnancy and gestational diabetes (when appropriate).

5. Diabetes self-management training must be sufficient in length to meet the goals of the basic comprehensive plan of care. Individual sessions must be sufficient in number and designed to meet the medical and instructional needs of the individual.

6. Repeat of any or all of a diabetes self-management program is limited to new conditions or alteration of health status that warrants the need for new training.

7. Home Health Agency participation in diabetes self-management is limited to providing service to the patient who is receiving other skilled services in the home based on physician order and plan of care, when the home is the most appropriate site for the care provided.

8. Diabetes self-management training services provided by a home health agency must be provided only by state licensed health care providers who are certified or recognized by the American Diabetes Association (ADA) program or the Utah Department of Health. Qualified providers for the diabetes self-management training program include registered nurses, registered pharmacists and certified dieticians licensed by the state.

SERVICES FOR INDIVIDUALS AGE 65 OR OLDER
IN INSTITUTIONS FOR MENTAL DISEASE (IMD)

LIMITATIONS

1. Services for individuals age 65 or older in an institution for mental disease are a benefit of the Medicaid program in a hospital licensed as a Specialty Hospital - Psychiatric, under the authority of Utah Administrative Code R432-101. Services must be provided under the direction of a physician.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

INTERMEDIATE CARE FACILITY SERVICES

Intermediate care facility services (other than services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

In accordance with section 1919(f)(7) of the Act, personal hygiene items and services may be charged to the patient's personal needs fund. The following limitations apply.

LIMITATIONS

1. The following personal hygiene items and services may, at the request of the patient or the patient's advocate, be charged to the patient's personal needs fund:

   a. Personal grooming services such as cosmetic hair and nail care;

   b. Personal laundry services;

   c. Specific brands of shampoo, deodorant, soap, etc., requested by the patient or patient's advocate and not ordinarily supplied by the nursing home as required in 2(a) and (b) below.

2. In accordance with State Plan amendment 4.19-D, Nursing Home Reimbursement, the following personal hygiene items and services may not be charged to the individual's personal needs fund:

   a. Items specific to a patient's medical needs, such as protective absorbent pads (such as Chux), prescription shampoo, soap, lotion.

   b. General supplies needed for personal hygiene such as toothpaste, shampoo, facial tissue, disposable briefs (diapers), etc.

INPATIENT PSYCHIATRIC FACILITY SERVICES
FOR INDIVIDUALS UNDER 21 YEARS OF AGE

LIMITATIONS

1. Inpatient psychiatric services for individuals under age 21 are a benefit of the Medicaid program only for care and treatment provided under the direction of a physician in a hospital licensed as a Specialty Hospital - Psychiatric, under the authority of the Utah Administrative Code R432-101, 1992 as amended.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

HOSPICE SERVICES

TB RELATED SERVICES TO TB INFECTED INDIVIDUALS

LIMITATIONS

1. Directly Observed Therapy (DOT)/Behavior Modification services will provide for directly observed administration of tuberculosis medication, which means the direct observation of patients swallowing anti-tuberculosis medication. Recipients must be assessed as medically appropriate for DOT based upon the recipient's risk of non-adherence to medication regimen necessary to cure and prevent the spread of an infectious, potentially fatal disease which may not respond to conventional therapies. Services shall be furnished five or more days per week, unless otherwise ordered by the physician in the recipient's plan of care. This service is provided in accordance with a therapeutic goal in the plan of care. The plan of care will include a behavior modification program to aid in establishing a pattern of adherence to treatment. The behavior modification program will be developed on an individual basis based on the patients history of non-compliance. Daily monitoring of adherence and behavior modification is necessary to ensure completion of the prescribed drug therapy, since inconsistent or incomplete treatment is likely to lead to drug resistance or reactivation, posing a major threat to the public health. DOT includes security services designed to encourage completion of medically necessary regimens of prescribed drugs by certain non-compliant TB infected individuals on an outpatient basis.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

EXTENDED SERVICES TO PREGNANT WOMEN

The following major categories of service are available as pregnancy related or postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

1. Inpatient Hospital Services
   Limitations identified in ATTACHMENT 3.1-A (Attachment #1)

2. Outpatient Hospital Services
   Limitations identified in ATTACHMENT 3.1-A (Attachment #2)

3. Family Planning Services
   Limitations identified in ATTACHMENT 3.1-A (Attachment #4.c)

4. Physician Services
   Limitations identified in ATTACHMENT 3.1-A (Attachment #5)

5. Home Health Visits
   Limitations identified in ATTACHMENT 3.1-A (Attachment #20.b, page 3)

6. Medical Supplies and Equipment
   Limitations identified in ATTACHMENT 3.1-A (Attachment #7.c)

7. Prescription Drug Services
   Limited to treatment of pregnancy related conditions, complications, and family planning. Limited also to those limitations identified in ATTACHMENT 3.1-A (Attachment #12.a)

8. Certified Registered Nurse Midwife Services
   Limited to maternity cycle, i.e., pregnancy, labor, birth, and the immediate post-partum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

9. Certified Pediatric and Family Nurse Practitioners
   Limitations identified in ATTACHMENT 3.1-A (Attachment #23)

EXTENDED SERVICES TO PREGNANT WOMEN (Continued)

The following services are being expanded beyond limitation for all groups described and the services are provided only for pregnant women.

A. Physician Services

Risk Assessment

Risk assessment is the systematic review of relevant client data to identify potential problems and plan for care. Early identification of high risk pregnancies with appropriate consultation and intervention contribute significantly to an improved perinatal outcome and lowering of maternal and infant morbidity and mortality. The care plan for low risk clients incorporates a primary care service package and additional services specific to the needs of the individual client. High risk care includes referral to or consultation with an appropriate specialist, individualized counseling and services designed to address the particular risk factors involved. Risk assessment will be accomplished using the Utah Perinatal Record System or other formalized risk assessment tool. Consultation standards will be consistent with the Utah Medical Insurance Association guidelines.

Limited to two risk assessments during any 10-month period.

Prenatal Assessment Visit (Initial Visit Only)

The initial 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 medical data, and initiation of a plan of care.

Limited to one visit in any 10-month period, to be used only when patient is referred immediately to a community practitioner because of identified risks or otherwise lost to follow-up because patient does not return.

