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MEDICAID INFORMATION BULLETIN

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21-69 New Online Provider Directory

Utah Medicaid is publishing an online provider directory called, Find A Provider, available at https://fp.medicaid.utah.gov/find-provider. Creation of this directory is in compliance with the federal 21st Century Cures Act. The purpose of the directory is to help Medicaid members find a provider by name, type, specialty, and location in order to increase access to care. For the best user experience, members need to be able to find accurate provider contact information and Utah Medicaid encourages you to access the Find A Provider directory and do a search for your own provider record.

Utah Medicaid is not widely publicizing this directory at this time in order to give providers time to update their information. The information displayed is from Utah Medicaid's PRISM Provider Enrollment System. Please verify that your provider information is accurate. If not, you may update your provider information at https://prism.health.utah.gov/. In particular, we encourage you to update:

- Public Phone Number (the number you would like members to contact you at)
- Accepting New Patients (Y/N)
- Handicap Accessibility (Y/N)
- Servicing Address Location
- Public Email Address (your preferred email contact for the public)
- Provider Type/Specialty/Subspecialty

At this time, the Find A Provider directory will only contain names of physicians and advanced practice providers. Additional provider types will be added in the near future. If you have questions about your provider information, please contact Provider Enrollment at 1-800-662-9651, option 3, then option 4.

21-70 Deficit Reduction Act Administrative Rule

Effective August 16, 2021, Utah Administrative Rule R414-1-31 (Withholding of Payments) has been amended to establish authorities of the Utah Department of Health with respect to section 6032 of the Deficit Reduction Act (DRA). Section 6032 of the DRA established section 1902(a)(68) of the Social Security Act, and relates to "Employee Education About False Claims Recovery." It applies to any entity receiving at least $5 Million from the State Medicaid agency annually. The $5 Million threshold

may consist of claims payments, supplemental payments, cost settlements or any other payments under the Medicaid State Plan.

Sec. 1902(a)(68) of the Social Security Act defines the compliance responsibilities of such entities receiving at least $5 Million annually. An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

Compliance with DRA section 6032 has long been part of the terms of the Medicaid provider agreement. The amended administrative rule R414-1-31 establishes that the Utah Department of Health may withhold payment if the Department or the Utah Office of the Inspector General determines a provider or contractor to be noncompliant. Noncompliance may be determined if the provider is unable to submit, upon request:

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

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

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

21-71 Coverage for COVID-19 Vaccines

Effective March 2020, The Utah Medicaid fee for service program began covering COVID-19 vaccines in accordance with the Public Health Emergency Declaration.

Utah Medicaid will reimburse an administration fee of $40 when a COVID-19 vaccine is billed with the appropriate information via pharmacy point of sale or medical claims. Medical claims will use the vaccine code and the vaccine administration code listed in the table below. The coverage and reimbursement of COVID-19 vaccines and incentive amount will be billed as fee for service. Pharmacies

administering the vaccine to nursing home residents will be reimbursed the administration fee for the vaccine.

COVID-19 vaccine Emergency Use Authorization covers administration of this vaccine for Medicaid members 12 years and older (Pfizer) and 18 years and older (Moderna & Janssen). COVID-19 vaccines are not approved for members who are less than 12 years of age.

Vaccine Code	Vaccine Code Descriptor	Vaccine Administration Code(s)	Vaccine Manufacturer	Vaccine Name(s)	NDC 10/NDC 11 Labeler Product ID (Vial)	Minimum Dosing Interval
91300	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use	0001A (1st dose) 0002A (2nd dose) 0003A (additional dose)	Pfizer	Pfizer-BioNTech COVID-19 Vaccine	59267-1000-1 59267-1000-01	21 days
91301	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use	0011A (1st dose) 0012A (2nd dose) 0013A (additional dose)	Moderna	Moderna COVID-19 Vaccine	80777-273-10 80777-0273-10	28 days
91303	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage, for intramuscular use	0031A (1 dose)	Janssen	Janssen COVID-19 Vaccine	59676-580-05 59676-0580-05	n/a

https://www.ama-assn.org/system/files/2020-11/covid-19-immunizations-appendix-q-table.pdf

Pharmacy Point of Sale Claims:

Billing for reimbursement of a free product (no associated cost) including an administration fee per NCPDP guidelines:

- The submitted Transaction Code (103-A3) is a “B1” (Claim Billing).
- The submitted Prescription/Service Reference Number Qualifier (455-EM) is a “1” (Rx Billing).
- The claim pricing segment follows the prescription claim request formula.
- The Product/Service ID (407-D7) should be submitted with the correct Product/Service ID Qualifier (436/E1) (in this example “03” (NDC))
- Product/Service ID (407-D7) contains the NDC Number of the vaccine or other product that was administered and obtained at zero cost.
- The Days’ Supply (405-D5) should be submitted with a value of “1”.
- The Quantity Dispensed (442-E7) should be submitted with the value that represents the quantity of drug product administered.
- The DUR/PPS Segment, with a “MA” (Medication Administered) in the Professional Service Code (440-E5), is submitted to identify the product was administered.
- The Incentive Amount Submitted (438-E3) is submitted to identify the pharmacy is seeking reimbursement for the administration of the product.

- The submission clarification code (420-DK)
  - Initial Dose(s): Submission Clarification Code of **2 "Other Override"** - defined as "Used when authorized by the payer in business cases not currently addressed by other SCC values to indicate the first dose of a multi-dose vaccine is being administered"
  - Second Dose: Submission Clarification Code of **6 "Starter Dose"** - defined as "The pharmacist is indicating that the previous medication was a starter dose and now additional medication is needed to continue treatment to indicate the second dose of a multi-dose vaccine is being administered"
  - Additional Doses: Submission Clarification Code of 7 "Medically Necessary"-
- Utah Medicaid Incentive amount (administration fee) is as follows:
  - Single dose vaccine $40
  - Vaccines requiring more than one dose
    - Initial dose $40
    - Each subsequent dose $40
- Basis of Cost Determination (423-DN) should be submitted with the value "15" (Free product or no associated cost).

