April 2022

MEDICAID INFORMATION BULLETIN

Medicaid Information: 1-800-662-9651 | medicaid.utah.gov

Unless otherwise noted, all changes take effect on April 1, 2022

22-25 Medicaid Operations Contact Update

Effective April 1, 2022, the Medicaid Operations fax number, (801) 538-6805, will no longer be in service. Please refer to the Medicaid website at https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/All%20Providers%20General%20Attachments for the most recent fax list.

22-26 Telehealth Place of Service (POS) Update

The Utah Medicaid Provider Manual Section I: General Information has been updated. Chapter 8-4.2.2, *Billing*, is revised to include the use of POS 10 - Telehealth Provided in Patient's Home. This POS is in addition to the existing Telehealth POS 02, which has been redefined as Telehealth Provided Other than in Patient's Home.

22-27 Qualifying Clinical Trials

On December 7, 2021, the Centers for Medicare and Medicaid Services (CMS) issued a letter (SMD #21-005) outlining new Medicaid State Plan requirements. Section 210 of the Consolidated Appropriations Act, 2021 mandates that the amendment to the State Plan must ensure coverage of routine patient costs for items and services related to participation in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition.

Following this CMS letter, the Utah Medicaid State Plan will be updated, effective January 1, 2022.

22-28 Preventive Services

Chapter 9-11, *Specific Non-Covered Services,* of the Physician Services Provider Manual has been revised to remove language concerning routine preventative medicine services for adults.

The language was removed because preventative service coverage varies depending on the service provided and Medicaid eligibility. Specific code coverage has not changed for these services. All code coverage information for routine preventive services is found in the Coverage and Reimbursement Code Lookup.

22-29 Inpatient Hospital Three-Day and One-Day Admission Policy

If an admitting hospital furnishes services in an outpatient setting up to three days before an inpatient admission, Medicaid will incorporate the outpatient services into the DRG determination for the inpatient reimbursement. Medicaid defines this as the Three-Day Admission policy.

For example, if a member is admitted to an inpatient hospital on a Wednesday, services performed on the previous Sunday, Monday, or Tuesday would be considered part of the inpatient services.

The Three-Day Admission policy only applies to acute inpatient hospital admissions.

Additionally, there is a One-Day Admission policy which applies to the following facilities types:

- psychiatric hospitals,
- acute inpatient rehabilitation hospitals,
- long-term acute care,
- children's hospitals, and
- cancer hospitals.

For these facilities, Medicaid will incorporate services furnished in an outpatient setting up to one day before an inpatient admission into the DRG determination for the inpatient reimbursement.

For example, if a member is admitted on a Wednesday to one of the facility types listed above, the services performed on Tuesday are part of the One-Day Admission policy.

Preadmission services furnished within the admission window that are determined not clinically related to an inpatient admission are not subject to the Three-Day (or One-Day) Admission DRG payment policy.

22-30 PT/OT Updates

The Physical Therapy and Occupational Therapy Services Medicaid provider manual has been restructured and formatted to align with other Medicaid provider manuals.

Chapter 9-2.1 Physical Therapy Limitations is updated to include the following:

- Physical therapy services for Traditional Medicaid members are limited to twenty (20) therapy sessions, per member, per calendar year, when criteria are met. (The evaluation

is NOT counted as one of the 20 sessions.) Prior authorization is required for more than 20 sessions per calendar year.

- Physical therapy and occupational therapy services for Non-Traditional Medicaid members are limited to sixteen (16) total aggregate physical or occupational therapy sessions, per member, per calendar year, when criteria are met. (The evaluation is NOT counted as one of the 16 sessions). Prior authorization is required for more than 16 sessions per calendar year.

Chapter 9-2.2 Occupational Therapy is updated to include the following:

- Occupational therapy services for Traditional Medicaid members are limited to twenty (20) therapy sessions, per member, per calendar year, when criteria are met. (The evaluation is NOT counted as one of the 20 sessions.) Prior authorization is required for more than 20 sessions per calendar year.
- Occupational therapy and physical therapy for Non-Traditional Medicaid members are limited to sixteen (16) total aggregate physical or occupational therapy sessions, per member, per calendar year, when criteria are met. (The evaluation is NOT counted as one of the 16 sessions). Prior authorization is required for more than 16 sessions per calendar year.

