

# MEDICAID INFORMATION BULLETIN

Medicaid Information: 1-800-662-9651

[medicaid.utah.gov](http://medicaid.utah.gov)

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

## 22-53 Medicaid Statewide Provider Training

Utah Medicaid will be offering the 2022 Statewide Provider Training in an online live webinar format. This year we are hosting multiple trainings covering specific topics. Providers can sign up to attend multiple trainings.

### Training Sessions:

- Provider Reimbursement Information System for Medicaid (PRISM) Overview
- Utah Office of Inspector General
- Provider Enrollment
- Claims/Billing
- Prior Authorization
- Pharmacy
- Healthcare Policy

To register for the 2022 training, please complete the [Google Form](#).

The 2021 and 2020 statewide provider trainings are available on the [Medicaid website](#). The 2022 trainings will be posted after the trainings conclude.

The following dates and times are scheduled for the 2022 Medicaid Statewide Provider Training. Each session, with the exception of the OIG, will include managed care and behavioral health information.

Date	Time	Training	Description
Tuesday, August 16	10:00 am-11:00 am	Provider Reimbursement Information System for Medicaid (PRISM) Overview	High-level overview of the January 2023 implementation of the new PRISM system with information regarding trainings for providers.
Wednesday, August 17	9:00 am-11:00 am	Utah Office of Inspector General	Overview of the OIG; common fraud, waste, and abuse schemes; avoiding improper Medicaid payments; and provider tips and resources.
Thursday, August 18	9:00 am – 11:00 am	Provider Enrollment	How to process new enrollments, retro enrollments, end dating an association, and new updates.
Tuesday, August 23	1:00 pm-3:00 pm	Claims/Billing	How to process claims, electronic data interchange (EDI), corrected claims, billing modifiers, denials,

			appeals, coordination of benefits, and new updates.
Wednesday, August 24	1:00 pm- 3:00 pm	Prior Authorization	How to submit a prior authorization, requirements, resources, and new updates.
Thursday, August 25	1:00 pm- 3:00 pm	Pharmacy	Overview of coverage, billing, opioids, retro-drug utilization review (DUR), medication therapy management (MTM) services, pharmacy prior authorization, and new updates.
Tuesday, August 30	9:00 am- 11:00 am	Healthcare Policy	<p>Overview of specific and new Medicaid policies such as:</p> <ul style="list-style-type: none"> <li>· Autism Spectrum Disorder Services and Applied Behavior Analysis (ABA)</li> <li>· Central Nervous System Neurological Assessment</li> <li>· COVID-19 Vaccination Counseling</li> <li>· Dental</li> <li>· Hospice Care Services</li> <li>· Laboratory Services and Clinical Laboratory Improvement Amendments (CLIA)</li> <li>· Medical supplies</li> <li>· Personal Care Services</li> <li>· Physician Assistants and Nurse Practitioners Reporting as Assistants to Surgery</li> <li>· Physical Therapy and Occupation Therapy Coverage for Tradition and Non-Traditional Members</li> <li>· Qualified Clinical Trials</li> <li>· Radiation Treatment and Delivery Management</li> <li>· Transportation Services</li> </ul>

## 22-54 TPL/COB Reporting for Claims Processing

As a reminder, providers must report the Third-Party Liability (TPL)/Coordination of Benefits (COB) on the claim at the level of reimbursement from other payer(s). With the implementation of PRISM, Medicaid will deny claims when the TPL reported on the claim header is out of balance with the sum of TPL reported at the claim line level. If a member has multiple third-party insurances, claims will be denied if TPL is not reported on the claim for all payers identified in the member's eligibility record for the type of claim submitted. If unsure of a member's TPL, the eligibility lookup tool at <https://medicaid.utah.gov/eligibility/> should be utilized. Each payer's TPL information must be reported separately and include the paid amount, patient responsibility, and any adjustments made by another payer.

Medicaid encourages providers to review their TPL/COB reporting to ensure it meets the above criteria now and not wait until PRISM implementation. Contact your practice management software support, clearinghouse, or billing agency to ensure claims contain the appropriate TPL/COB information.

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## 22-55 Hospice Billing

Effective July 1, 2022, hospice providers are required to report the location of where services are rendered in order to ensure appropriate payment. For electronic billing of the 837 professional claim, complete the service facility location name, 2310C loop. For claims submitted on a paper CMS 1500 form, report the service facility location information in boxes 32, 32a, and 32b.

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## 22-56 Dental Billing

Effective July 1, 2022, when billing dental services, Medicaid will only accept one tooth number per service line. If the same service is performed on multiple teeth, a separate line must be submitted for each service and tooth number combination.

## 22-57 CLIA Updates

The Medicaid claims processing system allows 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 CLIA-related claims to have the appropriate CLIA certification number, or the claim, or line item(s), will be denied.

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](#).

