January 2024

Utah Department of Health & Human Services
Integrated Healthcare

MEDICAID INFORMATION BULLETIN

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

Unless otherwise noted, all changes take effect on January 1, 2024

24-01 Provider Enrollment Contracts

With the end of the Public Health Emergency (PHE) on May 11, 2023, Provider Enrollment will restart the auto-closure process in January of 2024 that was previously waived per 1135(b)(1)(B).

Per Utah Administrative Code R414-23-4, the Department may automatically close a provider contract for any of the following reasons:

(1) Failure to revalidate within the required five-year cycle as directed by 42 CFR 424.515.

(2) Expiration of professional license, or expiration of any license associated with the program for clinical laboratory improvement amendments (CLIA).

(3) Upon state or federal reporting of a deceased provider.

(4) Failure to bill Medicaid for one or more years without notification.

Providers who fail to complete their revalidation timely, will be closed at the end of their revalidation cycle. For questions or concerns, contact providerenroll@utah.gov.

24-02 Non-Traditional Benefits Changes for Members

Effective January 1, 2024, members previously on the Non-Traditional Medicaid benefit plan will have the same benefits of the Traditional Medicaid benefit plan.

With the renewal of Utah's Medicaid Reform 1115 Demonstration (formerly known as the "Primary Care Network Demonstration Waiver"), the Centers for Medicare and Medicaid Services directed Utah Medicaid to eliminate the disparity between the Traditional Medicaid benefit plan and Non-Traditional Medicaid benefit plan.

The following Medicaid programs will now have the Traditional Medicaid plan benefits:

- Parents on Adult Expansion Medicaid or members receiving Parent/Caretaker Relative (PCR) Medicaid
- 12-month Transitional Medicaid
- 4-month Transitional Medicaid
- Family Medically Needy Program (Spenddown)

The following changes will be made to Non-Traditional benefits:

1. Benefit packages will be aligned so the entire Adult Expansion population has the same state plan benefits as the Traditional population.
2. All language addressing the benefit plan changes has been removed or updated in systems, documents, and webpages.
3. Language in the Medicaid provider manuals and the Coverage and Reimbursement Lookup Tool will remain until January 1, 2025, so that providers have access to the information for billing purposes.
4. The list below is a summary of the benefit changes. A benefit comparison chart, detailing benefit change information, is available online.
    a. Non-Emergency Medical Transportation (NEMT)
    b. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services available for eligible PCR 19 and 20-year-old members
    c. Additional physical therapy and occupational therapy visits
    d. Speech services
    e. Audiology services
    f. Medical supplies and medical equipment
    g. Long term care

Members may call a Health Program Representative (HPR) with questions at (801) 538-6155 or 1-800-662-9651. The following online resources are also available:

Medicaid website: https://medicaid.utah.gov/

Medicaid Member Guide: https://medicaid.utah.gov/medicaid-benefits/

Non-Emergency Transportation and UTA Transit Card information: https://medicaid.utah.gov/non-emergency-transportation/

View benefits, eligibility status, health plan details, and request a UTA Transit Card at MyBenefits: http://mybenefits.utah.gov

24-03 Ending of the Non-Traditional Medicaid Program

On December 31, 2023, the Non-Traditional Medicaid (NTM) benefit plan ended, and members formerly enrolled in the NTM plan have the same benefits as the Traditional benefit plan starting on January 1, 2024. Information regarding NTM services will remain in the Utah Medicaid provider manuals until January 1, 2025, for reporting and eligibility purposes.

Information regarding the NTM benefit plan will remain in the following manuals until 1/1/2025:

- Section I: General Information
  - Chapter 1-2 Overview of the Medicaid Program
  - Chapter 1-9 Definitions
  - Chapter 8-2.7 Non-Traditional Medicaid Plan
  - Chapter 8-2.8 EPSDT Medical Services for Individuals Ages Birth through 20
- EPSDT Services
  - Chapter 1 EPSDT Services
  - Chapter 1-2 Expanded Services
- Physical Therapy and Occupational Therapy Services
  - Chapter 9-2.1 Physical Therapy Limitations
  - Chapter 9-2.2 Occupational Therapy Limitations

The references to the Non-Traditional Medicaid Program will be removed from the following areas of the Utah Medicaid provider manuals:

- Section I: General Information
  - Chapter 1-6 Medicaid Member Card
  - Chapter 14 Acronyms
- Targeted Case Management for Individuals with Serious Mental Illness
  - Chapter 1-3 Definitions
- Hospital Services
  - Resource Table
- Physician Services
  - Resource Table

24-04 Cost Sharing and Copays

During the transition of the Medicaid claims processing system in April 2023, Medicaid Management Information System (MMIS) to Provider Reimbursement Information System for Medicaid (PRISM), some services were inadvertently changed to no longer require a copayment while others now required copayment. To address this matter, the unintended changes to copayment requirements will be restored in PRISM to the policy in place in April of 2023.