Chapter 10 Prior Authorization is updated to remove the following paragraph:

> For members with Traditional Medicaid, prior authorization is not required for the first twenty (20) physical therapy visits or the first twenty (20) occupational therapy visits. Please see the Non-Traditional Manual for limitations for members with Non-Traditional Medicaid. (The evaluation for either PT or OT is not counted towards the limitation).

Chapter 10-1 Prior Authorization Criteria, of this manual has been updated to remove the reference to the Physical Therapy and Occupational Therapy Decision Tables attachment in the second open bullet point of the bulleted list. The list will now read as follows:

- Prior Authorization Request Form (found at: https://medicaid.utah.gov, Forms)
- Written plan of treatment for the member or a document which includes:
  - The diagnosis and the severity of the medical disorder or disability
  - The prognosis for progress within a reasonable and predictable time to an identified level

22-31 CLIA Updates

The Medicaid claims processing system has been allowing claims with reported lab testing codes to adjudicate without the provider's Clinical Laboratory Improvement Amendments (CLIA) certification number. Beginning July 1, 2022, the Medicaid claims processing system will be updated to require the appropriate CLIA certification number on the provider record in order to allow related claims to be paid. This update is consistent with existing Medicaid policy that requires CLIA certification for correct billing.

The Centers for Medicare and Medicaid Services (CMS) requires each location performing laboratory services to have their own CLIA certification except under certain circumstances as outlined in the CMS document titled, Clinical Laboratory Improvement Amendments (CLIA) - How to Obtain a CLIA Certificate. Providers with multiple locations, that do not meet the CMS exception criteria, must submit to Medicaid a unique CLIA certification number for each location that bills claims to Medicaid.

CLIA certification requirements apply to, but are not limited to, the following types of testing:

- Chemistry
- Drug Assays and Therapeutic Drug Assays
- Hematology
- Histocompatibility
- Immunohematology
- Immunology
- Microbiology
- Pathology
- Urinalysis

CLIA has designated the following CLIA Certificate types:

- **Certificate of Waiver** - This certificate is issued to a laboratory to perform only waived tests.
- **Certificate for Provider-Performed Microscopy Procedures (PPMP)** - This certificate is issued to a laboratory where a physician, midlevel practitioner, or dentist performs no tests other than waived and specific microscopy procedures.
- **Certificate of Registration** - This certificate is issued to a laboratory that enables the entity to conduct moderate or high complexity laboratory testing or both until a survey determines the entity to comply with the CLIA regulations.
- **Certificate of Compliance** - This certificate is issued to a laboratory after an accreditation organization approved by CMS finds the laboratory to comply with its standards.
- **Certificate of Accreditation** - This certificate is issued to a laboratory after an accreditation organization approved by CMS finds the laboratory to comply with their standards.

Providers can find information on how they can apply for the appropriate level of CLIA certification on the following CMS documents:

- Clinical Laboratory Improvement Amendments (CLIA) - How to Obtain a CLIA Certificate
- Laboratory Quick Start Guide to CMS CLIA Certification

Providers can review the specific type of CLIA certificate required for laboratory tests on the U.S. Food and Drug Administration (FDA) CLIA Test Complexity Database. Providers may only perform CLIA-related tests that fall within their CLIA certification.

In addition to CLIA requirements, providers performing urine drug testing must continue to meet the requirements found in Chapter 8-11.3 Urine Drug Testing of the Physician Services Provider Manual and the under the American Society of Addiction Medicine (ASAM) in The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine guidelines.

22-32 Provider Enrollment Updates – CLIA in PRISM

Utah Medicaid providers must validate their enrollment before July 1, 2022, to ensure there is no delay in the claims adjudication process once the additional PRISM Subsystems Go Live in 2023. The following optional sections must be completed if applicable.