Medical Claims:
For guidance on how to bill for COVID-19 Vaccines and Administration, visit: https://www.cms.gov/medicare/covid-19/medicare-billing-covid-19-vaccine-shot-administration.

21-72 Physician Assistant Updates

Medicaid has updated policy to align with Senate Bill (SB) 27, which permits physician assistants to work interdependently of a physician while acting within their scope of practice as outlined in Utah Code, Title 58: Occupations and Professions, Chapter 70a: Utah Physician Assistant Act. In alignment with SB27, updates to the Utah Administrative Code include:

- R414-1-6. Utah Medicaid Program. *Services Available*
- R414-10-2. Physician Services. *Services Available*
- R414-10-5. Physician Services. *Service Coverage and Limitations*
- R414-200-3. Non-Traditional Medicaid Health Plan Services. *Services Available*

Additionally, Medicaid provider manuals have been modified to reflect the changes outlined by SB 27. The updated provider manuals and chapters within each manual are as follows:

- *Section I: General Information Provider Manual*
  - Chapter 3.6 Referrals

- *Physician Services Provider Manual*
  - Chapter 8-10.6.1 Perinatal Care Coordination Qualified Providers
  - Chapter 8-10.6.2 Perinatal and Postnatal Home Visits Qualified Providers
  - Chapter 8-10.6.3 Group Perinatal education Qualified Providers
  - Chapter 8-10.6.4 Nutritional Assessment and Counseling
  - Chapter 8-10.6.6 Risk Assessment
  - Chapter 8-10.6.7 Prenatal Assessment Visit
  - Chapter 8-10.6.8 Single Prenatal Visit(s) other than Initial Visit
  - Chapter 9-9 Consultation Services
- *Rural Health Clinics and Federally Qualified Health Clinics Provider Manual*
  - Chapter 8-3 Covered Services

Please note that the provider manual links above will take you to the Utah Medicaid Official Publications Directory Contents page. From there, you will have to select the applicable manual.

21-73 Section I: General Information Provider Manual Updated

The following changes have been made to Section I: General Information Provider Manual:

Chapter 8-2.7 has been retitled as *Non-Traditional Medicaid Plan*.

Due to the discontinuation of the PCN benefit, effective April 2019, Chapter 8-2.7, formerly known as the *Primary Care Network (PCN)* of Section I: General Information Provider Manual has been retitled *Non-Traditional Medicaid Plan* and includes:

> Non-Traditional Medicaid (NTM) provides a scope of service similar to that currently covered by the Utah Medicaid State Plan (i.e., Traditional Medicaid) but with some additional limitations or reduced benefits. Authorization of Non-Traditional Medicaid is by way of waiver approval through the Centers for Medicare and Medicaid Services (CMS) and allowed under Section 1115(a) of the Social Security Act.
>
> Providers of NTM services are responsible for complying with all applicable federal and state laws and regulations and Medicaid policy and requirements outlined in the 1115 Waiver, Utah Administrative Code R414-200. Non-Traditional Medicaid Health Plan

Services, the Medicaid Provider Agreement, the Medicaid provider manuals, attachments specific to the provider manuals, and the Medicaid Information Bulletins.

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

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

For specific code coverage and reimbursement information, see the Coverage and Reimbursement Code Lookup.

Limitations

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

Emergency Transportation Services- Coverage of ambulance (ground and air) for medical emergencies only.

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

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

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

Vision services- NTM covered services are the same as those for non-pregnant adults.

Non-Covered Services

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

The following services are also non-covered for Non-Traditional Medicaid members:

- Chiropractic services
- Dental services
    - Limited emergency dental services may be covered when determined to be medically necessary
- Long-term care services

- Non-emergency transportation of any kind
- Preventive services
- Private duty nursing
- Speech-language pathology services

Chapter 10-3.1, *Circumstances Eligible for Retroactive Authorization,* is updated and includes a policy change that increases the request for retroactive authorization time from 90 days to 180 days.

Chapter 10-3.1.6, *Circumstances Eligible for Retroactive Authorization,* is updated to include:

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

Acquisition of a PA before the rendering of services is not necessary for inmates. However, Medicaid only authorizes requests for retroactive approval when services are medically necessary. Additionally, Medicaid must cover the procedure, and documentation must meet Medicaid policy requirements for PA.

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

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

Chapter 12-7.3, *Modifier used in a Claim,* clarifying language regarding modifiers 24 and 25 includes:

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

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

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

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

21-74 Inpatient Rehabilitation Facility Claims Submission Clarification

To ensure that claims submitted related to an inpatient rehabilitation facility (IRF) adjudicate correctly, Medicaid is publishing the following guidance:

- For members with an inpatient admission to an IRF with an **admission and discharge date before 10/1/2020,** providers must report the following as part of their claim's submission.
    1. DRG 945 or 946
    2. Revenue code 0120
    3. The prior authorization number issued by Medicaid

- For members with a date of **admission and discharge starting on or after 10/1/2020,** providers must report the following as part of their claim submission.
    1. Revenue code 0128
    2. The prior authorization number issued by Medicaid

- When a member's **admission date is before 10/1/2020, and their discharge date is on or after 10/1/2020,** providers must report the following as part of their claim submission.
    1. Revenue code 0128
    2. The prior authorization number issued by Medicaid

If a provider submits a claim for an IRF and it does not contain the guidance as mentioned above, the claim will be denied. Moreover, this claims guidance does not negate any of the other Medicaid policies in place that are required when providing services or submitting claims for Medicaid members.