Single Prenatal Visit (Visit Other Than Initial Visit)

A single prenatal visit for an established patient who does not return to complete care for unknown reasons. Initial assessment visit was completed, plan of care established, one or two follow-up visits completed but no follow through with additional return visits.

Limited to a maximum of three visits in any 10-month period, to be used outside of global service, only when the patient is lost to follow-up for any reason.

High Risk Pregnancy Care

High risk pregnancy as determined and reported through use of the formalized risk assessment tool shall be managed by physicians according to the Utah Medical Insurance Association guidelines. Additional reimbursement will be considered when criteria for high risk pregnancy care are met.

EXTENDED SERVICES TO PREGNANT WOMEN (Continued)

B. Certified, Registered Nurse Midwife Services

Risk Assessment

Risk assessment is the systematic review of relevant client data to identify potential problems and plan for care. Early identification of high risk pregnancies with appropriate consultation and intervention contribute significantly to an improved perinatal outcome and lowering of maternal and infant morbidity and mortality. The care plan for low risk clients incorporates a primary care service package and additional services specific to the needs of the individual client. High risk care includes referral to or consultation with an appropriate specialist, individualized counseling, and services designed to address the particular risk factors involved. Risk assessment will be accomplished using the Utah Perinatal Record system or other formalized risk assessment tool. Consultation standards will be consistent with the Utah Medical Insurance Association guidelines.

Certified nurse midwives may care for some psycho socially or demographically high risk women according to written agreements with consulting physicians or admitting hospitals.

Limited to two risk assessments during any 10-month period.

Prenatal Assessment Visit (Initial Visit Only)

The initial 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 medical data, and initiation of a plan of care.

Limited to one visit in any 10-month period, to be used only when patient is referred immediately to a community practitioner because of identified risks or otherwise lost to follow-up because patient does not return.

Single Prenatal Visit (Visit Other Than Initial Visit)

A single prenatal visit for an established patient who does not return to complete care for unknown reasons. Initial assessment visit was completed, plan of care established, one or two follow-up visits completed, but no follow through with additional return visits.

Limited to a maximum of three visits in any 10-month period, to be used outside of global service, only when the patient is lost to follow-up for any reason.

EXTENDED SERVICES TO PREGNANT WOMEN (Continued)

The following services are being added as certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

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, psycho social, nutritional, educational, and other services for the pregnant women.

Prenatal and Postnatal Home Visits

Home visits can be included in the management plan of pregnant patients when there is a need to assess the home environment and implications for management of prenatal and postnatal care, to provide direct care, to encourage regular visits for prenatal care, to provide emotional support, to determine educational needs, to monitor progress, to make assessments, and to re-evaluate the plan of care.

Limited to no more than six visits during any 12-month period.

Group Prenatal/Postnatal Education

Classroom learning experience for the purpose of improving the knowledge of pregnancy, labor, childbirth, parenting and infant care. The objective of this planned educational service is to promote informed self care, to prevent development of conditions which may complicate pregnancy, and to enhance early parenting and child care skills.

Limited to eight units during any 12-month period. One unit is equal to one class at least one hour in length.

The following services are being added for specific providers. These services will be limited only to pregnant women throughout pregnancy and up to the end of the month in which the 60 days following the pregnancy occurs.

C. Licensed, certified social worker, clinical psychologist, marriage and family counselor services.

Prenatal and Postnatal Psychosocial Counseling

Psycho social evaluation is provided to identify patients and families with high psychological and social risks, to develop a psycho social care plan and provide or coordinate appropriate intervention, counseling or referral necessary to meet the identified needs of families.

Limited to 12 visits in any 12-month period.

EXTENDED SERVICES TO PREGNANT WOMEN (Continued)

D. Registered Dietitian Services

Nutritional Assessment/Counseling

All women are referred to the WIC program for nutritional assessment. Women with complex nutritional or related medical risk factors as determined in initial prenatal visits may require intensive nutrition education, counseling, monitoring and frequent consultation, and may receive service by referral from a physician, certified nurse midwife, or a family nurse practitioner to a registered dietitian.

Limited to 14 visits during any 12-month period.

E. Community Health Nurse Services

Perinatal Care Coordination.

Prenatal and Postnatal Home visits, as defined above in B, may be provided by the community health nurse.

Group Prenatal/Postnatal education, as defined above in B, may be provided by the community health nurse.

F. Registered Nurse Services

Perinatal Care Coordination

Prenatal/Postnatal Home visits, as defined above in B, may be provided by the registered nurse.

Group Prenatal/Postnatal education, as defined above in B, may be provided by the registered nurse.

G. Certified Family Nurse Practitioner Services

Perinatal Care Coordination

Risk Assessment, as defined above in B, may be provided by the certified family nurse practitioner.

Prenatal and Postnatal Home visits, as defined above in B, may be provided by the certified family nurse practitioner.

Group Prenatal/Postnatal education, as defined above in B, may be provided by the certified family nurse practitioner.

Prenatal Assessment visit, as defined above in B, may be provided by the certified family nurse practitioner.

Single prenatal visits, as defined above in B, may be provided by the certified family nurse practitioner.

EXTENDED SERVICES TO PREGNANT WOMEN (Continued)

H. Health Educator Services

Any one of the following health care professionals is qualified to provide perinatal care coordination services:

(i) A certified nurse midwife/certified nurse practitioner who is licensed in accordance with the Nurse Practice Act of the State of Utah;

(ii) A registered nurse who is licensed in accordance with the Nurse Practice Act of the State of Utah;

(iii) A Licensed Practical Nurse (LPN) who works under the supervision of a registered nurse and has additional training and experience to be a perinatal care coordinator. The LPN must be licensed in accordance with the Nurse Practice Act of the State of Utah;

(iv) A certified social worker with at least a master's degree in social work who is licensed in accordance with the Social Work Licensing Act of the State of Utah;

(v) A social service worker with at least a bachelor's degree in social work who is licensed in accordance with the Social Work Licensing Act of the State of Utah.

Group Prenatal/Postnatal education, as defined above in B, may be provided by the health educator.

I. Social Worker Services

Perinatal Care Coordination may be provided by a licensed social service worker (SSW) who meets the established criteria.

Perinatal Care Coordination may be provided by a licensed certified social worker (LCSW) who meets the established criteria.