1. CLIA (License and Certifications) - Providers who provide services that require a CLIA Certificate need to add the CLIA certification number to Step 5 of their PRISM enrollment. Providers will need to upload a copy of the certificate in Step 16. When PRISM goes live with claims, all procedures requiring a CLIA certificate will deny if the CLIA certificate is not present in PRISM.
2. Mode of Claims Submission - When the PRISM claims subsystem goes live in 2023, the Mode of Claims Submission will be utilized to determine whether a provider is allowed to use Direct Data Entry (DDE), Electronic Batch, or another mode of submission. All billing providers must complete their PRISM EDI enrollment in steps 8, 9, and 13 to ensure claims are accepted into the PRISM Medicaid system. Mark the appropriate mode of submission for your claims or EDI transactions.
3. Specialties – To ensure claims adjudication, at least one specialty must be selected in step 3. Select all applicable additional specialties. In claims adjudication, the specialty identifies the services that may be performed.

Additional information is available at https://medicaid.utah.gov/pe-training/ under the heading 'Managing the Information of a Provider'.

22-33 Code Updates

All new April 2022 code updates have been completed. Below is a list of all new open services. Please see the Medicaid Coverage and Reimbursement Lookup for code-specific details.

0051A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 30 mcg/0.3 ml dosage, tris-sucrose formulation; fi
0052A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 30 mcg/0.3 ml dosage, tris-sucrose formulation; se
0053A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 30 mcg/0.3 ml dosage, tris-sucrose formulation; th
0054A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 30 mcg/0.3 ml dosage, trissucrose formulation; boo
0073A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 10 mcg/0.2 ml dosage, diluent reconstituted, tris-
91305	Severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 30 mcg/0.3 ml dosage, tris-sucrose formulation, for intramuscular use
A2011	Supra sdrm, per square centimeter
A2012	Suprathel, per square centimeter
A2013	Innovamatrix fs, per square centimeter
A4100	Skin substitute, fda cleared as a device, not otherwise specified
C9090	Injection, plasminogen, human-tvmh, 1 mg
C9091	Injection, sirolimus protein-bound particles, 1 mg
C9092	Injection, triamcinolone acetonide, suprachoroidal (xipere), 1 mg
C9093	Injection, ranibizumab, via sustained release intravitreal implant (susvimo), 0.1 mg
C9781	Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon), includes debridement (e.g., limited or extensive), subacromial decompression, acromioplasty, and biceps tenodesis when performed
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg
J0248	Injection, remdesivir, 1 mg
J0491	Injection, anifrolumab-fnia, 1 mg
J9071	Injection, cyclophosphamide, (auromedics), 5 mg

J9273	Injection, tisotumab vedotin-tftv, 1 mg
J9359	Injection, loncastuximab tesirine-lpyl, 0.075 mg
K1031	Non-pneumatic compression controller without calibrated gradient pressure
K1032	Non-pneumatic sequential compression garment, full leg
K1033	Non-pneumatic sequential compression garment, half leg
M0220	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromis
M0221	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromis
Q0220	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromis
Q4224	Human health factor 10 amniotic patch (hhf10-p), per square centimeter
Q4225	Amniobind, per square centimeter
Q4256	Mlg-complete, per square centimeter
Q4257	Relese, per square centimeter
Q4258	Enverse, per square centimeter
Q5124	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg
T2050	Financial management, self-directed, waiver; per diem
T2051	Supports brokerage, self-directed, waiver; per diem

22-34 Closing Codes

The treatment of sacroiliac pain through thermal radiofrequency ablation or cooled radiofrequency ablation is non-covered by Medicaid. These services continue to be unproven and not accepted as a standard of care. Such services are non-covered as outlined in Section I: General Information Utah Medicaid Provider Manual, Chapter 9.2, *Services Not Covered Regardless of Medical Necessity*. Medicaid will deny reporting of these services beginning April 1, 2022.

- 64451 - Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)
- 64625 - Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)

22-35 Radiation Treatment and Delivery Management Codes

Coverage of the radiation treatment delivery and management policy has been updated to align with CMS guidance. For complete criteria and requirements, refer to Chapter 9-10, *Radiation Treatment and Management,* of the Physician Services Provider Manual and the Coverage and Reimbursement Code Lookup.