21-75 October 2021 CPT Code Coverage

The following table shows coding updates related to coverage. While this table contains general information related to the changes in coverage, providers must verify any additional changes using the Coverage and Reimbursement Code Lookup.

CPT/HCPCS Codes	Code Short Descriptor	Update Type	Effective Date
B4157	Ef special metabolic inherit	Prior authorization requirements removed	8/1/21
B4162	Ef ped spec metabolic inherit	Prior authorization requirements removed	8/1/21
C9779	Esd endoscopy or colonoscopy	New code from CMS	10/1/21
D2750	W resin denture bas	Open for coverage	10/1/21
D2753	Crown - porcelain fused to titanium and titanium a	Open for coverage	10/1/21
D5130	Immediate upper dentures (incl post-delivery care)	Limitation changed from once per lifetime to once every five years	10/1/21
D5140	Immediate lower dentures (incl post-delivery care)	Limitation changed from once per lifetime to once every five years	10/1/21
D5211	Upper partial-resin base (incl clasp, rests & teeth)	Limitation changed from once per lifetime to once every five years	10/1/21
D5212	Lower partial-resin base incl clasps, rests, teeth	Limitation changed from once per lifetime to once every five years	10/1/21
D5213	Upper partial-cast metal frame w resin denture bas	Limitation changed from once per lifetime to once every five years	10/1/21
D5214	Lower partial-cast metal frame	Limitation changed from once per lifetime to once every five years	10/1/21
D6740	Crown - porcelain/ceramic	Closed	10/1/21
D6752	Crown - porcelain fused to noble metal	Closed	10/1/21

G2066	Inter devc remote 30d	Replacing discontinued code 93299	8/1/21
K1022	Endoskel posit rotat unit	New code from CMS	10/1/21
P9025	Plasma cryo redu path each	New code from CMS	10/1/21
P9026	Cryo fib comp path redu each	New code from CMS	10/1/21
Q4251	Vim, per square centimeter	New code from CMS	10/1/21
Q4252	Vendaje, per square centimet	New code from CMS	10/1/21
Q4253	Zenith amniotic membrane psc	New code from CMS	10/1/21
S9435	Medical foods for inborn errors of metabolism	Open for coverage	8/1/21

21-76 Hospital Services Provider Manual Updated

The *Hospital Services Provider Manual* is updated to outline coverage requirements for inpatient stays in psychiatric hospitals considered mental diseases institutions. The manual updates include the following language:

8-12.1 Psychiatric Hospitals Considered Institutions for Mental Diseases (IMDs)

Admissions to psychiatric hospitals considered IMDs are covered when medically necessary, for up to 60 days, for members ages 21 through 64.

Enrollment, Licensing and Certification or Accreditation Requirements

Coverage of admissions to psychiatric hospitals requires the hospital to be:

- Enrolled Medicaid providers
- Licensed by the Department of Health
- Have Medicare certification or be deemed Medicare certified through accreditation by The Joint Commission

Prepaid Mental Health Plans (PMHPs), Utah Medicaid Integrated Care (UMIC) Plans or the Healthy Outcomes Medical Excellence (HOME) Program

Inpatient psychiatric hospitalizations are covered through the PMHPs, UMIC Plans, or the HOME program and require prior authorization.

Medicaid Fee for Service Prior Authorization (PA) Requirements

Psychiatric hospitals must obtain a PA as notification of the admission.

The initial PA request must be submitted to the PA department no later than two business days after the date of admission and may be approved for up to seven days.

Inpatient stays that exceed seven days require an additional PA.

For these PA requests, the psychiatric hospital must:

- Submit the most pertinent and recent comprehensive documentation from the medical record for inpatient psychiatric hospital stays and continued stay reviews that must:
  - Support medical necessity
  - Address evidence-based criteria
  - Specify the number of additional days being requested (maximum of up to seven days per request)
  - Include the anticipated discharge date
- Submit each additional request to the PA department:
  - No later than the first requested date of service indicated on the PA request
  - No earlier than four calendar days of and including the first requested date of service indicated on the PA request form

The PA request form can be found at Psychiatric Hospital Inpatient Services- Individuals Age 21-64 Prior Authorization Request Form.

PA requests may be faxed to the PA Unit at (801) 323-1587, or emailed to: mentalhealthservicesprior@utah.gov.

21-77 Denture Policy Limitations

Denture coverage allows for replacing upper dentures and lower dentures once every five years when medically necessary. For example, a member that receives an immediate upper denture within the last five years would not be eligible for complete or partial upper dentures within the same five-year period, the same being applicable to lower dentures. This policy change aligns with evidence-based standards of care. Refer to the Utah Medicaid Coverage and Reimbursement Code Lookup and the *Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual* for additional requirements.

The following denture service codes are open to coverage and are limited to once every five years as outlined above.

D5110 *complete upper denture*
D5120 *complete lower denture*
D5130 *immediate upper denture*
D5140 *immediate lower denture*
D5211 *upper partial-resin base denture*
D5212 *lower partial-resin base denture*
D5213 *upper partial-cast metal frame with resin denture*
D5214 *lower partial-cast metal frame with resin denture*

21-78 Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual Updated

The *Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual* has been updated. Updates include reorganizing the manual in alignment with the other Medicaid provider manuals and removing duplicative information.