J. Other Services

In accordance with 42 CFR 440.250, pregnant women may receive pregnancy related services and services for other conditions that might complicate the pregnancy. These services shall not include any not allowed in section 1905(a) of the Social Security Act.

TRANSPORTATION SERVICES

LIMITATIONS

1. Coverage of optional transportation service is limited to the most reasonable and economical means of transportation necessary to secure medical examination and/or treatment for a recipient by a provider to whom a direct vendor payment can be made.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
State/Territory: Utah

SECTION 3 – SERVICES: GENERAL PROVISIONS

3.1 Amount, Duration, and Scope of Services

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act; section 245A(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483.

28. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (in accordance with section 1905(a)(29) of the Social Security Act and 42 CFR 440.170).

a. Transportation (provided in accordance with 42 CFR 440.170 as an optional medical service) excluding "school-based" transportation.

_ Not Provided:

_ Provided without a broker as an optional medical service: (If state attests "Provided without a broker as an optional medical service" then insert supplemental information.)

Describe below how the transportation program operates including Types of transportation and transportation related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.

X Non-emergency medical transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4). Brokerage contracted provider selected through RFP process.

X The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

State/Territory: Utah

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

__ (1) state-wideness (indicate areas of State that are covered)
__ (10)(B) comparability (indicate participating beneficiary groups)
X (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

X wheelchair van
X taxi/commercial carrier
X stretcher car
_ bus passes
_ tickets
_ secured transportation
_ other transportation (if checked describe below other transportation)

X (3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on
(ii) the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs:
(iii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed qualified, competent and courteous:
(iv) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services:
(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

State/Territory: Utah

(4) The broker contract will provide transportation to the following mandatory populations:

__ Low-income families with children (section 1931)
__ Deemed AFCD-related eligibles
X Poverty-level related pregnant women
X Poverty-level infants
X Poverty-level children 1 through 5
X Poverty-level children 6 – 18
X Qualified pregnant women AFDC – related
X Qualified children AFDC – related
X IV-E foster care and adoption assistance children
__ TMA recipients (due to employment) (section 1925)
__ TMA recipients (due to child support)
X SSI recipients

(5) The broker contract will provide transportation to the following optional populations:

X Optional poverty-level - related pregnant women
X Optional poverty-level - related infants
X Optional targeted low income children
X Non IV-E children who are under State adoption assistance agreements
X Non IV-E independent foster care adolescents who were in foster care on their 18th birthday
__ Individuals who meet income and resource requirements of AFDC or SSI
__ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
__ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
X Children aged 15-20 who meet AFDC income and resource requirements
__ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
__ Individuals infected with TB
X Individuals screened for breast or cervical cancer by CDC program
__ Individuals receiving COBRA continuation benefits
__ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard

State/Territory: Utah

X Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution (the broker will provide NEMT only to 1905(a) services)
___ Individuals terminally ill if in a medical institution and will receive hospice Care
X Individuals aged or disabled with income not above 100% FPL
___ Individuals receiving only an optional State supplement in a 209(b) State
X Individuals working disabled who buy into Medicaid (BBA working disabled group)
___ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
X Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:
X (i) risk capitation
___ (ii) non-risk capitation
___ (iii) other (e.g., brokerage fee and direct payment to providers)
(If checked describe any other payment methodology)

(B) Who will pay the transportation provider?
X (i) Broker
___ (ii) State
___ (iii) other

The broker will be paid at the contracted capitated rate and will have sole responsibility to pay door-to-door subcontracted NEMT transportation providers. Commercial bus, airline or train tickets for prior approved out of state medical services will be the responsibility of the appropriate Accountable Care Organization (ACO) or the State. The Medicaid beneficiary is reimbursed mileage for use of their personal vehicle by the state as outline in State Transportation policy.

State/Territory: Utah

X (C) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

X (D) The State assures that payments proposed under this State plan amendment will be made directly to capitated transportation providers and that the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

X (7) The broker is a non-governmental entity:

X The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

__ The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

__ transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

__ transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

__ the availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

__ (8) The broker is a governmental entity

__ The broker provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

__ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

__ Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

__ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the rate charged to other State human services agencies for the same service.

State/Territory: Utah

(9) Please describe below how the NEMT brokerage program operates. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

The broker shall be responsible for and perform all administrative brokerage functions to include: establish and monitor Medicaid program compliance of a transportation network; receive NEMT service requests through a customer service call center for at least nine (9) consecutive hours during the hours of 8:30 a.m. though 5:30 pm. (Mountain Standard Time or Mountain Daylight Time, whichever is applicable) Monday through Friday, and on-call representative for urgent care trips; verify client Medicaid eligibility, and their requested medical service provider is an active Medicaid provider through Department provided access to Medicaid eligibility information, screen client need for service and mobility status for the most appropriate mode of transportation; approve and arrange the least expensive transport to the closest appropriate Medicaid provider, for Medicaid covered services from the State. The broker provides oversight to assure services through:

a. Client Surveys;
b. Monthly reports and required subcontractor documentation regarding their Drivers and Vehicles used to provide NEMT through this contract.
c. Provides training and inspections to assure all subcontractors meet the quality levels required in the Brokerage NEMT contract as out lined in the Brokerage contract.

SKILLED NURSING FACILITY SERVICES
(Children under 21 years of age)

LIMITATIONS

1. In accordance with section 1919(f)(7) of the Act, Residents may be charged for the following personal hygiene items and services:
   a. Cosmetic and grooming items and services in excess of those included in the basic service;
   b. Private room, unless medically necessary;
   c. Specially prepared food, beyond that generally prepared by the facility;
   d. Telephone, television, radio;
   e. Personal comfort items including tobacco products and confections;
   f. Personal clothing;
   g. Personal reading materials;
   h. Gifts purchased on behalf of a resident;
   i. Flowers and plants;
   j. Social events and activities beyond the activity program; and
   k. Special care services not included in the facility's Medicaid payment.

2. In accordance with ATTACHMENT 4.19-D, Nursing Home Reimbursement, each nursing facility must provide the following personal hygiene items and services (and residents may not be charged for):
   a. Nursing and related services;
   b. Specialized rehabilitative services (treatment and services required by residents with mental illness or intellectual disability, not provided or arranged for by the State);
   c. Pharmaceutical services (with assurance of accurate acquiring, receiving, dispensing, and administering of drugs and biologicals);
   d. Dietary services individualized to the needs of each resident;
   e. Professionally directed program of activities to meet the interests and needs for well-being of each resident;
   f. Emergency dental services (and routine dental services to the extent covered under the State Plan);
   g. Room and bed maintenance services; and
   h. Routine personal hygiene items and services.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
   a. the proposed services are medically appropriate; and
   b. the proposed services are more cost effective than alternative services.