Policy associated with copayments is found in the Medicaid State Plan under Attachments:

- 4.18-A page #1 - Charges Imposed on Categorically Needy
- 4.18-C page#1 - Charges Imposed on Medically Needy for Services
- 4.18-H page#1 - Emergency Room Co-payment for Non-emergency Care

Members and providers can use pages 23-24 of the *Utah Medicaid Member Guide* for additional information related to copays at https://medicaid.utah.gov/Documents/pdfs/Medicaid_Member_Guide.pdf.

Medicaid policy regarding copayments outlines the following types of services as requiring copayment:

- Outpatient hospital services
- Physician services
    - Physician visits, to include other licensed non-physician practitioners.
    - Podiatric visits
    - Physical therapy, occupational therapy, and speech language pathology
- Inpatient hospital stays
- Pharmacy services
- Non-emergency services received in the emergency department.
- Chiropractic services
- Vision services

Services excluded from copayment:

- Emergency services
- Family planning services. This includes contraceptives and other related pharmaceuticals.
- Provider preventable conditions (PPC) also known as hospital acquired conditions (HAC)
- Preventive services. These include wellness checks, vaccinations, and health education.

- Tobacco cessation
- Pregnancy related services
- Dental services
- Outpatient mental health and substance use disorder services
- Nursing home stays
- Laboratory and radiology services

It should be noted that certain member populations enrolled in Medicaid are excluded from the copay requirements. Providers can determine if an enrolled member is exempt from copayments using the Eligibility Lookup Tool.

24-05 Telephonic Medication Therapy Management Services

Effective January 1, 2024, Medicaid members may receive telephonic Medication Therapy Management (MTM) services provided by a Medicaid enrolled pharmacist in an outpatient setting.

Pharmacists must 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 at 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
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
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
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
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

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.

24-06 DUR Board Updates

In December 2023, the Drug Utilization Review (DUR) Board met to review antidepressants used in children and adolescents. In January 2024, the DUR Board met to review Lantidra (donislecel). The review included prescribing information, place in therapy, and prior authorization.

DUR Board meeting minutes are posted on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/drug-utilization-review-board/. DUR Board meeting recordings can be found on the YouTube Channel @dmhf_webdohdhhs2.

24-07 Morphine Milligram Equivalents (MME) Factor for Hydromorphone, Tramadol, and Methadone

In accordance with the CDC Clinical Practice Guideline for Prescribing Opioids for Pain—United States, 2022|MMWR, effective December 1, 2023, the MME values for oral hydromorphone, methadone, and tramadol have been updated. Other policies regarding MME and quantity limits remain unchanged.

Opioid	Current MME Factor	MME Factor Effective 12/1/2023
Hydromorphone	4	5
Methadone	3	4.7
Tramadol	0.1	0.2

24-08 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:
❑ 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.

24-09 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.

24-10 Respiratory Syncytial Virus (RSV)

Beginning January 1, 2024, CPT Code 87634 *Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique* will be expanded to include coverage for all age groups.

24-11 Monitoring Hemoglobin A1C

Medicaid will open the following, Category II CPT codes for hemoglobin A1c monitoring for all Medicaid members. These codes are for reporting purposes only and have no associated payment rate. This update will take effect January 1, 2024.