Dental Crown Coverage

The following crown-related CDT codes are open to coverage:

D2750 *crown - porcelain fused to high noble metal*

D2753 *crown - porcelain fused to titanium and titanium alloys*

The following pontic/bridge-related CDT codes have been closed:

D6740 *retainer crown - porcelain/ceramic*

D6752 *retainer crown - porcelain fused-to-noble metal*

The coverage of these services is limited to enrolled Medicaid members that are eligible for Targeted Adult Medicaid (TAM) undergoing substance use disorder (SUD) treatment, aged, and/or blind and disabled Medicaid populations. Dental services for these populations must be provided through the University of Utah School of Dentistry, or their associated state-wide provider network.

21-79 Medical Supplies and Durable Medical Equipment Provider Manual Updated

Effective August 1, 2021, the *Medical Supplies and Durable Medical Equipment Provider Manual* has been updated for medical foods' coverage for inborn metabolism errors. In addition, the following clarifying language changes have been made to the provider manual:

Chapter 8-9.4, Inborn Errors of Metabolism

Medical foods for the treatment of inborn errors of metabolism are covered services. Reporting of these medical foods is limited to HCPCS code S9435 – *Medical foods for inborn errors of metabolism* and is open for coverage to EPSDT eligible members.

Additional specifics for medical food coverage are located in the Coverage and Reimbursement Code Lookup.

21-80 Change Healthcare (InterQual®) Evidence-Based Criteria Updates

InterQual® criteria are continually reviewed and updated. Updates to the 2021 criteria version are implemented October 1, 2021, and have a Change Healthcare subset release date of July 23, 2021. These updates included revisions primarily in the Imaging product.

21-81 Update on the ACIP 2021-2022 Influenza Vaccine Recommendations

The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) released the 2021-2022 Influenza Vaccine Recommendations.[1]

Utah Medicaid aligns with these recommendations and broadly covers influenza vaccines administered to adults and children. Claims for influenza vaccines for Medicaid adult members can be submitted through the pharmacy point of sale.[2] Influenza immunizations for Medicaid members who are 18 years old or younger must be obtained through the Vaccines for Children Program.[3]

All members aged ≥ 6 months who do not have contraindications should be vaccinated annually. However, vaccination to prevent influenza is particularly important for members who are at increased risk for severe illness and complications from influenza. Emphasis should be placed on vaccination of high-risk groups including:

- Children aged 6 through 59 months
- Adults aged ≥ 50 years
- Persons with chronic pulmonary (including asthma), cardiovascular (excluding isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)
- Persons who are immunocompromised due to any cause, including (but not limited to) medications or human immunodeficiency virus (HIV) infection
- Women who are or will be pregnant during the influenza season
- Children and adolescents (aged 6 months through 18 years) receiving aspirin or salicylate-containing medications who might be at risk for Reye syndrome associated with influenza
- Residents of nursing homes and long-term care facilities
- American Indians/Alaska Natives
- Persons who are extremely obese (BMI ≥40 for adults)
- Caregivers and contacts of those at risk:
    - Household contacts and caregivers of children aged ≤ 59 months (i.e., <5 years), particularly contacts of children aged < 6 months, and adults aged ≥ 50 years;
    - Household contacts and caregivers of persons with medical conditions associated with increased risk of severe complications from influenza.
- Health care personnel who have the potential for exposure to patients or to infectious materials.

Timing of vaccination: Vaccine should be ideally administered by the end of October, but should continue to be offered as long as influenza viruses are circulating locally and unexpired vaccine is available. For non-pregnant adults, vaccination in July and August should be avoided, even if vaccine is available during these months, unless there is concern that later vaccination might not be possible.

Vaccination of members with COVID-19: Members in isolation for COVID-19 or in quarantine for known or suspected exposures should not be vaccinated if vaccination will pose an exposure risk to others in the vaccination setting. For members who are moderately or severely ill, vaccination should be deferred until recovery. For members who are mildly ill may be vaccinated; alternatively, vaccination may be deferred until recovery.[4]

Administration of influenza vaccines with COVID-19 vaccines: COVID-19 vaccines may be administered without regard to timing of other vaccines, including influenza vaccines. This includes simultaneous administration of COVID-19 vaccine and other vaccines. If multiple vaccines are administered at a single visit, administer each injection in a different injection site.[4]

Choice of influenza vaccine is one appropriate for the age and health status of a patient. No specific preference is given to the use of either the live attenuated influenza vaccine (LAIV) or the inactivated influenza vaccine. Utah Medicaid recognizes the ACIP recommendations and will cover "FluMist Quadrivalent" for administration during the 2021-2022 Flu Season.

Available influenza vaccines for 2021 – 2022 influenza season:*

	Route	Trade Name (Manufacturer)	Presentation	Age Indication
IIV4 (Standard dose, egg based†)	IM	Afluria Quadrivalent(Seqirus)	0.25-mL PFS[§] 0.5-mL PFS 5.0-mL MDV[§]	6 through 35 mos ≥3 yrs ≥6 mos (needle/syringe) 18 through 64 yrs (jet injector)
		Fluarix Quadrivalent (GlaxoSmithKline)	0.5-mL PFS	≥6 mos
		FluLaval Quadrivalent (GlaxoSmithKline)	0.5-mL PFS	≥6 mos
		Fluzone Quadrivalent(Sanofi Pasteur)	0.5-mL PFS** 0.5-mL SDV 5.0-mL MDV	≥6 mos ≥6 mos ≥6 mos
ccIIV4 (standard-dose, cell	IM	Flucelvax Quadrivalent (Seqirus)	0.5-mL PFS 5.0-mL MDV	≥4 yrs ≥4 yrs
HD-IIV4 (high-dose, egg-based vaccine†)	IM	Fluzone High-Dose Quadrivalent (Sanofi Pasteur)	0.7-mL PFS	≥65 yrs
aIIV4 (standard-dose, egg-based† vaccine with MF59 adjuvant)	IM	Fluad Quadrivalent (Seqirus)	0.5-mL PFS	≥65 yrs
RIV4 (recombinant HA vaccine)	IM	Flublok Quadrivalent (Sanofi Pasteur)	0.5-mL PFS	≥18 yrs
LAIV4 (egg-based vaccine†)	NAS	FluMist Quadrivalent (AstraZeneca)	0.2-mL prefilled single-use intranasal sprayer	2 through 49 yrs