HOME-BASED PERSONAL CARE SERVICES

Home-based personal care services are covered benefits when provided by an agency licensed to provide personal care outside of a 24-hour supervised living setting, in accordance with Utah Code Annotated, Title 26, Chapter 21. The services are delivered by a personal care aide or a home health aide (performing only personal care level tasks) who has obtained a certificate of completion from the State Office of Education, or a licensed practical nurse, or a licensed registered nurse.

LIMITATIONS

1. Home-based personal care services are covered benefits when prescribed by a physician.

2. Home-based personal care services are not covered benefits:

   (a) for recipient's residing in an institution; or

   (b) when delivered current with Medicaid home health aide services.

3. Home-based personal care services are limited to 60 hours per month.

EMPLOYMENT-RELATED PERSONAL CARE SERVICES

Employment-related personal care services are covered benefits provided to support integrated employment opportunities for individuals with a moderate to severe level of disabilities. Services are delivered by an agency licensed to provide personal care services outside of a 24-hour supervised living setting, in accordance with Utah Code Annotated, Title 26, Chapter 21, or a non-agency individual employed by the recipient as a personal care assistant who meets provider qualifications established by the Medicaid Agency. Employment-related personal care services include physical assistance and cognitive cuing to direct self-performance of necessary activities.

LIMITATIONS

A. Employment-related personal care services are covered benefits only for recipients who:
   1. meet the disability definition of the SEC 1614 [42 /y,/s,/c, 1382c](a)(3), and
   2. are gainfully employed in an integrated community setting.

B. Employment-related personal care services are limited to:
   1. assistance with daily living activities;
   2. assistance with instrumental activities of daily living;
   3. transportation to and from the worksite;
   4. case management support to access and coordinate services and supports available at the work site through education, vocational rehabilitation, and other work-related public programs; and
   5. case management support to access and coordinate employment-related personal care services with other Medicaid State Plan services, including home-based personal care services.
   6. services provided to eligible individuals outside the home necessary to assist them in obtaining and retaining competitive employment of at least 40 hours per month. Services are designed to assist an individual with a disability to perform daily activities on and off the job that the individual would typically perform if they did not have a disability.

C. Employment-related personal care services are not covered benefits:
   1. when provided by a legally responsible family member or guardian;
   2. when provided to individuals residing in hospitals, nursing facilities, ICFs/MR, when the recipient is employed by the facility; or
   3. when provided to individuals enrolled in a 1915(c) Home and Community-Based Services waiver when personal care services are provided as a component of a covered waiver services currently being utilized by the recipient.

EMPLOYMENT-RELATED PERSONAL CARE SERVICES (Continued)

D. Scope, amount, and duration of employment-related personal care services will be determined on an individual recipient basis through a needs assessment process approved by the Department and completed by staff of the Department or its designee.

E. Scope, amount, and duration of employment-related personal care services will be authorized through completion of a written individualized service plan prepared jointly by the individual recipient and the Department staff or designee conducting the needs assessment.

F. Non-agency personal care assistants employed by the recipient to provide employment-related personal care services are required to utilize a Department approved fiscal intermediary to coordinate Medicaid claims submittal and payment, and to coordinate payment of employer-based taxes.

G. Recipients who cannot direct the activities of a personal care assistance employee may designate a proxy to act in this capacity within parameters established by the Department.

NURSE PRACTITIONERS

LIMITATIONS

1. Services provided by a licensed certified pediatric nurse practitioner (CPNP) or a licensed certified family nurse practitioner (CFNP) are limited to ambulatory, non-institutional services provided to the extent that licensed certified pediatric and family nurse practitioners are authorized to practice under state law.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. the proposed services are medically appropriate; and

   b. the proposed services are more cost effective than alternative services.

FREESTANDING BIRTHING CLINICS

(a) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ___ No limitations _X_ With limitations ___ None licensed or approved

Please describe any limitations:

Birthing center maternal patients shall be limited to women initially determined to be at low maternity risk and evaluated regularly throughout pregnancy to ensure they remain at low risk for a poor pregnancy outcome.

(b) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ___ No limitations _X_ With limitations (please describe below)

___ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Must be licensed in the State of Utah to provide such services.

Please check all that apply:

_X_ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

_____ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).

_____ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

MEDICALLY NECESSARY SERVICES

Medically necessary services not otherwise provided under the State plan but available to EPSDT (CHEC) eligibles

A. Target Group
Targeted case management for EPSDT-eligibles for whom the service is determined to be medically necessary. Targeted case management services will be considered medically necessary when a needs assessment completed by a qualified targeted case manager documents that:

1. The individual requires treatment and/or services from a variety of agencies and providers to meet his or her documented medical, social, education, and other needs; and

2. There is a reasonable indication that the individual will access needed services only if assisted by a qualified targeted case manager who (in accordance with an individualized case management service plan) locates, coordinates and regularly monitors the services.

B. Areas of the State in Which Services Will Be Provided:
Services will be available statewide.

C. Comparability:
Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:
1. Targeted case management is a service that assists the eligible clients 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 recipients to access needed services, but to ensure that services are coordinated between all agencies and providers involved.
2. The following activities/services are covered by Medicaid under targeted case management:
   a. assessing and documenting the client's need for community resources and services;
   b. developing a written, individualized and coordinated case management service plan to assure the client's adequate access to needed medical, social, educational and other related services with input, as appropriate, from the client, family and other agencies knowledgeable about the client's needs;
   c. linking the client with community resources and needed services, including assisting the client to establish and maintain eligibility for entitlements other than Medicaid;
   d. coordination of the delivery of services to the client including CHEC screenings and follow-up;
   e. monitoring the quality and appropriateness of the client's services;
   f. instructing the client or caretaker as appropriate, in independently obtaining access to needed services for the client;
   g. assessing, periodically, the client's status and modifying the targeted case management service plan as needed; and
   h. monitoring the client's progress and continued need for targeted case management and other services.