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](#)

Provider inquiries regarding the type of CLIA certificate required for laboratory tests can be found on the U.S. Food and Drug Administration (FDA) CLIA [Test Complexity Database](#). Please note, providers can only perform CLIA-related tests that fall within their CLIA certification.

Additionally, 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. Providers must ensure their CLIA certification number is in PRISM provider enrollment on the certification step.

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## 22-58 Provider Enrollment Updates – CLIA in PRISM

Utah Medicaid providers should have validated their enrollment before July 1, 2022, to ensure there is no delay in the claims adjudication process once the PRISM system goes 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 must 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 system 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 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'.

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## 22-59 One-Day Admission Policy

On April 1, 2022, Medicaid published a MIB article, *22-29 Inpatient Hospital Three-Day and One-Day Admission Policy*, which added clarification to the Hospital Services provider manual regarding the Three-Day Admission and One-Day Admission policies.

The One-Day Admission Policy was published in error as Medicaid did not implement this policy for processing claims. As such, this policy has been rescinded and removed from the provider manual.

The Three-Day Admission Policy and the information published on April 1, 2022, remains the same.

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## 22-60 Diabetes Prevention Program Services

The Utah State Legislation approved House Bill 80 (H.B.80), allowing Medicaid to cover nationally recognized diabetes prevention services. The Physician Services provider manual is updated to reflect the coverage of these services and is effective July 1, 2022.

In order to participate in the Diabetes Prevention Program, billing providers must ensure they are actively enrolled with Utah Medicaid and are qualified to provide a CDC-recognized Diabetes Prevention Lifestyle Change Program.

### Chapter 8-7 Diabetes Prevention Programs

Medicaid encourages providers to screen and refer their patients to evidence-based diabetes prevention programs (DPPs) recognized by the Centers for Disease Control and Prevention (CDC) when they are at risk for developing type 2 diabetes.

DPP services include behavioral counseling and lifestyle-change programs, which have proven effective when delivered to prediabetic patients at high risk for developing type 2 diabetes, specifically those with minimal physical activity, obesity, and genetic predisposition. Intensive behavioral counseling includes care management, lifestyle coaching, the facilitation of a peer support group, and the provision of clinically validated educational lessons based on a standardized



curriculum focused on nutrition, exercise, stress, and weight management while allowing care plan oversight by a trained provider.

DPP services must be performed by trained lifestyle coaches who have completed a nationally recognized training program. Lifestyle coaches must be available to interact with the participants.

For a member to be considered eligible for coverage of these services, they must meet the following requirements:

- Receive DPP from a CDC-recognized diabetes prevention lifestyle change program
- Meet all of the following requirements
  - 18 years of age or older
  - Overweight – BMI of 25 or higher
  - Not diagnosed with diabetes type 1 or 2
  - Not currently pregnant
- Have at least one of the following
  - Had a blood test result in the prediabetes range within the past year (includes any of these tests and results):
    - Hemoglobin A1C: 5.7–6.4%.
    - Fasting plasma glucose: 110–125 mg/dL.
    - 2-hour plasma glucose (after a 75 g glucose load): 140–199 mg/dL.
  - Previously diagnosed with gestational diabetes
  - High-risk results on prediabetes risk test
    - A score of 5 or higher
    - <https://www.cdc.gov/prediabetes/pdf/Prediabetes-Risk-Test-Final.pdf>

See Chapter 12-1 Coding for Diabetes Prevention Programs of this manual for reporting requirements of DPP services.

#### Chapter 12-1 Coding Related to Diabetes Prevention Programs

Providers must report DPP services using the appropriate coding guidelines outlined by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS). In addition, when submitting claims for DPP, providers must ensure that coverage criteria are met and that the services rendered are medically necessary.



DPP is reported with CPT codes 0403T and 0488T. Guidance for reporting these codes is outlined below. Do not report either of these codes for members diagnosed with diabetes type 1 or diabetes type 2.

*0403T - Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day*

0403T is reported by a CDC-recognized organization delivering a standardized DPP curriculum in a group setting. The lifestyle coach conducts a face-to-face, intensive behavior change therapy session lasting at least 60 minutes.

Report CPT code 0403T once per day. Providers cannot report this code in the same 30-day period as CPT code 0488T.

*0488T - Preventive behavior change, online/electronic structured intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days.*

0488T is reported by a CDC-recognized organization or provider delivering a standardized DPP curriculum online or electronically. This code is reported per 30 days of intense therapy. In-person components of the program are included when performed.

Do not report 0488T with CPT code 0403T in the same 30-day period covered under 0488T.

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## 22-61 Retroactive Authorization Policy

The following changes and additions have been made to the Section I: General Information Provider Manual. Chapter 10-3 *Retroactive Authorization* has been updated and revised to provide clarity, including renaming of section headings for consistency.