Abbreviations:

ACIP = Advisory Committee on Immunization Practices
FDA = Food and Drug Administration
HA = hemagglutinin
IIV4 = inactivated influenza vaccine, quadrivalent
IM = intramuscular
LAIV4 = live attenuated influenza vaccine, quadrivalent
MDV = multidose vial
NAS = intranasal
PFS = prefilled syringe
RIV4 = recombinant influenza vaccine, quadrivalent
SDV = single-dose vial

* Vaccination providers should consult FDA-approved prescribing information for 2021–22 influenza vaccines for the most complete and updated information, including (but not limited to) indications, contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at https://www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-statesexternal icon. Availability and characteristics of specific products and presentations might change or differ from what is described in this table and in the text of this report.

† Although a history of severe allergic reaction (e.g., anaphylaxis) to egg is a labeled contraindication to the use of egg-based IIV4s and LAIV4, ACIP recommends that persons with a history of egg allergy may receive any licensed, recommended influenza vaccine that is otherwise appropriate for their age and health status. Those who report having had reactions to egg involving symptoms other than urticaria (e.g., angioedema or swelling, respiratory distress, lightheadedness, or recurrent emesis) or who required epinephrine or another emergency medical intervention should be vaccinated in an inpatient or outpatient medical setting (including but not necessarily limited to hospitals, clinics, health departments, and physician offices) supervised by a health care provider who is able to recognize and manage severe allergic reactions, if a vaccine other than ccIIV4 or RIV4 is used.

§ The dose volume for Afluria Quadrivalent is 0.25 mL for children aged 6 through 35 months and 0.5 mL for persons aged ≥3 years.

¶ IM-administered influenza vaccines should be given by needle and syringe only, with the exception of the MDV presentation of Afluria Quadrivalent, which may alternatively be given by the PharmaJet Stratis jet injector for persons aged 18 through 64 years only. For adults and older children, the recommended site for IM influenza vaccination is the deltoid muscle. The preferred site for infants and young children is the anterolateral aspect of the thigh. Additional specific guidance regarding site selection and needle length for IM administration is available in the ACIP General Best Practice Guidelines for Immunization, available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html.

** Fluzone Quadrivalent is currently approved for ages 6 through 35 months at either 0.25 mL or 0.5 mL per dose; however, 0.25-mL prefilled syringes are not expected to be available for the 2021–22 influenza season. If a prefilled syringe of Fluzone Quadrivalent is used for a child in this age group, the dose volume will be 0.5 mL per dose.

References:

1. Centers for Disease Control and Prevention. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on the Immunization Practices – United States, 2021-22 Influenza Season. August 27, 2021. https://www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm
2. Division of Medicaid and Health Financing. Utah Medicaid Provider Manual. Pharmacy Services. Updated July 2021. https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Pharmacy/Pharmacy.pdf
3. Utah Office of Administrative Rules. R414-60-7. https://rules.utah.gov/publicat/code/r414/r414-60.htm#content

4. Centers for Disease Control and Prevention. Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States. August 31, 2021. https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

21-82 DUR Board Updates

The Drug Utilization Review (DUR) Board met in July 2021 to review Evkeeza. The review included product descriptions, pharmacokinetics, and place in therapy. The DUR Board approved using the Rare Disease Prior Authorization form for Evkeeza. In addition, The Pharmacy Team provided an update on the Antipsychotic in Children Intervention, which started in 2019. The DUR Board also received training on the Utah Open Public Meeting Act from the Assistant Attorney General.

The DUR Board did not meet in August 2021. The DUR Board met in September 2021 to review the annual 2019-2020 DUR Report.

The DUR Board meeting minutes are posted on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board/.

21-83 P&T Committee Update

The Pharmacy and Therapeutics (P&T) committee met in September 2021 to review Wakefulness-Promoting Agents and to consider the addition of this class to the Utah Medicaid Preferred Drug List (PDL), effective January 1, 2022.

21-84 Pharmacy Policy, Coverage, Prior Authorization, and HCPCS Codes

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

Pharmacy prior authorization forms and pharmacy-related HCPCS codes are reviewed and updated at a minimum annually, but may be updated more frequently in accordance with drug labeling and clinical information.

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

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

Utah Department of Health

UTAH DEPARTMENT OF HEALTH MEDICAID

APPLY MEMBERS PROVIDERS PROGRAMS ADMINISTRATION ESPAÑOL

> PHARMACY > MEDICAID PHARMACY PROGRAM

Medicaid Pharmacy Program

Welcome to the Utah Medicaid Pharmacy Program! Here you will find information regarding the Utah Medicaid Drug Program, the Drug Utilization Review Board (DUR), and the Drug Regimen Review Center (DRRC) project through the University of Utah. Click to Contact the Pharmacy Program

Preferred Drug List

P&T Committee

Prior Authorization

Drug Regiment Review Center

Drug Utilization Review Board

Resource Library

FFS Preferred Drug List: https://medicaid.utah.gov/pharmacy/preferred-drug-list

FFS Pharmacy Prior Authorizations: https://medicaid.utah.gov/pharmacy/prior-authorization

Coverage and Reimbursement Code Lookup: https://health.utah.gov/stplan/lookup/CoverageLookup.php

HCPCS/NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

21-85 Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness

Updates have been made to the *Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness*.