9-10 Radiation Treatment and Management

The Centers for Medicare and Medicaid Services (CMS) has provided distinct coding and reporting guidance for delivery and management of radiation treatment.

Treatment Planning

Treatment planning is reportable once per course of therapy. This is a professional service only and the physician is responsible for all the technical aspects of the treatment planning process.

Simulation

Following treatment planning, simulation is used to direct the treatment beams to the specific volume of interest. However, the inclusion of treatment devices in the simulation process typically increases the complexity.

Simulation without the inclusion of devices or with any pre-made devices (e.g., blocks, immobilization) is considered simple. The addition of custom immobilization devices or tangential ports is an indicator of complex level of simulation. No more than one simulation should be reported on any given day.

Simple or Complex Device and Port Reporting

Providers should report devices at the beginning of the treatment course and then may report again later in the course of treatment when additional or new devices are required. Coverage for one set of treatment devices may be allowed per separate port when radiation therapy is started. However, a pair of mirror imaged opposing ports, ports that direct parallel beams such as anterior-posterior or left lateral-right lateral pairs are considered one port for reporting purposes, regardless of the complexity of the devices used to create the ports.

A pair of devices for opposing ports, constructed from drawings made by a physician on a single film, is considered for physician professional reporting purposes to be one port. Therefore, each device constructed may be reported separately by the facility. Nevertheless, the physician must be directly involved in the design, selection, and placement of the devices.

When the member has a combination of a wedge compensator and a bolus covering the same treatment port, report as a single complex treatment device rather than as a separate charge for each of the additional items of lower complexity. If beam modification devices of two distinct levels of complexity are utilized for the same treatment port, only report the highest complexity. Restraining devices and beam modification devices may be reported separately for the same port, but only report one restraining device for each volume of interest treated.

Treatment Delivery

Radiation treatment delivery codes are reported once per treatment session. These codes recognize the technical component only. Treatment management codes contain only the professional component. When more than one treatment is performed on the same date of service, each treatment should be reported on a separate claim line.

Radiation treatment delivery codes are reported using a date range if the treatments are performed on consecutive days and the energy and level of service are the same; the total number is indicated in the 'units' field on the claim. If the dates of service are not consecutive or the energy or level of service is not the same, each date of service must be reported on a separate claim line.

Basic radiation dosimetry is a separate and distinct service from intensity-modulated radiation treatment (IMRT) planning. It is appropriate to report a treatment device CPT code for each complex IMRT field (i.e., gantry/table angle for step and shoot and sliding windows). It is not reported for each segment within the field.

Image Guided Radiation Therapy (IGRT) is used in conjunction with IMRT in members whose tumors are located near or within critical structures or in tissue with inherent setup variation. Although an IGRT is a different service, it may be used and documented along with IMRT treatment delivery.

Additional Reporting Guidance

To aid in the reporting of radiation therapies, please see *the Radiation Management and Treatment Table.* This table will assist providers in reporting the delivery and management of radiation treatments.

Note: Reporting of CPT codes 77385 or 77386 is appropriate when reporting guidance and tracking performed in an outpatient hospital setting. For freestanding non-out-patient hospital facility claims, report guidance and tracking using HCPCS codes G6015 and G6016.

Category	Code	Descriptions	IGRT (77387)-T.C. bundled into code?	IGRT (77387)-P.C. bundled into code?	Code Type (Technical/Professional)
Radiation Treatment Management	77427	Radiation treatment management, 5 treatment	N	N	Professional
	77431	Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only	N	N	Professional
	77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)	N	Y	Professional
	77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	N	Y	Professional
Stereotactic Radiosurgery Treatment Delivery	77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	Y	N	Technical