- Chapter 10-3.1 *Inaccurate Information* has been added and includes the following:

### 10-3.1 Inaccurate Information

If a provider demonstrates that a Medicaid representative or Medicaid's website gave inaccurate information about the need for prior authorization, a retroactive authorization may be requested.

Providers must submit supporting documentation of inaccurate information in writing via email, fax, or mail. The documentation must include corroborating

information such as the customer service representative's name with the date and time of the phone call or screenshots from the website with a timestamp, etc.

- Chapter 10-3.8 *Members with Medicaid and Medicare (Dual Eligibility)* has been added and includes:

#### 10-3.8 Members with Medicaid and Medicare (Dual Eligibility)

Due to considerable variances in Medicare and Medicaid coverage policies, retroactive authorization for durable medical equipment, medical supplies, prosthetics, or orthotics may qualify for retroactive authorization of services.

Medicaid does not make exceptions for retroactive authorization for Medicare Supplement Plans. For additional information regarding dual eligibility, refer to *Chapter 11-5.1 Medicare Crossover Claims* of this manual.

Note: Medicare Crossover claims only apply to Medicare Part A and Part B. No exceptions will be made for Medicare Supplement Plan Coverage

- Chapter 10-3.9 *Exceeding Quantity Limits* has been added and includes:

#### 10-3.9 Exceeding Quantity Limits

Providers may request retroactive authorization when quantity limits are inadvertently exceeded. For example, a provider unknowingly exceeds quantity limits for a previously performed service by a different provider. The new provider should make every reasonable effort, for example, by contacting customer service to determine if quantity limits have been met.

Each provider is responsible for checking quantity limits and requesting prior authorization once quantity limits are met. Quantity limits count to the member and are not unique to the provider. Additionally, if more than one request is received for the same item or service, the authorization for the first complete request will be the one approved.

Note: This exception does not apply to pharmacy claims. For information regarding pharmacy claims, refer to the Pharmacy Services provider manual.

## 22-62 Radiation Treatment Delivery and Management Services

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.

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## 22-63 InterQual Criteria Updates

InterQual™ criteria are continually reviewed and updated. Revisions are released at least annually. Each release of the criteria reflects a thorough review of new medical literature, society guidelines, current practice standards, and incorporation of expert clinical consultant and user feedback.

InterQual™ criteria updates to the 2022 version are implemented on July 1, 2022. These updates primarily affect the following subsets:

- Imaging, abdomen and pelvis
  - Cardiac Imaging, CT or MRI
  - Imaging, Spine (cervical, lumbar, and thoracic)
  - Electroconvulsive Therapy (ECT)
  - Vagus Nerve Stimulation (VNS)
  - Breast Reconstruction
  - Artificial disc replacement, cervical
  - Scoliosis or kyphosis surgery
  - Spinal cord stimulator
  - Negative pressure wound therapy (NPWT) devices
  - Orthoses, cranial remodeling
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## 22-64 Laboratory Services

Information and policy related to laboratory services have been updated in the Physician Services and Hospital Services provider manuals. The information changed throughout the manuals is outlined in the Respiratory Virus Proprietary Laboratory Analysis (PLA) Codes and the Clinical Laboratory Improvement Amendments CLIA MIB articles. For additional information beyond the following publications, providers are encouraged to review the information found in the provider manuals.

## 22-65 Respiratory Virus Proprietary Laboratory Analysis (PLA) Codes

The [Hospital Services Manual](#), Chapter 8-10 *Laboratory Services*, and the [Physician Services Manual](#) Chapter 8-12.4 *Laboratory Services* have been updated to include the following information:

Following the American Medical Association (AMA) coding guidelines, PLA codes must be reported when available in place of corresponding CPT codes. Do not report PLA codes with related CPT codes. If the PLA code is not available to be used by the billing laboratory, the CPT code should be billed.

## 22-66 Qualifying Clinical Trials

The Centers for Medicare and Medicaid Services (CMS) issued a letter ([SMD #21-005](#)) to all state Medicaid directors outlining a new Medicaid state plan requirement for assuring coverage of routine patient costs associated with participation in qualifying clinical trials performed on or after January 1, 2022.

Division CC, Title II, Section 210 of the [Consolidated Appropriations Act, 2021](#) (Public Law 116-260) (section 210) amended section 1905(a) of the Social Security Act (the Act) by:

- adding a new benefit for routine patient costs for items and services related to qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening condition as outlined, and
- making coverage mandatory under the state plan and any benchmark or benchmark equivalent coverage, also referred to as alternative benefit plans

The qualifying clinical trial information, including the provisions outlined in the [Consolidated Appropriations Act, 2021](#), is being added to the Utah Medicaid State Plan and to Utah Administrative Rule, R414-71 *Early and Periodic Screening, Diagnostic and Treatment Program*.