In Chapter 1-2, Target Group, B, has been changed from Pregnant Women to Pregnant Members.

Throughout the manual, the term recipient has been replaced with member.

Chapter 1-4, Qualified Targeted Case Management Providers, has been updated for clarity and consistency with the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*.

In the 'Record' section, documentation of the setting in which the service was rendered has been updated to reference telehealth.

Providers can access the revised provider manual at https://medicaid.utah.gov/utah-medicaid-official-publications/.

If providers have questions, contact Medicaidbh@utah.gov.

21-86 Attention: Licensed Mental Health Residential Treatment Programs With 16 or Fewer Beds

Programs serving Medicaid members 21 years of age or older

Fee for service Medicaid members:

Effective April 1, 2021, for Medicaid members 21 years of age or older, DMHF will reimburse licensed mental health residential treatment programs with 16 or fewer beds on a per diem bundled payment basis.

For dates of service on or after April 1, 2021, providers should report the per diem procedure code (H2013), unless the individual services have already been billed to Medicaid.

To allow for time to transition to the per diem code, providers may continue to report the individual service codes until dates of service on or after January 1, 2022, at which point programs must begin using the per diem procedure code. See the 'Procedure Codes and Unit of Service' section of Chapter 2-17 of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*.

Prior authorization is not required for Medicaid members who have fee for service Medicaid and are 21 years of age or older.

Medicaid members enrolled in Prepaid Mental Health Plans (PMHPs), Utah Medicaid Integrated Care (UMIC) Plans or HOME:

For Medicaid members 21 years of age or older who are enrolled in PMHPs, UMIC Plans or HOME, programs must contact these plans for information on using the per diem procedure code and prior authorization and utilization review requirements.

Programs serving Medicaid members under age 21

There are no changes for programs serving Medicaid members under 21 years of age. Providers must continue to report the individual services provided in accordance with Chapters 2-2 through 2-12 of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*.

For Medicaid members under age 21 who are enrolled in PMHPs, UMIC Plans or HOME, programs must contact these plans for information on prior authorization and utilization review requirements.

All programs with 16 or fewer beds

In Chapter 2-17 of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*, a new subsection for programs with 16 or fewer beds has been added.

Changes have also been made for clarification or consistency with changes in other chapters, including changes in the opening paragraph of this chapter, as well as in the 'Who', 'Limits', and 'Record' sections. In the 'Record' section of Chapter 2-17, there are updated documentation requirements including the estimated length of stay and post-discharge plans.

Also, other changes have been made throughout the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*. Please refer to the associated article in this bulletin for information on these changes.

Providers can access the revised provider manual at https://medicaid.utah.gov/utah-medicaid-official-publications/.

If providers have questions, contact Medicaidbh@utah.gov.

21-87 Attention: Licensed Mental Health Residential Treatment Programs With 17 or More Beds

Changes have been made in Chapter 2-17 and Chapter 6 of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*.

Please review these updated chapters in their entirety.

Changes in Chapter 2-17:

Changes have been made for clarification or consistency with changes in other chapters, including changes in the opening paragraph of this chapter, as well as in the 'Who', 'Limits', 'Prior Authorization (PA)' and 'Record' sections.

Subsections for programs with 17 or more beds and programs with 16 or fewer beds have been created with policy specific to each included.

Clarification has been made that programs with 17 or more beds must report services using the per diem bundled procedure code (H0017). See the 'Procedure Codes and Unit of Service' section of this chapter.

Overview of Changes in the 'Record' Section:

This section has been updated to include all documentation requirements in one section, some of which were previously included in Chapter 6.

Updated documentation requirements include:

- estimated length of stay,
- post-discharge plans, and
- documentation that must be submitted with a continued stay (clinical) PA request and the timeframe for completion.

Changes to Chapter 6:

Chapter 6 has been reformatted for clarity.

The opening paragraph of Chapter 6 has been updated. Providers are now referred to the procedures for requesting PA in the *Utah Medicaid Provider Manual, Section I: General Information*, Chapter 10, 'Prior Authorization'; therefore, Chapter 6 only retains PA procedures unique to licensed mental health residential treatment programs with 17 or more beds.

In new Chapter 6-1, procedures for requesting admission (non-clinical) PA and for requesting continued stay (clinical) PA have been revised for clarity.

In new Chapter 6-1, A. and B., requirements are specified and include:

- number of days that may be requested, and
- timeframes for submitting PA requests which are now referred to as admission (non-clinical) PA requests and continued stay (clinical) PA requests.

In addition, in Chapter 6-1, B., updated requirements include:

- clinical documentation that must be submitted with the continued stay (clinical) PA request, and
- allowed timeframe for completion of clinical documentation, which has been changed to:

  no earlier than four calendar days of (and including) the first requested date of service indicated on the PA request form.

  Transition Period

  To allow time to comply with the timeframe specified above for completing clinical documentation, continued stay (clinical) PA requests with the first date of service on or after December 1, 2021, may be returned or a denial may be issued if the required documentation is not submitted with the PA request form or the documentation is not completed within the required time frame.

In Chapter 6-1, a new section C., 'Transition Days', provides clarification regarding authorization of transitional days when medical necessity for continued stay is not supported.

In Chapter 6-1, a new section D., 'Member Absence from the Program', has been added.

Also, other changes have been made throughout the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*. Please refer to the associated article in this bulletin for information on these changes.

Providers can access the revised *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* at https://medicaid.utah.gov/utah-medicaid-official-publications/.

If providers have questions, contact Medicaidbh@utah.gov.