MEDICALLY NECESSARY SERVICES (Continued)

D. Definition of Services (Continued)

3. Covered services provided to patients in a hospital, nursing facility or other institution may be covered only in the 30-day period prior to the patient's discharge into the community. This service is limited to nine hours of reimbursement per year for CHEC eligibles.

E. Medicaid providers of targeted case management services to CHEC-Medicaid eligible recipients may include:

1. Independent Professional -- An individual who:
   a. is licensed as a clinical or certified social worker and practicing within the scope of his/her license in accordance with Title 58, Occupational and Professional Licensing, Utah Code Annotated, 1953 as amended;
   b. has at least five years experience providing case management to the target group;
   c. has current malpractice insurance of at least $1,000,000; and
   d. has filed an approved targeted case management Provider Agreement with the Division of Health Care Financing.

2. Agencies that specialize in providing case management services to children -- An agency that:
   a. is licensed by the Department of Human Services as a child placement agency or an agency that receives Title V funding and has statutory responsibility for services to children with special health care needs; and
   b. employs or contracts with licensed physicians, registered nurses, licensed psychologists, licensed physical therapists, licensed occupational therapists, licensed social workers, and/or licensed social service workers to provide case management services. The agency may utilize non-licensed individuals to provide targeted case management services, if the individual has education and experience related to high risk children and adolescents and has successfully completed a targeted case management course approved by the DHCF. The DHCF will approve training curriculums that include:
      (1) detailed instruction in the Medicaid targeted case management provider manual requirements, and methods for delivering and documenting covered case management services;
      (2) up-to-date information on community resources, and how to access those resources; and
      (3) techniques and skills in communicating successfully with clients and other agency/provider personnel.

F. Freedom of Choice:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Non-Duplication of Payment:
Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State law (most commonly a physician assistant) and APRNs not otherwise specified above.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
_**X**___ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [**Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]** Qualified providers of targeted case management services to recipients in this target group are (1) employed by or under contract with a local mental health and/or substance abuse authority; (2) employed by or under contract with a local authority's designated mental health and substance abuse services provider; 3) employed by or under contract with the Utah Department of Human Services; or 4) employed by or under contract with a program providing Medicaid-covered services, including targeted case management for individuals with serious mental illness, under 1915(a) authority. Providers authorized under 1915(a) authority provide targeted case management services only to recipients enrolled in the 1915(a) program.

As an integral part of the public mental health/substance abuse system, or an entity providing Medicaid-covered services under 1915(a) authority, targeted case managers understand the service systems delivering mental health/substance use disorder services and the array of services their clients need. As a member of the mental health and/or substance use disorder service delivery team, they can ensure recipients are able to access all needed services timely and in a coordinated manner.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

necessary based on recipient needs. Re-assessments include a review and update of the recipient's specific care plan.

❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual;

❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

❖ Monitoring and follow-up activities:
- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. **[Specify the type of monitoring and justify the frequency of monitoring.]**

Case management monitoring consists of regular contacts between the case manager and the recipient, family members, service providers, or other entities or individuals to determine if goals specified in the targeted case management care plan are being met. For this target group, it is also critical that regular monitoring occurs to ensure that problems are identified and resolved in a timely manner, to determine if the recipient is successfully accessing needed services, and adhering to medication regimens (if applicable), and to determine if there are changes in the recipient's mental health status (e.g., decompensation/changes in the recipient's symptomatology or functioning) that could result in the need for more restrictive levels of care including inpatient hospital care. Monitoring is performed in accordance with the frequency specified in the recipient's

is performed in accordance with the frequency specified in the recipient's targeted case management service plan which is based on recipient needs.

- **_X_** Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
- (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[**Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]**

Qualified targeted case managers are:

A. Primary providers of this service are: (1) licensed social service workers, licensed substance use disorder counselors, licensed registered nurses and licensed practical nurses; and (2) individuals who are not licensed (and are not otherwise included in B (3) below) who are at least 18 years old and under the supervision of an individual identified in B(1), B(2), B(4) or B(5) below, or A(1) of this paragraph with the exception of licensed practical nurses. Individuals in A(2) also complete a training course sponsored through the Utah Department of Human Services, Division of Substance Abuse and Mental Health (DSAMH, the State's Substance Abuse and Mental Health Authority) and receive certification as a targeted case manager from DSAMH.

B. In addition to the primary service providers specified in A above, these individuals may also provide this service: (1) An individual licensed under State law as a mental health therapist including physicians, advanced practice registered nurses (APRNs) with psychiatric specialty certification, psychologists, social workers, marriage and family therapists, and clinical mental health counselors; (2) licensed APRNs and licensed APRN interns working toward psychiatric specialty certification and qualification as mental health therapist; (3) individuals exempted from licensure: students engaged in activities constituting the practice of a regulated mental health or substance abuse-related occupation or profession in accordance with the State's Division of Occupational and Professional Licensing (DOPL) under the supervision of qualified faculty, staff, or designee, and individuals who were 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 have 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); and (5) other licensed medical practitioners licensed under:

State law (most commonly a physician assistant) and APRNs not otherwise specified above.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

3. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
4. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
_**X**___ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [**Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]** Qualified providers of targeted case management services to recipients in this target group are (1) employed by or under contract with a local mental health and/or substance abuse authority; or (2) employed by or under contract with a local authority's designated mental health and substance abuse services provider; or 3) employed by or under contract with a program providing Medicaid-covered services, including targeted case management for individuals with serious mental illness, under 1915(a) authority. Providers authorized under 1915(a) authority provide targeted case management services only to recipients enrolled in the 1915(a) program.

As an integral part of the public mental health/substance abuse system, or an entity providing Medicaid-covered services under 1915(a) authority, targeted case managers understand the service systems delivering mental health/substance use disorder services and the array of services their clients need. As a member of the mental health and/or substance use disorder service delivery team, they can ensure recipients are able to access all needed services timely and in a coordinated manner.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

State Plan under Title XIX of the Social Security Act State/Territory:
State of Utah

TARGETED CASE MANAGEMENT SERVICES
Individuals with Serious Mental Illness

Supplement 1 to Attachment 3.1-B

- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

[Specify any additional limitations.]

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES

A. Target Group:

Case management services are provided to a woman with a medically verifiable pregnancy who is a Medicaid client or who meets the financial requirement for presumptive eligibility to receive ambulatory prenatal care services provided by a provider that is eligible for payment under the State Plan.