The following Utah Medicaid Provider Manuals are updated to include language surrounding the coverage of qualifying clinical trials:

- EPSDT Services manual Chapter 2-1.1 *Genetic Testing*
- Hospital Services manual Chapters 9-15 *Non-Covered Services*
- Physician Services manual Chapters:
  - 8-11.1.3 *Non-Covered*
  - 8-11.2.5 *Non-Covered Testing*
- Section I: General Information manual Chapters:
  - 8-1 *Medical Necessity*

- *9-2 Services Not Covered Regardless of Medical Necessity*
- *9-3.1 Limiting Amount, Duration, or Scope of Services*
- *9-3.3 Experimental, Investigational, or Unproven Medical Practices*
- *Create new Subchapter 9-3.3.1 Qualifying Clinical Trials*
- *10-3.6 Anesthesia Providers*

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## 22-67 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, 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.

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## 22-68 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 means required information is missing, which 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:
<input type="checkbox"/> 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: <i>Percocet 5/325mg</i>	Dose:
<input checked="" type="checkbox"/> 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: <i>Percocet 5/325mg</i>	Dose:
<input type="checkbox"/> 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.

## 22-69 DUR Board Updates

The Drug Utilization Review (DUR) Board met in April 2022 to review Guideline Treatment Recommendations for Nonspecific Low Back Pain with or without Radiculopathy. The review included evidence-based non-pharmacologic therapies and first-line and second-line pharmacologic recommendations.

The Drug Utilization Review (DUR) Board met in May 2022 to review Tezspire (tezepelumab). The review included product prescribing information, peer-reviewed research regarding indications for use, safety and efficacy, treatment guidelines, and considerations for prior authorization criteria for Tezspire (tezepelumab). The Board also reviewed Hetlioz (tasimelteon) prior authorization criteria.

The Drug Utilization Review (DUR) Board met in June 2022 to review guideline recommended treatments for pediatric insomnia.

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

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## 22-70 Short-Acting Opioid Quantity Limit Changes

Beginning June 1, 2022, quantity limits for the following short-acting opioids and opioid combinations were expanded from 4 tablets daily to 6 tablets daily. See below:

- Hydromorphone 2mg and 4mg tablets
- Oxycodone 5mg and 10mg tablets
- Acetaminophen/codeine tablets
- Acetaminophen/hydrocodone tablets
- Acetaminophen/oxycodone tablets

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## 22-71 Medication Therapy Management Reimbursement

Effective July 1, 2022, members may receive face-to-face Medication Therapy Management (MTM) services provided by a Medicaid enrolled pharmacist in an outpatient setting.

Pharmacists shall be licensed in the state of Utah and will need to enroll as a provider with Utah Medicaid to provide these services. Additional information on how to become a Medicaid provider can be found here: <https://medicaid.utah.gov/become-medicaid-provider/>.

MTM services will be covered for Medicaid enrolled adult and pediatric eligible members. Medicaid members may receive one initial MTM service and three follow-up services per calendar year. Medicaid members must be taking at least three medications to treat or prevent at least one chronic disease. Medicaid members cannot be eligible for Medicare Part D to receive these services.

Pharmacies may receive reimbursement for MTM services when billed with the following CPT codes:

CPT Code	Description	Reimbursement
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient	\$53.48
99606	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient	\$32.94
99607	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes	\$16.68

Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup. For a full description of the MTM program, please see the [Utah Medicaid Pharmacy Resource Library](#).

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## 22-72 P&T Committee Updates

The Pharmacy and Therapeutics (P&T) Committee reviewed Colony Stimulating Factors in May 2022. Committee recommendations regarding updates to the Preferred Drug List (PDL) go into

effect with the July 2022 PDL. Minutes for P&T Committee meetings can be found at <https://medicaid.utah.gov/pharmacy/pt-committee>.

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## 22-73 Apnea Monitors

The Medicaid contract for apnea monitors with Apria Healthcare, LLC expired on June 30, 2022, and will not be renewed. Effective July 1, 2022, any eligible enrolled Medicaid providers may supply medically necessary apnea monitors to members following the policy guidelines found in the [Medical Supplies and Durable Medical Equipment](#) provider manual and the [Coverage and Reimbursement Lookup tool](#).

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## 22-74 Nutritional Services

The Medical Supplies and Durable Medical Equipment Provider Manual has been updated to reflect the current coverage of medical foods and enteral formulas and to provide clarification for providers concerning coverage of medical foods and enteral formulas for members with dual eligibility for Medicaid and the Utah Women, Infants and Children (WIC) nutrition program. In addition, clarification has also been provided concerning coverage of medical foods and enteral formulas for the treatment of inborn errors of metabolism.