	77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	Y	N	Technical
Stereotactic Body Radiation Therapy Treatment Delivery	77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Y	N	Technical
Radiation Treatment Delivery	77401	Radiation treatment delivery, superficial and/or ortho voltage, per day	N	N	Technical
	77402	Radiation treatment delivery, => 1 MeV; simple	N	N	Technical
	77407	Radiation treatment delivery, => 1 MeV; intermediate	N	N	Technical
	77412	Radiation treatment delivery, => 1 MeV; complex	N	N	Technical
Intensity Modulated Radiation Treatment Delivery	77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	Y	N	Technical
	77386	Intensity modulated radiation treatment	Y	N	Technical

		delivery (IMRT), includes guidance and tracking, when performed; complex			
Neutron Beam Treatment Delivery	77423	High energy neutron radiation treatment delivery, 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)	N	N	Technical
Proton Treatment Delivery	77520	Proton treatment delivery; simple, without compensation	N	N	Technical
	77522	Proton treatment delivery; simple, with compensation	N	N	Technical
	77523	Proton treatment delivery; intermediate	N	N	Technical
	77525	Proton treatment delivery; complex	N	N	Technical

22-36 Oxygen Concentrators

Effective March 30, 2022, Alpine Home Medical will continue as the contracted vendor for oxygen concentrators and backup oxygen supply. The contract applies to fee-for-service Medicaid members and Medicaid members enrolled in a Managed Care Entity (MCE) residing in a voluntary county. Members enrolled in a MCE living in a mandatory county must receive oxygen concentrator services through their MCE.

This contract for oxygen concentrators will run through March 29, 2027. If you have a question regarding oxygen concentrators, please contact Alpine Home Medical Equipment at 1-888-988-2469.

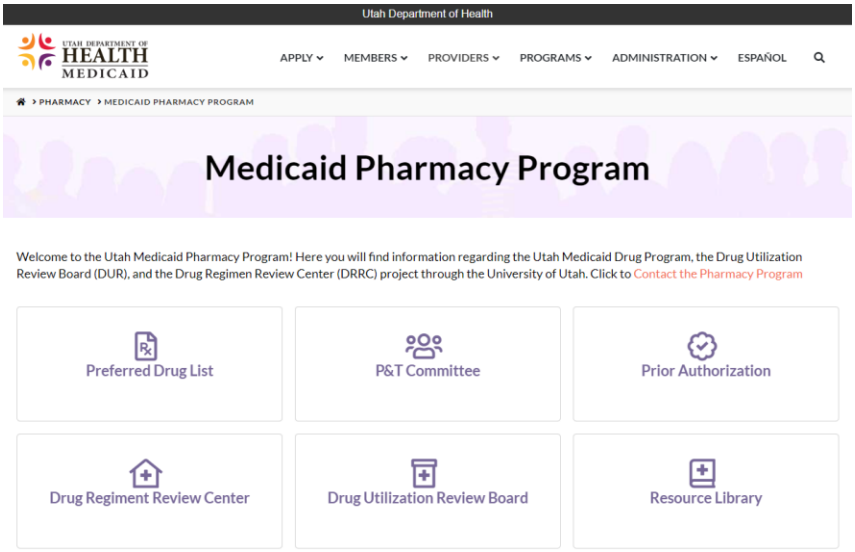
22-37 Pharmacy Policy, Coverage, Prior Authorization and HPCS Codes

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, in addition to the Utah Medicaid State Plan, Utah Administrative Rule, Utah Medicaid Provider Manuals and Medicaid Information Bulletins, 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 as drug labels are expanded.

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, go to https://medicaid.utah.gov/, click on Healthcare Providers, Medicaid Pharmacy Program. An example is provided below:



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

22-38 Pharmacy Prior Authorization Processing

Pharmacy prior authorization requests received for pharmacy services, including pharmacy related HCPCS codes, must be complete upon submission. An incomplete submission may result in the prior authorization being denied. The Utah Medicaid pharmacy team attempts to contact providers to obtain additional information for the prior authorization request at least two times. Providers and their staff are encouraged to complete the prior authorization request to include the exact medication name the member will be using, or indicate if a substitution is not permissible.

Medication Name/ Strength:	Dose:
❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

If a provider's intent is for a member to use a brand product, they will check "Do Not Substitute". In the example below, the request would be reviewed for the non-preferred name brand Percocet 5/325mg.