21-88 Attention: Licensed Substance Use Disorder Residential Treatment Programs

Changes have been made in Chapter 2-13 and Chapter 5 of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*.

Please review these updated chapters in their entirety as substantive changes have been made in documentation requirements in the 'Record' section of Chapter 2-13, and in Chapter 5 regarding some documentation completion dates and in prior authorization (PA) request submission dates.

Changes in Chapter 2-13:

Changes have been made for clarification, or consistency with changes in other chapters, including changes in the opening paragraph of this chapter, as well as in the 'Who', 'Limits', 'Prior Authorization (PA)' and 'Record' sections.

Clarification has been made that SUD residential treatment programs must report services using the applicable per diem bundled procedure code specified in the 'Procedure Codes and Unit of Service' section of this chapter.

Overview of Changes in the 'Record' Section

This section has been updated to include all documentation requirements in one section, some of which were previously included in Chapter 5.

Documentation requirements have been clarified and/or added regarding:

- ASAM assessments and ASAM reassessments, including an ASAM level of care and ASAM risk/severity rating for each ASAM dimension. For reassessments, ASAM continued service criteria points for each dimension that indicates the need for continued stay in residential treatment,
- treatment plans and treatment plan reviews, including the dates the goals and objectives were added, that there must be at least one active treatment goal and one active treatment objective for each ASAM dimension for which there is an identified need for admission and continued stay, and progress toward active treatment goals and objectives,
- post-discharge plans, and
- how frequently documentation must be completed.

Changes to Chapter 5:

Chapter 5 has been reformatted for clarity.

The opening paragraph of Chapter 5 has been updated. Providers are now referred to the procedures for requesting PA in the *Utah Medicaid Provider Manual, Section I: General Information*, Chapter 10,

'Prior Authorization'; therefore, Chapter 5 only retains PA procedures unique to licensed substance use disorder residential treatment programs.

In new Chapter 5-1, A. and B., requirements are specified and include:

- number of days that may be requested; and
- timeframe for submitting PA requests which are now referred to as admission (non-clinical) PA requests and continued stay (clinical) PA requests.

In addition, in Chapter 5-1, B., requirements include:

- clinical documentation that must be submitted with the continued stay (clinical) PA request, and
- allowed timeframe for completion of clinical documentation, which has been changed to:

  no earlier than seven calendar days of (and including) the first requested date of service indicated on the PA request form.

Transition Period

A transition period is allowed through November 30, 2021, to give providers time to comply with new documentation requirements related to continued stay (clinical) PA requests. Continued stay (clinical) PA requests which have a first date of service on or after December 1, 2021, must meet the new requirements.

In Chapter 5-1, a new section C., 'Transition Days', provides clarification regarding authorization of transitional days when medical necessity for continued stay is not supported.

In Chapter 5-1, a new section D., 'Member Absence from the Program', has been added.

Also, other changes have been made throughout the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*. Please refer to the associated article in this bulletin for information on these changes.

Providers can access the revised *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* at https://medicaid.utah.gov/utah-medicaid-official-publications/.

If providers have questions, contact Medicaidbh@utah.gov.

21-89 Attention: Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM) Social Detoxification Providers

Effective April 1, 2021, clinically managed residential withdrawal management (social detoxification) may be provided by all Medicaid-enrolled social detoxification providers.

Chapter 2-16, 'Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM)', of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*, has been updated to reflect this policy change.

For dates of service between April 1, 2021, and June 30, 2021, providers will report services directly to Medicaid on a fee for service basis.

Effective July 1, 2021, for Medicaid members enrolled in Prepaid Mental Health Plans (PMHPs), Utah Medicaid Integrated Care (UMIC) Plans, or HOME, social detoxification is covered under these plans. For Medicaid members not enrolled in one of these plans, providers will continue to report services directly to Medicaid on a fee for service basis.

PMHPs, UMIC Plans, and HOME may also implement utilization review, including prior authorization of services. For information on PMHPs', UMIC Plans', and HOME's PA and utilization review requirements and processes, programs must contact these plans. See Chapter 1-3, 'Medicaid Behavioral Health Delivery System' of the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*, for information on managed care plans.

In Chapter 2-16, the 'Record' section has also been updated regarding documentation requirements.

Also, other changes have been made throughout the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*. Please refer to the associated article in this bulletin for information on these changes.

Providers can access the revised *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* at https://medicaid.utah.gov/utah-medicaid-official-publications/.

If providers have questions, contact Medicaidbh@utah.gov.

21-90 Use of CG Modifier for Pharmacologic Management for Behavioral Health Conditions

In the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*, clarification has been provided regarding Medicaid policy on the use of the CG modifier. The policy is contained in Chapter 2-8, 'Pharmacologic Management (Evaluation and Management (E/M) Services)', under the 'Procedure Codes and Unit of Service' section. The definition of pharmacologic management in Chapter 2-8 has also been revised for clarity.

Providers can access the revised provider manual at https://medicaid.utah.gov/utah-medicaid-official-publications/.

If providers have questions, contact Medicaidbh@utah.gov.

21-91 Attention: Mental Health and Substance Use Disorder Providers

Updates have been made to the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services*.

In Chapter 1-2, Definitions, in the definition of Fee for Service, the acronym 'FFS' is also given. The manual has been updated to consistently use the FFS acronym throughout.

In chapters in the manual, where 'psychotherapy with patient and/or family member' was stated, the term 'and/or family member' has been removed for consistency with the name of the service in the Psychiatry section of the CPT Manual.

In Chapter 1-5, Provider Qualifications, minor changes have been made for clarity.