### 8-9 Nutritional Services

Medical foods, enteral formula, and parenteral formula are covered services when medically necessary. When reporting or requesting medical foods or enteral formula, providers must ensure the appropriate HCPCS code is used and is listed as covered in the [Coverage and Reimbursement Code Lookup](#). Medicaid uses the [Pricing Data Analysis and Coding \(PDAC\)](#) to ensure the appropriate HCPCS code is requested for each product.

As a primary payor to the Utah Women, Infants and Children (WIC) Program, Medicaid covers medically necessary nutritional services. When nutritional services are non-covered, providers are encouraged to direct members to WIC when the member meets the criteria for receiving WIC benefits. Pregnant members and children younger than five years of age are eligible for the WIC program.

Medical foods and enteral formulas require prior authorization. Quantity limits control the associated supplies and equipment.

Requests for enteral formula and medical foods must include the following documentation:

- A physician's order includes:
  - Diagnosis(es)
  - Product name
  - Total daily prescribed intake amount (e.g., ml, gram, etc.)
  - Daily frequency of ingestion
  - Duration or period the product is to be used (e.g., days, weeks, months, etc.)
  - Height and weight of the member
    - History regarding significant changes should be included.
- Documentation supporting medical necessity
  - If less expensive nutritional products are available, documentation to justify the costlier product.

### 8-9.2 Total Nutrition by Enteral Tube

Total nutrition by enteral tube feeding is covered when a member receives 90% or more of their daily nutritional requirements via an enteral tube. Members weaning from total enteral tube feedings are covered for three months and then transition to the supplemental enteral nutrition policy.

Enteral formula is non-covered for members under one year of age. An exception to this policy is found under chapter 8-9.4, *Inborn Errors of Metabolism*

### 8-9.3 EPSDT Oral and Supplemental Enteral Nutrition:

EPSDT eligible members requiring oral nutrition or supplemental enteral nutrition requires the member has one of the following medical conditions:

- Acquired Immune Deficiency Syndrome (AIDS),
- Malnutrition/Malabsorption because of a stated primary diagnosed disease and be in a wasting state
  - Have a Weight for Length (WFL)  $\leq$ 5th percentile for three years of age or under
  - Body Mass Index (BMI)  $\leq$ 5th percentile (ages 4-17)
  - BMI  $\leq$ 18.5 percentile (ages 18-20)
  - BMI  $\leq$ 25 percentile with an unintentional weight loss of five percent in one month, seven and a half percent in three months, or 10 percent in six months
- Metabolic Disorders requiring a specialized nutrition product
- Cancer
  - Receiving chemotherapy or radiation therapy
  - Up to 3 months following completion of chemotherapy or radiation therapy
- Chronic Renal Failure
- Decubitus Pressure Ulcers
  - Stage three or greater
  - Stage two with documentation that member is malnourished

- Maintenance patients with an increase of less than 10 BMI percentile points or an increase of less than 2 BMI in the past year

Failure to thrive and calorie packing options are non-covered services as well as medical foods or enteral formula used to treat inadequate growth rate or weight gain.

Oral or supplemental enteral nutrition is non-covered for adults 21 years of age or older except for members with inborn errors of metabolism. Refer to chapter 8-9.4, Inborn Errors of Metabolism, for additional information.

### 8-9.4 Inborn Errors of Metabolism

Enteral formula and medical foods for the treatment of inborn errors of metabolism are covered services. Both services are covered for members under one year of age. Reporting of these services is limited to the following:

- Members 21 years of age or older should report the following code regardless of delivery method.
  - B4157 - *Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit*
- EPSDT members receiving enteral formula or medical foods for the treatment of inborn errors of metabolism are reported with the following:
  - B4162 - *Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit*
  - S9435- *Medical foods for inborn errors of metabolism.*

Specific medical food coverage information is found in the [Coverage and Reimbursement Code Lookup](#).

## 22-75 Personal Care Services

The Personal Care Services provider manual has been updated to reflect the following changes:

- Restructuring of the manual to align with other Medicaid provider manuals.
- Removal of language specifying the services a personal care aide can perform and instead reference the [Tasks an Unlicensed Individual May Perform Without Delegation](#) published by The Division of Occupational and Professional Licensing (DOPL)

- Updating the definitions for home health aide, personal care aide, and certified nursing assistant (CNA) to:
  - Certified Nurse Aide (CNA): As stated in [Utah Administrative Code Rule R432-45](#): A "Certified nurse aide" means any person who completes a nurse aide training and competency evaluation program (NATCEP) and passes the state certification examination. CNAs are required to practice within the parameter of their training and certifications.
  - Home Health Aide (HHA): an individual who meets federal and State of Utah requirements of a home health aide, including those outlined in 42 CFR [484.80](#) and [440.70](#), Utah Administrative Code [R414-14](#) and [R432-700](#) (22)(23), and [R432-725](#).
  - Personal Care Aide: an individual who meets federal and State of Utah requirements for personal care aide services, including 42 CFR [440.167](#), [484.80\(i\)](#) Administrative Code [414-38](#), [432-700-23](#), and [R432-725-14](#).
- A nurse's assessment and reassessments for personal care services no longer require the appending of the "SE" modifier.