Medication Name/ Strength: *Percocet 5/325mg*	Dose:
☒ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

If a provider submits a prior authorization request without indicating "Do Not Substitute", the request will be processed for the preferred Generic/Brand equivalent. In the example below, the request would be reviewed for the preferred generic equivalent, Oxycodone/APAP 5/325mg.

Medication Name/ Strength: *Percocet 5/325mg*	Dose:
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

In all cases, providers should submit prior authorization requests using the most current form available on the Utah Medicaid Pharmacy Website, complete all fields legibly, and include all supporting documentation required for the pharmacy service requested.

22-39 DUR Board Updates

The Drug Utilization Review (DUR) Board met in January 2022 to review treatments for Lupus Nephritis, including Benlysta (belimumab) and Lupkynis (voclosporin). The DUR Board also reviewed the PCSK9 Inhibitor prior authorization criteria and extended the specialist criteria to include cardiologists and endocrinologists.

The DUR Board met in February 2022 to review the use of codeine in children.

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

22-40 P&T Committee Updates

The Pharmacy and Therapeutics (P&T) Committee reviewed non-steroidal treatments for Atopic Dermatitis in February 2022. Committee recommendations regarding updates to the preferred drug list (PDL), will go into effect with the April 2022 PDL.

Additionally, the Diuretics – Thiazide class is eliminated from the PDL, effective April 2022.

The P&T Committee meeting minutes are published on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/preferred-drug-list/.

22-41 COVID-19 Carved-Out Services

The following COVID-19 services or treatments are carved out and should be billed to the Utah Medicaid Fee-for-Service program:

- COVID-19 Vaccines and administration:
    - Pfizer-BioNTech

  - Moderna
  - Janssen

  For additional information see the November 2021 Interim MIB

- COVID-19 Antivirals:
  - Paxlovid (Nirmatrelvi)
  - Molnupiravir
- COVID-19 Monoclonal Antibodies:
  - Bamlanivimab injection
  - Etesevimab injection
  - Sotrovimab injection
  - Casirivimab injection
  - Imdevimab injection

22-42 Coverage for COVID-19 Vaccines

Effective December 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 should use the vaccine code and the vaccine administration code listed in the table below. The coverage and reimbursement of COVID-19 vaccines and administration fee 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 5 years and older (Pfizer) and 18 years and older (Moderna & Janssen). COVID-19 vaccines are not approved for members who are less than 5 years of age.

Effective Date	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
12/11/20	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 (3rd dose) 0004A (Booster)	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine / Comirnaty	59267-1000-1 59267-1000-01	1st Dose to 2nd Dose: 21 Days 2nd Dose to 3rd Dose (CDC recommended population[s] [eg, immunocompromised]): 28 or More Days Booster: Refer to FDA/CDC Guidance
1/3/2022	91305	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	0051A (1st Dose) 0052A (2nd Dose) 0053A (3rd Dose) 0054A (Booster)	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine	59267-1025-1 59267-1025-01	1st Dose to 2nd Dose: 21 Days 2nd Dose to 3rd Dose(CDC recommended population[s] [eg, immunocompromised]): 28 or More Days Booster: Refer to FDA/CDC Guidance

Effective Date	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
10/29/21	91307	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris- sucrose formulation, for intramuscular use	0071A (1st Dose) 0072A (2nd Dose) 0073A (3rd dose)	Pfizer, Inc	Pfizer-BioNTech COVID-19 Pediatric Vaccine	59267-1055-1 59267-1055-01	1st Dose to 2nd Dose: 21 Days
12/18/20	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 (3rd dose)	Moderna, Inc	Moderna COVID-19 Vaccine	80777-273-10 80777-0273-10	1st Dose to 2nd Dose: 28 Days 2nd Dose to 3rd Dose (CDC recommended population[s] [eg, immunocompromised]): 28 or More Days
10/20/21	91306	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25 mL dosage, for intramuscular use	0064A (Booster)	Moderna, Inc	Moderna COVID-19 Vaccine	80777-273-10 80777-0273-10	Refer to FDA/CDC Guidance
2/27/21	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 (Single Dose) 0034A (Booster)	Janssen	Janssen COVID-19 Vaccine	59676-580-05 59676-0580-05	Booster: Refer to FDA/CDC Guidance

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 "M.A." (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 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.