The Case Manager for this program will be known as the Perinatal Care Coordinator.

B. Areas of State in Which Services Will Be Provided:

_X_ Entire State

___ Only in the following geographic areas. Authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide.

C. Comparability of Services

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services:

Perinatal care coordination is the process of planning and coordinating care and services to meet individual needs and maximize access to necessary medical, psycho social, nutritional, educational and other services for the pregnant woman.

Perinatal care coordination services are available to the pregnant woman throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

This coordination process requires the skill and expertise of professionals who have broad knowledge of perinatal care, interviewing and assessment techniques, alternative community resources, and referral systems required to develop an individual service plan.

The Perinatal Care Coordinator serves as a liaison between clients and individuals or agencies involved in providing care, as a contact person for the client and family, as a resource to prepare and counsel the client regarding essential services that are determined necessary and scheduled for the client.

Needs of pregnant women are individual and influenced by varying medical, personal, socioeconomic and psycho social factors. A plan of care with intervention to meet identified needs or resolve problems may be indicated on a limited, intermediate, or comprehensive basis. The initial assessment made by the Perinatal Care Coordinator will be the basis for determining the level of care and the extent of coordination and monitoring necessary for each individual.

Monitoring of the individual plan of services by the Perinatal Care Coordinator is essential to minimize fragmentation of care, reduce barriers, link clients with appropriate service, and assure that services are provided consistent with optimal perinatal care standards.

Monitoring involves direct contact with the client through clinic, home visits, or telephone contact. Monitoring includes a contact resulting in assessment, planning of care and services, and reevaluation of the plan of care. Monitoring may also include consultation with care providers to assess the need for further follow-up or coordination and arrangement of necessary services.

The number, duration, scope and interval between contacts will vary among clients and even across one client's pregnancy. At a minimum, contacts, including telephone contacts with the client, must include: assessment and documentation of current physical, psycho social, socioeconomic, and nutritional status. Follow-up on the outcome of previous referrals must be included along with documentation of any referrals arranged for additional services. Anticipatory guidance regarding pregnancy and parenting must also be documented.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services (Continued)

A record of contacts made with the client or with providers on behalf of the client, and services arranged or provided by the Perinatal Care Coordinator must be documented and maintained in the medical record, and must include:

Name of recipient,
Date of service,
Name of provider agency and person providing the service,
Place of service,
Nature and extent of the service, including outcome of the contact,
Intake assessment,
Individualized care plan (including risk factors and proposed referrals to deal with those risk factors), and
Changes to care plans as indicated by contact with client or providers.

Providers of perinatal care coordination services are expected to meet the following qualifications:

Registered Nurse -- Licensed in accordance with the Nurse Practice Act of the State of Utah.

Certified Registered Nurse Midwife -- Licensed in accordance with the Certified Nurse Midwifery Practice Act of the State of Utah.

Certified Family Nurse Practitioner -- Licensed in accordance with the Nurse Practice Act of the State of Utah.

Social Service Worker (SSW) -- With a minimum of a bachelor's degree in social work, and licensed in accordance to the Social Work Licensing Act of the State of Utah.

Licensed Certified Social Worker (LCSW) -- With a minimum of a master's degree in social work, and licensed in accordance to the Social Work Licensing Act of the State of Utah.

Health Educator -- Bachelor's degree in health education with a minimum of three years experience, at least one of which must be in a medical setting.

Health Educator -- Master's degree with a minimum of one year of experience working in a medical setting or with pregnant women.

Certified Health Education Specialist -- With a minimum of a bachelor's degree and a certificate showing completion of a certification examination in health education.

Licensed Practical Nurse -- Licensed in accordance with the Nurse Practice Act of the State of Utah. Must have additional training and experience to meet the expectations of the Perinatal Care Coordinator and must work under the supervision of a registered nurse.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services (Continued)

Provided by: Perinatal Care Coordinator who is an enrolled Medicaid provider
Billed by: Perinatal Care Coordinator using a HCFA 1500 Claim Form
Billing Code: Y7000 Perinatal Care Coordination

E. Qualification of Providers:

Recipients will have the free choice of any enrolled qualified Case Manager (Perinatal Care Coordinator). Qualified Case Managers are registered nurses, certified nurse midwives, certified family nurse practitioners, licensed social service workers, certified social workers, health educators or licensed practical nurses licensed under the authority of Title 58 (Occupational and Professional Licensing) of the Utah Code Annotated, 1953 as amended, practicing within the scope of their licensure, and recognized by the Utah Department of Health, Division of Health Care Financing and the Division of Family Health Services prenatal program.

The Case Manager (Perinatal Care Coordinator) can be employed by a physician who is a Medicaid provider, or employed by a Qualified Provider of Presumptive Eligibility services.

F. The State assures that the provision of Case Management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of Case Management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for Case Management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES

A. Target Group:

Targeted case management services are provided to adults with serious and often persistent mental illness and children with serious emotional disorders. In general, these disorders severely limit the individual's development or functioning and welfare, and result in the need for a comprehensive coordinated system of care to meet the individual's needs. The need for case management service will be identified through a case management needs assessment. With exception of the two counties noted, reimbursement for TCM services is provided in other areas of the State as described in the managed care contracts which operate under 1915(b) authority.

B. Areas of State in Which Services Will Be Provided:

_X_ Entire State

___ Only in the following geographic areas. Authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide.

C. Comparability of Services

___ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services

Targeted case management services are a set of planning, coordinating, and monitoring activities that assist individuals in the target group to access needed medical, social, educational, and other services and thereby promote the individual's ability to function independently and successfully in the community.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services (Continued)

1. Covered case management activities include:

   a. assessment of the recipient's potential strengths, resources, and needs and the development of a comprehensive service plan with input, as appropriate, from the family and other agencies knowledgeable about the client's needs;

   b. advocating for and linking the recipient with community resources and needed services;

   c. coordinating the delivery of needed service and monitoring to assure the appropriateness and quality of services delivered, including coordinating with the hospital and nursing facility discharge planner in the 30-day period prior to the patient's discharge into the community. (This is the only case management service provided to hospital or nursing facility inpatients and is limited to a maximum of five hours per patient per inpatient hospitalization.) In addition, case management services will not be provided to individuals between the ages of 22 and 64 who are inpatients in institutions for mental disease;

   d. periodically assessing and monitoring the client's status and functioning and modifying the targeted case management service plan as needed; and

   e. monitoring the client's process and continued need for targeted case management and other services.