## 22-76 Dental Services Updates

### Posterior Resin-Based Composite Restorations

Effective July 1, 2022, Medicaid covers posterior resin-based composite restorations for EPSDT, Pregnant, Aged, Blind/Disabled, and Targeted Adult Medicaid (TAM) members undergoing treatment for substance use disorders. The Utah Administrative Code Rule R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia is in the process of being updated with this information.

The following resin-based composite restoration CDT codes have been opened for coverage:

- D2391 - *Resin-based composite - one surface, posterior; Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure*
- D2392 - *Resin-based composite - two surfaces, posterior two surfaces*
- D2393 - *Resin-based composite - three surfaces, posterior three surfaces*
- D2394 - *Resin-based composite - four or more surfaces, posterior four and + surfaces*

Providers are encouraged to reference the [Coverage and Reimbursement Lookup Tool](#) for additional information concerning these codes.



## Crown Coverage

Effective July 1, 2022, Medicaid covers porcelain dental crowns for EPSDT and Pregnant Members. Services are covered for permanent teeth only. Dental crown services for Aged, Blind/Disabled, and Targeted Adult Medicaid (TAM) members undergoing treatment for substance use disorders continue to be provided by the University of Utah School of Dentistry (UUSOD) and their network. The Utah Administrative Code Rule R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia is in the process of being updated with this information.

The following dental crown CDT codes have been updated:

- D2740 – *crown – porcelain/ceramic*
- D2750 – *crown – porcelain fused to predominantly base metal*
- D2751 – *crown – porcelain fused to predominantly base metal*
- D2752 – *crown – porcelain fused to noble metal*
- D2753 – *crown – porcelain fused to titanium and titanium alloys*
- D6740 – *retainer crown – porcelain/ceramic*
- D6752 – *retainer crown – porcelain fused to noble metal*

Providers are encouraged to reference the [Coverage and Reimbursement Lookup Tool](#) for additional information concerning these codes.

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## 22-77 Transportation Services

The Medical Transportation Services manual, Chapter 1, *Non-Emergency Medical Transportation Services*, has been updated to define the process a member must take to secure a UTA Transit Card. Members must have a UTA Transit Card in order to utilize Utah Transit Authority (UTA) services. Additionally, further information has been added to Chapter 1 that details the different options available for Non-Emergency Medical Transportation (NEMT), and the entire chapter was restructured.

The Medical Transportation Services manual, Chapter 1, *Non-Emergency Medical Transportation Services*, has been updated to include additional chapters and new information as follows:

- Chapter 1 *Non-Emergency Medical Transportation Services*: This chapter was restructured. No policy changes were added.
- Chapter 1-1 *Personal Transportation*: This chapter was restructured. No policy changes were added.
- Chapter 1-2 *Utah Transit Authority (UTA)*: This chapter was added to further define the process of obtaining UTA access

- Chapter 1-2.1 *UTA Transit Card*: This chapter was added to define the process a member must take to obtain a UTA Transit Card
- Chapter 1-2.2 *Paratransit*: This chapter was added to further define the process of obtaining paratransit access
- Chapter 1-3 *Cedar Area Transportation Services (CATS)*: This chapter was added to further define the process of obtaining CATS access
- Chapter 1-4 *ModivCare*: This chapter was added to further define the process of obtaining ModivCare access
- Chapter 1-6 *General Pathway for Securing Non-Emergency Transportation Services*: This chapter was added to meet the standard provider manual formatting. No policy changes were added.

## 22-78 Closed CPT Codes

Effective July 1, 2022, the following CPT codes will be closed in accordance with Medicaid policy: 84591, 87797, 87798, 80299, 87799, and 87899.

## 22-79 Code Updates

All new July 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.

0094A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sarscov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 50 mcg/0.5 ml dosage, booster dose
87913	Infectious agent genotype analysis by nucleic acid (dna or rna); severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), mutation identification in targeted region(s)
91309	Severe acute respiratory syndrome coronavirus 2 (sarscov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 50 mcg/0.5 ml dosage, for intramuscular use
C9094	Inj, sutimlimab-jome, 10 mg
C9095	Inj, tebentafusp-tebn, 1 mcg
C9096	Injection, filgrastim-ayow, biosimilar, (releuko), 1 microgram
C9097	Inj, faricimab-svoa, 0.1 mg