22-43 Transportation Services Updates

The name of the statewide contracted non-emergency medical transportation (NEMT) broker has been updated from LogistiCare to ModivCare throughout the Medical Transportation Services Manual.

The Medical Transportation Services Manual, Chapter 1, *Non-Emergency Medical Transportation Services,* has been updated to include:

1.1 General Pathway for Securing Non-Emergency Transportation Services

The available options for NEMT services are based on the needs of the member and include UTA, Paratransit, ModivCare, ambulance, and payment for personal car mileage. To maintain cost-effectiveness while providing necessary services to Traditional Medicaid members, utilization is based upon where the member lives and what services are available to them.

Note: It is important for a Medicaid member to discuss their medical transportation needs with a DWS eligibility worker as they can assist the member in finding the most effective way to get to and from appointments.

Hierarchy of NEMT:

- Members who live within the boundaries of UTA or Cedar Area Transportation Services (CATS) should utilize "fixed bus route" services or UTA's TRAX light rail for NEMT. "Fixed bus route" refers to buses that operate on a predetermined route according to a predetermined schedule.
    - UTA and CATS buses can only support members with an aggregate weight (member and wheelchair combined) of 800 lbs.
- If a member cannot use the UTA/CATS fixed bus services or TRAX and they live within the established boundaries, they can apply for UTA Paratransit transportation or the CATS Dial-A-Ride service.
    - UTA Paratransit Services
        - Members must complete the application process and be certified as eligible before scheduling any Paratransit rides.
        - UTA's base level of Paratransit service is Curb-to-Curb service.
            - For Curb-to-Curb service, members are responsible for getting to and from the curb at the pick-up and drop-off locations by themselves.
        - Beyond-the-Curb service is available as a reasonable modification for customers who, without such assistance, are unable to access Paratransit service.
            - Assistance is available from the vehicle to the first exterior door at the rider's pick up and/or drop off location.
            - Be aware, this type of service may not always be feasible or safe to provide.

        - Requests should be made ahead of time to allow UTA to asses any safety risks that would prevent its drivers from providing beyond-the-curb service.
        - Requests may be granted by the driver on a case-by-case basis
    - Paratransit service vehicles can only support members with an aggregate weight (member and wheelchair combined) of 800 lbs.
  - CATS Dial-A-Ride
    - Services are available by appointment only and require a 24-hour minimum notice.
    - Curb-to-Curb service is available.
    - Service vehicles can only support members with an aggregate weight (member and wheelchair combined) of 800 lbs.
- Members who live outside the boundaries of the UTA/CATS service areas or who are unable to use the previously mentioned services for medical reasons can utilize the contracted NEMT broker, ModivCare, for transportation services.
  - ModivCare
    - Members who live in areas served by the UTA/CATS and are capable of riding the bus or Paratransit as determined by the mobility evaluation completed by a physician chosen by the Member are exempt from using ModivCare.
      - Members utilize ModivCare services for up to four weeks or until the evaluation is returned and a decision of eligibility for NEMT is made, whichever occurs first.
    - Requests for ModivCare services must be made 3 business days before transportation is needed with the exception of urgent scheduling which may require a medical provider's note.
    - Vehicles can only support members with an aggregate weight (member and wheelchair combined) of 600lbs.
- If the member exceeds the weight limits and cannot obtain or use a manual wheelchair then NEMT ambulance services are available for their use.
  - Members may obtain a manual wheelchair for transportation purposes. Please refer to Section II: Medical Supplies and Durable Medical Equipment, Chapter 8-14, *Wheelchairs,* for more information.

- Members may receive round-trip reimbursement when using personal transportation for medical appointments. Please refer to the Medicaid Eligibility Policy Manual for more information.

22-44 UTA Bus Passes

Medicaid is working with Utah Transit Authority (UTA) to transition Medicaid members from UTA paper punch bus passes to a UTA transit card on July 1, 2022. More information will be forthcoming.