In Chapter 1-9, Collateral Services, the policy has been revised for consistency with the CPT manual which requires for psychotherapy with patient and psychotherapy with evaluation and management (E/M) services that the patient be present for all or some of the service. Policy has also been revised for consistency with the Centers for Medicare and Medicaid Services (CMS) policy on collateral services.

In the 'Who' sections throughout Chapter 2, minor changes have been made regarding provider qualifications, and other revisions have been made for clarity.

In the 'Record' sections of Chapter 2, some documentation requirements have been revised and/or additional requirements have been added.

In Chapter 2-5, Psychotherapy, and Chapter 2-7, Psychotherapy with Evaluation and Management (E/M) Services, minor changes have been made for clarity or consistency with the Psychiatry section of

the CPT manual.

In Chapter 2-8, Pharmacologic Management (Evaluation and Management (E/M) Services), and Chapter 2-9, Nurse Medication Management, the definitions have been revised for clarity and consistency. Also, in the 'Procedure Codes and Unit of Service' and 'Record' sections, revisions have been made for consistency with the current CPT manual.

In the 'Procedure Codes and Unit of Service' section of Chapter 2-8, clarification has been provided regarding Medicaid policy on the use of the CG modifier.

In Chapter 2-10, Therapeutic Behavioral Services and Chapter 2-11, Psychosocial Rehabilitative Services, revisions have been made to the definitions for clarity.

In the 'Limits' section of Chapter 2-12, Peer Support Services, the second limit has been removed.

The 'Limits' section of Chapter 2-16, Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM), has been updated to include policy effective April 1, 2021, that all Medicaid-enrolled social detoxification providers may be reimbursed for this service. Please refer to the associated MIB article in this bulletin, Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM) Social Detoxification Providers, for more information regarding fee for service coverage or managed care plan coverage of this service.

In the 'Limits' section of Chapters 2-13, 2-14, 2-16, and 2-17, revisions and clarifications have been made.

In Chapter 2-13, additional revisions and updates have been made, and revisions have also been made in Chapter 5. Please refer to the associated MIB article in this bulletin, Licensed Substance Use Disorder Residential Treatment Programs, for information on these changes.

In Chapter 2-17, additional revisions and updates have been made, and revisions have also been made in Chapter 6. Please refer to the associated MIB articles in this bulletin, Licensed Mental Health Residential Treatment Programs with 16 or Fewer Beds, or Licensed Mental Health Residential Treatment Programs with 17 or More Beds, for information on the changes.

In Chapter 3, which is directed only to Prepaid Mental Health Plan (PMHP) Contractors and Utah Medicaid Integrated Care (UMIC) Plans, a 'Limits' section has been added, and the same revisions to the 'Who' sections have been made as in the 'Who' sections of Chapter 2. Also, revisions to the 'Record' sections have been made regarding qualified providers and documentation requirements.

In Chapter 4, Procedure Codes and Modifiers, revisions have been made to the CG and UC modifier footnotes.

Providers can access the revised provider manual at https://medicaid.utah.gov/utah-medicaid-official-publications/.

If providers have questions, contact Medicaidbh@utah.gov.

21-92 CHIP Program to Cover Autism Spectrum Disorder Services

Services for the treatment of Autism Spectrum Disorder (ASD) are now covered for children enrolled in the Utah Children's Health Insurance Program (CHIP). During the 2021 General Session, Children's Health Insurance Plan Payments, HB 292, passed. This bill appropriated funds for CHIP to add coverage of services for the treatment of ASD.

The CHIP coverage for ASD services is as follows:

- Coverage of ASD related services began July 1, 2021, for all members on CHIP.
- Covered benefits for ASD are:
  - Applied behavior analysis (ABA) services related to ASD.
  - ASD related physical, occupational, and speech therapy.
- Clinicians, psychologists, and behavior analysts (BCBA-D and BCBA) who can render an ASD diagnosis under the scope of their licensure can provide ABA services for eligible CHIP members. All providers rendering the service must be enrolled with Utah Medicaid and the member's CHIP managed care plan.
- All services must be billed to the eligible member's CHIP managed care plan.
- The following CPT codes have been opened for ABA services:

97151 Behavior and Functional Identification Assessment
97153 Adaptive Behavior Treatment by Protocol
97154 Group Adaptive Behavior Treatment by Protocol
97155 Adaptive Behavior Treatment with Protocol Modification
97156 Family Adaptive Behavior Treatment Guidance
97157 Multiple Family Adaptive Behavior Treatment Guidance
97158 Adaptive Behavior Treatment Social Skills Group

If you would like to enroll as a network provider with a CHIP health plan, please contact:
SelectHealth: 1-800-538-5038 or www.selecthealth.org
Molina: 1-888-483-0760 or www.molinahealthcare.com

21-93 UOIG Provider Training for 2022

The Utah Office of Inspector General (UOIG) offers training and education to Medicaid providers, state and local government employees, and to community partners and stakeholders on ways to identify and detect potential Medicaid fraud, waste, or abuse.

The UOIG will begin providing a quarterly Medicaid Fraud, Waste, and Abuse Prevention training on the first Thursday of each quarter. The next session will be offered virtually on January 6, 2022, from 1:00-2:30 PM.

To register, please follow this link:
https://docs.google.com/forms/d/e/1FAIpQLScCEFQu8l5dKyCJVhg4vYirWz4o4U0c9FhAQ0RjcJjzCT-fzw/viewform

In addition to the quarterly Fraud, Waste, and Abuse Prevention training, the UOIG is available to provide training directly to professional organizations such as the Utah Hospital Association, Utah Dental Association, Utah Association of Community Services, and local AAPC chapters. If you belong to a professional organization and would like to arrange training, please email enapper@utah.gov to discuss your organization's training needs.