C9098	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose
D1708	Pfizer-biontech covid-19 vaccine administration - third dose
D1709	Pfizer-biontech covid-19 vaccine administration - booster dose
D1710	Moderna covid-19 vaccine administration - third dose
D1711	Moderna covid-19 vaccine administration - booster dose
D1712	Janssen covid-19 vaccine administration - booster dose
D1713	Pfizer-biontech covid-19 vaccine administration tris-sucrose pediatric - first dose
D1714	Pfizer-biontech covid-19 vaccine administration tris-sucrose pediatric - second dose
J0739	Injection, cabotegravir, 1 mg
J1306	Injection, inclisiran, 1 mg
J1551	Injection, immune globulin (cutaquig), 100 mg
J2356	Injection, tezepelumab-ekko, 1 mg
J2779	Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg
J2998	Injection, plasminogen, human-tvmh, 1 mg
J3299	Injection, triamcinolone acetonide (xipere), 1 mg
J9331	Injection, sirolimus protein-bound particles, 1 mg
J9332	Injection, efgartigimod alfa-fcab, 2mg
M0222	Intravenous injection, bebtelovimab, includes injection and post administration monitoring
M0223	Intravenous injection, bebtelovimab, includes injection and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency
Q0221	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 compromised
Q0222	Injection, bebtelovimab, 175 mg
Q4259	Celera dual layer or celera dual membrane, per square centimeter
Q4260	Signature apatch, per square centimeter
Q4261	Tag, per square centimeter

## 22-80 Attention: Targeted Case Management Providers

The *Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness* has been updated for July 1, 2022.

In Chapter 1-2, Target Group, the Community Transitions Waiver and the Limited Supports Waiver are added to the list of home and community-based waivers that include case management services.

In Chapter 1-3, Definitions, Centers for Medicare and Medicaid Services (CMS) is added and CMS is then referenced in Chapter 2-2, Non-Covered Services/Activities.

Effective July 1, 2022, the Utah Department of Health and the Utah Department of Human Services are merged to be the Department of Health and Human Services (DHHS). The Division of Integrated Healthcare (DIH) is the organizational unit in DHHS that administers the Medicaid program. Before July 1, 2022, this was the Division of Medicaid and Health Financing in the Department of Health. In Chapter 1-3, definitions of DHHS and the Division of Integrated Healthcare (DIH) are added and then used as applicable throughout the manual.

In Chapter 1-3, the definition of Prepaid Mental Health Plan (PMHP) is updated for consistency with other manuals and managed care plan contracts. The definitions of Non-Traditional Medicaid and Traditional Medicaid are removed as these terms are not used in the manual. To verify if a Medicaid member has Non-Traditional Medicaid or Traditional Medicaid, providers may refer to Chapter 6, 'Member Eligibility', of the Utah Medicaid Provider Manual, Section I: General Information, for information on tools providers can use to verify a Medicaid member's eligibility and type of coverage (Traditional Medicaid or Non-Traditional Medicaid). In Section I, providers may also refer to Chapter 1-9, Definitions, for the definitions of Non-Traditional Medicaid and Traditional Medicaid. Additional information on Non-Traditional Medicaid is also contained in Chapter 8-2.7 of Section I.

In Chapter 1-3, a definition for SUMH is added, which is the Office of Substance Use and Mental Health in the Division of Integrated Healthcare. Effective July 1, 2022, the Office of Substance Use and Mental Health (SUMH) replaces the Division of Substance Abuse and Mental Health (DSAMH) which was a division in the Department of Human Services. References to DSAMH are replaced with SUMH in Chapter 1-5, Targeted Case Management Training Curriculum.

In Chapter 1-4, Qualified Targeted Case Management Providers, in A. 3., the Department of Health is updated to be the Department of Health and Human Services.

In Chapter 1-6, Client Rights, A., clarification is made that reference is to the Utah Medicaid State Plan.

Chapter 1-7 is revised to reference both substance use disorder residential treatment programs of any size, and to reference mental health residential treatment programs.

Throughout the manual, minor revisions are made to refer to reporting services rather than billing services. Reporting services includes both providers billing services to Medicaid on a fee for service basis, and to Prepaid Mental Health Plans' and Utah Medicaid Integrated Care (UMIC) Plans' reporting of services through encounters.

Based on CMS clarification, assisting Medicaid members establish and maintain Medicaid eligibility does fall under activities necessary for the proper and efficient administration of the Medicaid State Plan. Therefore, in Chapter 2-1, Covered Services/Activities, 'other than Medicaid' is removed from B. 4, and in Chapter 2-2, Non-Covered Services/Activities, item I. is removed.

Providers can access the revised provider manual at <https://medicaid.utah.gov>.

If providers have questions, contact [Medicaidbh@utah.gov](mailto:Medicaidbh@utah.gov).

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## 22-81 Attention: Mental Health and Substance Use Disorder Providers

The *Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services* has been updated for July 1, 2022.