22-45 Section I: General Information Updated for PMHP

Please note that in Chapter 1-9 of Section I: General Information, *Definitions*, the definition of Prepaid Mental Health Plan has been updated. In Chapter 14, *Acronyms*, the acronym for PMHP has been corrected to include PMHP.

Please send any questions to Medicaidbh@utah.gov.

22-46 Correction to March Interim MIB Article 22-23; Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual Updated

Please note that Article 22-23, published in the March 2022 Interim MIB, contains extraneous policy that should not have been included in the article. The provider manual that was published along with this MIB is correct and will not need to be republished. The following text only should have been published in Article 22-23:

Updates to the *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* are effective March 1, 2022. Providers can access the revised provider manual at https://medicaid.utah.gov.

In Chapter 1-2, Definitions, in the definition of Behavioral health disorders, the term 'SUDs' has been defined.

In Chapter 1-4, Scope of Services, the 'Telemedicine' section, and in Chapter 1-10, Billings, place of service codes have been updated for dates of service on or after April 1, 2022. Providers must specify place of service as follows:

'02' (Telehealth Provided Other than in Patient's Home)
'10' (Telehealth Provided in Patient's Home)

For dates of service prior to April 1, 2022, continue to report behavioral health services provided via telehealth with the '02' place of service code.

Also, in Chapter 1-10, Billings, clarification has been made on reporting a range of dates on a single line of a claim.

In Chapter 2-5, Psychotherapy, the term 'and/or family member' has been removed from 'psychotherapy with patient' to align with the name of the service in the CPT manual.

In the 'Prolonged Services Add-On Codes' section of Chapter 2-5, the time rules for converting the duration of the service to the appropriate prolonged service add-on procedures codes have been revised to align with the rules in the CPT manual.

In Chapter 2-6, Psychotherapy for Crisis, in order to align with the CTP manual, 'and/or family member' has been removed from procedure codes 90832 and 90833. And 'with patient and/or family member' has been removed from procedure code 90839.

Also, in Chapter 2-6, under 'Procedure Codes and Unit of Service', the time rules for coding procedure codes 90839 and 90840 have been corrected to align with the CPT manual. For reporting 90839, the time frame is 31 minutes through 74 minutes (not 31 through 75 minutes as previously indicated).

This correction also results in corrections to the minutes listed in the time rules for procedure code 90840. Also, a minor change in the name of procedure code 90840 has been made to align with the CPT manual, which is 'each additional 30 minutes.'

Chapter 2-8, Pharmacologic Management (Evaluation and Management (E/M) Services), has been reorganized so that all prolonged services add-on codes (99354-99357 and 99417) are addressed in the same section of this chapter, 'Prolonged Services Add-On Codes 99354-99357 and 99417'. Minor changes have been made for clarity regarding use of prolonged services add-on codes.

In Chapter 2-13, Substance Use Disorder (SUD) Treatment in Licensed SUD Residential Treatment Programs (ASAM Levels 3.1, 3.3, 3.5, 3.7), and in Chapter 2-17, Mental Health Treatment in Licensed Mental Health Residential Treatment Programs, the 'Who' sections have been updated to clarify that providers are licensed residential treatment programs licensed in accordance with Section 62A-2-101 of the Utah Code.

In Chapter 2-16, Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM), the 'Record' section has been updated to clarify documentation requirements. Meeting written documentation requirements in Utah Rule, R501-11-6 (C) and R501-11-13 (B) suffice for the evaluation and treatment plans requirements in Chapter 1-6 and Chapter 1-7 of this manual.

Chapter 3 has been updated to clarify that the services contained in this chapter also apply to HOME, along with prepaid mental health plans (PMHPs) and Utah Integrated Care (UMIC) Plans. Other changes have been made for clarity.

22-47 Home and Community Based Waiver Services for Individuals Age 65 or Older Manual Updated

Chapter 2-2, *Provider Reimbursement*, has been updated to include policy regarding Personal Attendant Services (PAS) participant-employed reimbursement out-of-state or out-of-country. PAS participant-employed providers are able to be reimbursed for services up to two weeks when the participant and PAS provider travel together. There is a limitation of two visits per year. Any additional visits need to be approved by the Division of Aging and Adult Services (DAAS).