2. Non-covered services include:

   a. medical or other treatment services;

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CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services (Continued)

b. outreach to individuals who may or may not be eligible for case management services;

c. teaching, tutoring, training, instructing or educating the client or others, except insofar as the activity is specifically designed to assist the client to independently obtain needed services; and

d. directly assisting with personal care or activities of daily living such as bathing, hair or skin care, eating, etc., or instrumental activities of daily living such as assisting with budgeting, cooking, shopping, laundry, home repairs, moving residences, running errands, etc., or performing activities necessary for the proper and efficient administration of the Medicaid State Plan, including assisting the client to establish and maintain Medicaid eligibility (for example, locating, completing and delivering documents to the Medicaid eligibility worker).

E. Qualifications of Providers:

Qualified case managers include:

1. Employees of community mental health centers who are licensed mental health professionals including physicians, advanced practice registered nurses, psychologists, certified or clinical social workers, social service workers, registered nurses, marriage and family therapists or licensed professional counselors, or individuals working toward licensure in one of these professions to the extend permitted by Title 58 of the Utah Code Annotated; or

2. Licensed practical nurses or non-licensed individuals who have met the State Division of Substance Abuse and Mental Health's training standards for case managers and who are supervised by a mental health professional listed in section E-1 above.

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CASE MANAGEMENT SERVICES (Continued)

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care and services under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

HEMOPHILIA DISEASE MANAGEMENT SERVICES

A. Target Group:

Disease management services are provided to Medicaid eligibles who have a diagnosis of hemophilia.

B. Areas of State in Which Services Will Be Provided:

X Entire State

C. Comparability of Services:

X Services are provided in accordance with 1902(a)(10)(B) of the Act.

D. Definition of Services:

1. In accordance with 42 CFR §440.130(c), Disease Management Services are a set of planning, coordinating, training, and monitoring nursing services activities provided as part of a regular nursing visit that assist the recipients to receive needed disease education, medical, and nutritional services consistent with their identified needs related to hemophilia and include:
   a. assisting the recipient to determine the need for services and developing a service plan to assure adequate access to necessary services and community resources;
   b. conducting interviews with the recipient or recipient's guardian in person or by telephone to ascertain the severity, frequency and cause of each episode;
   c. ensuring that each recipient or recipient's guardian attend hemophilia clinics at least annually;
   d. reviewing the recipient's symptoms and vitals;
   e. training the recipient, guardian or both on how to infuse the hemophilia factor(s) (HF);
   f. training the recipient, guardian or both on how to handle, access, store, reorder, and record the use of HF;
   g. training the recipient, guardian or both on how to recognize and appropriately respond to bleeds and other disease specific symptomatology;

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HEMOPHILIA DISEASE MANAGEMENT SERVICES (Continued)

h. monitoring each recipient's utilization of HF to assure that products are used by the recipient and not by individuals outside the program;
i. reviewing the HF usage with each recipient's physician and working with the physician concerning usage and severity of disease;
j. training the recipient in appropriate log record keeping.

2. Hemophilia Disease Managers provide the following nursing based services during in-home visits:

a. Interview caregiver and patient;
b. Do a complete review of systems and vitals with an emphasis on joints;
c. Examine patient port and catheter;
d. Educate patient and caregiver on port and catheter maintenance;
e. Examine patient for bleeds;
f. Educate and train patient and caregiver on factor administration;
g. Educate patient and caregiver on disease management;
h. Educate caregiver concerning any observed problems;
i. View medication dating;
j. View medication dating;
k. Assist patient and caregiver with completion of dosage logs for bleeds requiring factor;
l. Compile data for patient action;
m. Complete order for factor if necessary;
n. Report activities to pharmacy director for factor usage;
o. Report any concerns to medical provider (physician);
p. Provide lifestyle education;
q. Encourage patient and caregiver to take advantage of disease education opportunities;
r. Document any and all activities (nurse and patient).

3. Hemophilia blood factor products.

E. Qualified Providers:

A qualified disease manager must be a licensed practical nurse or registered nurse employed by or contracted by a 340(B) qualified provider facility, and have at least one year experience dealing with hemophiliac patients, acting as authorized by Utah Code Title 58, Chapters 31b and 31c.

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State: UTAH

HEMOPHILIA DISEASE MANAGEMENT SERVICES (Continued)

F. Freedom of Choice:

This service is operating under a 1915(b) waiver program called the Choice of Health Care Delivery Program that includes a waiver of Section 1902(a)(23) – Freedom of Choice.

G. Oversight:

Service provider will report quarterly on each patient with regard to disease status, medication usage, visits conducted, plan achievement, education and training activities, and expenditures.

H. In-home Nursing Visits:

In-home nursing visits are capped at 8, 15- minute units per month. Additional in-home visits may be authorized through prior authorization by the Department on a case-by-case basis.

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CASE MANAGEMENT SERVICES

Deleted September 1, 2015

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES

A. Target Group IV

1. Targeted case management services are provided to Medicaid eligibles who are assessed as having a primary diagnosis of a chemical dependency or substance abuse; and

2. In addition, recipients of targeted case management services must demonstrate lack of adequate or available support networks and one or more of the following:

   a. Failure or inability to comply with treatment regimen or to access needed services independently;

   b. Experience frequent crisis episodes; or

   c. Require multiple services and their coordination.

3. The need for targeted case management services will be documented.

B. Areas of State in Which Services Will Be Provided

_X_ Entire State

___ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide).

C. Comparability of Services

___ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services

1. Targeted case management services are defined as those services that promote the effective and efficient utilization of resources, assure access to necessary comprehensive services, and prevent duplication of services.

2. Covered case management activities include:
   a. Assessing the recipient's potential risk factors, determining the need for services, and developing a service plan to assure adequate access to necessary services and community resources;
   b. Advocating for and building linkages for the recipient with basic community resources;
   c. Assisting in the access of needed services and monitoring to assure the appropriateness and quality of services delivered;
   d. Monitoring to assess the recipient's progress, and maintenance of treatment goals and participation in transition and aftercare activities.