In Chapter 1-2, Definitions, the definition of Division of Medicaid and Health Financing (DMHF) is removed. Effective July 1, 2022, the Utah Department of Health and the Utah Department of Human Services are merged to be the Department of Health and Human Services (DHHS). The Division of Integrated Healthcare (DIH) is the organizational unit in DHHS that administers the Medicaid program. Before July 1, 2022, this was the Division of Medicaid and Health Financing (DMHF) in the Department of Health. Chapter 1-2, and other chapters of the manual as applicable, are revised accordingly.

Additionally, in Chapter 1-2, the definition CMS is revised slightly for clarity, and the definition of Prepaid Mental Health Plan (PMHP) is updated for consistency with other manuals and managed care plan contracts.

A definition for SUMH is also added, which is the Office of Substance Use and Mental Health in the Division of Integrated Healthcare. Effective July 1, 2022, the Office of Substance Use and Mental Health (SUMH) replaces the Division of Substance Abuse and Mental Health (DSAMH) which was a division in the Department of Human Services. References to DSAMH are replaced with SUMH in Chapter 2-12, Peer Support Services, and Chapter 2-15, Mobile Crisis Outreach Team.

Throughout the manual, minor revisions are made regarding reporting of services to Fee for Service (FFS) Medicaid, to state that services are 'reimbursed through FFS Medicaid'.

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 Chapter 2-17, Mental Health Treatment in Licensed Mental Health Residential Treatment Programs, in the 'Limits' section, #5 is revised for clarity. Also, in the 'Record' section of each chapter, #1 is revised for clarity.

In Chapter 2-16, Clinically Managed Residential Withdrawal Management (SAM Level 3.2-WM), in the 'Limits' section, #1 is removed. This limit had stated that prior to April 1, 2021, the provider of this service was limited to Volunteers of America. Reference to this limit is no longer needed.

In Chapter 2-18, Behavioral Health Receiving Centers, in the 'Who' section, clarification is made that a receiving center may also be a facility that is included under a hospital's license.

Throughout the manual, the term 'reporting' services is used consistently, rather than 'billing' services which was used in some instances. Reporting services includes both provider billing services to Medicaid on a fee for service basis, and to Prepaid Mental Health Plans' and Utah Medicaid Integrated Care (UMIC) Plans' reporting for services through encounters.

Corrections have also been made to consistently refer to Utah's 1115 Waiver as such.

Other minor non-substantive wording changes have been made for consistency throughout the manual.

Providers can access the revised provider manual at <https://medicaid.utah.gov>.

If providers have questions, contact [Medicaidbh@utah.gov](mailto:Medicaidbh@utah.gov).

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## 22-82 Vaccine Billing Guidance

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.



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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.

Vaccine Code	Vaccine Code Descriptor	Vaccine Administration Code(s)	Vaccine Manufacturer	Vaccine Name(s)	NDC 10/NDC11 Labeler Product ID (Vial)	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 (3rd dose) 0004A (Booster)	Pfizer	Pfizer-BioNTech COVID-19 Vaccine	59267-1000-1 59267-1000-01	1st Dose to 2nd Dose: 21 Days 2nd Dose to 3rd Dose (CDC recommended population[s] [e.g., immunocompromised]): 28 or More Days Booster: Refer to FDA/CDC Guidance
91305	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, trisucrose formulation, for intramuscular use	0051A (1st Dose) 0052A (2nd Dose) 0053A (3rd Dose) 0054A (Booster)	Pfizer	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] [e.g., immunocompromised]): 28 or More Days Booster: Refer to FDA/CDC Guidance
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, trissucrose formulation, for intramuscular use	0071A (1st Dose) 0072A (2nd Dose) 0073A (3rd Dose)	Pfizer	Pfizer-BioNTech COVID-19 Vaccine	59267-1055-1 59267-1055-01	1st Dose to 2nd Dose: 21 Days 2nd Dose to 3rd Dose (CDC recommended population[s] [e.g., immunocompromised]): 28 or More Days



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						Booster: Refer to FDA/CDC Guidance
91301	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5 mL dosage, for intramuscular use	0011A (1st Dose) 0012A (2nd Dose) 0013A (3rd Dose)	Moderna	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] [e.g., immunocompromised]): 28 or More Days
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	Moderna COVID-19 Vaccine	80777-273-10 80777-0273-10	Refer to FDA/CDC Guidance
91309	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/ 0.5 mL dosage, for intramuscular use	0094A (Booster)	Moderna	Moderna COVID-19 Vaccine	80777-275-05 80777-0275-05	Booster: Refer to FDA/CDC Guidance
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 <sup>10</sup> viral particles/0.5 mL 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/covid-19-immunizations-appendix-q-table.pdf>

Pharmacy Point of Sale claims:

Billing for reimbursement of a free product (no associated cost) including an admin 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”
  - Booster/Additional Doses: Submission Clarification Code of 7 “Medically Necessary” – defines as “Additional dose for targeted population, where days between additional dose and last dose of series is no less than the dose series time period”
- 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>