E. Qualifications of Providers:

The recipients will have the free choice of any enrolled and qualified case manager. Qualified case managers are:

1. Licensed substance abuse professionals (psychologist, certified or clinical social worker, social service worker, registered nurse, professional counselor, and marriage and family therapist) employed by an agency that is under contract with or directly operated by a Local County Comprehensive Substance Abuse Plan; or
2. Non-licensed individuals who are supervised by a licensed professional listed in Section E-1 above.

F. The State assures that the provision of optional targeted case management services to eligible individuals will not restrict the right of those individuals to the free choice of service providers (Section 1902(a)(23) of the Act).

1. Eligible recipients will have free choice of the provider of their case management services.
2. Eligible recipients will have free choice of (other) medical care providers under the plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES (Continued)

G. Payment for targeted case management services will not duplicate payments made to public agencies, or private entities under other program authority, for the same purpose of targeted case management. Payment under this provision will not be made for case management services that are an integral part of another provider service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES

A. Target Group:

Targeted case management services are available to Medicaid eligible HMO ("Plan") enrollees and potential enrollees who a qualified case manager has determined:

1. Require assistance to identify, obtain access to, and coordinate medical and other services consistent with their identified needs; and for whom

2. There is a reasonable indication that the enrollee or potential enrollee will obtain the required assistance only through a qualified targeted case manager.

B. Areas of the State in Which Services Will Be Provided:

Services will be limited to the following geographic areas of the state: the urban counties of Davis, Salt Lake, Utah, and Weber.

C. Comparability:

Services are not comparable in amount, duration, and scope. Authority of Sec. 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Sec. 1902(a)(10)(B) of the Act.

D. Definition of Services:

1. This service is designed to assist eligible individuals in the target group ("clients") to identify and appropriately utilize the scope of medical and other services available to them.

2. Federal Financial Participation will be available at the FMAP percentage for costs incurred to perform the following activities/services with, and on behalf of, clients in the target group.

   a. assessing the eligible client's need for medical and other services including high risk assessments with all aged and disabled recipients;
   b. linking the client through direct or indirect referral with medical services and community resources in accordance with their identified needs;
   c. coordinating the availability of and the access to necessary services, acting as the liaison between the client, Plan, providers, and applicable public and private agencies;
   d. periodic follow-up and assistance as the recipient's service needs change; and
   e. instructing the client or the client's legal representative when applicable, in independently identifying, obtaining, and coordinating needed services.

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State: UTAH

CASE MANAGEMENT SERVICES

E. Qualified Providers:

Health Program Representatives (HPRs) employed by the State of Utah, Division of Health Care Financing, Bureau of Managed Health Care.

F. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Sec. 1902(a)(23) of the Act, except as authorized under the State's approved 1915(b) freedom of choice waiver.

1. Eligible recipients will have free choice of qualified providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Non-Duplication of Payment:

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Case management services provided by HRPs is solely for the purpose of augmenting, not supplanting or duplicating, service coordination activities that may be available to recipients through their Plan or other community providers. Services will be available only to Medicaid eligibles. Direct and indirect administrative activities related to the determination of Medicaid eligibility are outside the scope of services offered under this plan.

MEDICALLY NECESSARY SERVICES

Early Childhood services not otherwise provided under the State plan but available to EPSDT (CHEC) eligibles

A. Target Group
Targeted case management for Medicaid-eligible children ages birth to four, for whom the service is determined to be medically necessary. Targeted case management services will be considered medically necessary when a needs assessment completed by a qualified targeted case manager documents that:

1. The individual requires treatment and/or services from a variety of agencies and providers to meet his or her documented medical, social, education, and other needs; and

2. There is a reasonable indication that the individual will access needed services only if assisted by a qualified targeted case manager who (in accordance with an individualized case management service plan) locates, coordinates and regularly monitors the services.

B. Areas of the State in Which Services Will Be Provided:
Services will be available statewide.

C. Comparability:
Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:
1. Targeted case management is a service that assists the eligible clients 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 recipients to access needed services, but to ensure that services are coordinated between all agencies and providers involved.
2. The following activities/services are covered by Medicaid under targeted case management:
   a. assessing and documenting the client's need for community resources and services;
   b. developing a written, individualized and coordinated case management service plan to assure the client's adequate access to needed medical, social, educational and other related services with input, as appropriate, from the client, family and other agencies knowledgeable about the client's needs;
   c. linking the client with community resources and needed services, including assisting the client to establish and maintain eligibility for entitlements other than Medicaid;
   d. coordination of the delivery of services to the client including CHEC screenings and follow-up;
   e. monitoring the quality and appropriateness of the client's services;
   f. instructing the client or caretaker as appropriate, in independently obtaining access to needed services for the client;
   g. assessing, periodically, the client's status and modifying the targeted case management service plan as needed; and

MEDICALLY NECESSARY SERVICES (Continued)

h. monitoring the child's progress and continued need for targeted case management and other services.

3. Targeted case management services provided to a Medicaid eligible child in a hospital, nursing facility or other institution may be covered only in the 30-day period prior to the child's discharge into the community.

E. Qualified Providers

1. Medicaid providers of targeted case management services to CHEC-Medicaid eligible recipients may include:

a. An individual who is licensed as a Registered Nurse in the State of Utah, and is employed by a local, state or district health department; or

b. an agency that specializes in providing case management services to children and meets the following four criteria:

i. is authorized and responsible as oulined in Utah Code Annotated, Section 17-5-243, to provide directly or indirectly, basic public health services as outlined in Utah Code Section 26A-1-106(3);

ii. employs or contracts with Registered Nurses who perform targeted case management assessments and follow-up services. The agency may use non-licensed individuals to provide follow-up targeted case management services under the supervision of a qualified Registered Nurse, if the individual has education and experience related to high risk children and has completed training using a targeted case management curriculum approved by the DHCF. The DHCF will approve training curriculum that include:

- detailed instruction in the Medicaid targeted case management provider manual requirements, and methods for delivering and documenting covered case management services;
- detailed instruction in the Utah Medicaid CHEC/EPSDT provider manual;
- up-to-date information on community resources, and how to access those resources; and
- techniques and skills in communicating successfully with clients and other agency/provider personnel.

F. Freedom of Choice:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Non-Duplication of Payment:
Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.