3044F *Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)*
3046F *Most recent hemoglobin A1c level greater than 9%*
3051F *Most recent hemoglobin A1c level greater than or equal to 7% and less than 8%*
3052F *Most recent hemoglobin A1c level greater than or equal to 8% and less than or equal to 9%*

24-12 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 were implemented on July 1, 2022. These updates primarily affect the following subsets:

Imaging: Abdomen and Pelvis

Bariatric or Metabolic Surgery

Spinal Surgery including Decompression or Fusion

Hysterectomy, Bilateral Salpingooophorectomy (BSO) or Salpingectomy

Hysteroscopy, Dilation and Curettage, Radical Hysterectomy

Salpingooophorectomy

Exosterectomy, Bunionectomy

Spinal Cord Stimulator (SCS) Insertion

24-13 Postpartum Days Extension and Coverage for Members

Effective January 1, 2024, Utah Medicaid and the Children's Health Insurance Program (CHIP) will extend postpartum coverage from 60 days to 12 months. This coverage aims to provide comprehensive care for new mothers during the critical postpartum period. This policy change affects some members that were recently pregnant. The following outlines the changes:

Automatic Extension for Current Members: Medicaid and CHIP members who are currently pregnant or in their 60-day postpartum period will automatically receive an extension to 12 months of coverage. This will also apply to members whose 60-day postpartum coverage was

due to end on December 31, 2023. This will involve adjustments to certification periods to accommodate the extended coverage.

Coverage for Members Who Transitioned Programs: Medicaid members who were pregnant at any time in 2023 and have since transitioned to a Medicaid program without pregnancy benefits (such as Adult Expansion or Targeted Adult Medicaid) will be moved back to a program that offers pregnancy benefits. This ensures they are eligible to receive the remaining portion of the 12 months of postpartum coverage. This may result in changes to the certification period and managed care plan to accommodate this change.

Reapplication for Members who Closed: Medicaid and CHIP members whose coverage ended before December 31, 2023, due to a change in pregnancy status, and who were covered in 2023, are eligible to reapply for the extended postpartum benefits. However, this option is not available to individuals who lost coverage due to moving out of state.

The State Plan, Attachment 3.1-A & B, has been updated to reflect a policy change that extends postpartum coverage from the end of the month in which the 60th day falls after delivery to the end of the 12th month after the pregnancy ends. In addition, the following sections have been updated in the Utah Administrative Rules, Section I: General Information Provider Manual, and Physician Services Provider Manual to reflect this policy change.

R414-1. Utah Medicaid Program

R414-1-6. Services Available
(2) The following services provided in the Utah Medicaid State Plan are available to both the categorically needy and medically needy:
(bb) extended services to pregnant women, pregnancy-related services, postpartum services for 12 months, and additional services for any other medical conditions that may complicate pregnancy.

R414-49. Dental, Oral, and Maxillofacial Surgeons and Orthodontia

R414-49-4. Pregnant Members
This section defines the scope of dental services available to pregnant members who are eligible for Traditional Medicaid. Dental services extend to the end of the 12th month after the

pregnancy ends.

R414-308-6. Eligibility Period and Reviews
(8) The eligibility period ends on:

(e) for the pregnant woman program, the last day of the month 12 months after the pregnancy ends, except that for pregnant woman coverage for emergency services only, eligibility ends on the last day of the month in which the pregnancy ends; or

The following provider manuals are updated to reflect this policy change as follows:

Section I: General Information Provider Manual

8-4.3 Other Covered Services
26. Extended services to pregnant women including pregnancy-related and postpartum services to the end of the 12th month in which the pregnancy ends, including additional services for any other medical conditions that may complicate pregnancy with increases of service.

Physician Services Provider Manual

8-11 Maternity Services
Maternity Services are available as pregnancy-related or postpartum services to the end of the 12th month after the pregnancy ends.

8-11.1.3 Postpartum Care
Postpartum care includes hospital and office visits following vaginal or cesarean section delivery, a six-week postpartum visit, and obtaining a pap smear. Medicaid covers postpartum services to the end of the 12th month after the pregnancy ends. Family planning services are covered separately.

8-11.6 Extended Services for Pregnant Women
Extended services are available as pregnancy-related or postpartum services to the end of the 12th month after the pregnancy ends.

24-14 Mental Health Evaluations and Psychological Testing for Physical Health Purposes

Medicaid providers are reminded that mental health evaluations and psychological testing that are performed for physical health purposes (including before medical procedures, or to diagnose intellectual or developmental disabilities or organic disorders) are carved out of managed care plans. Providers should report these services to fee for service Medicaid using the UC modifier.

This carve-out policy does not apply to:

- psychiatric consultations during a physical health inpatient hospitalization;
- developmental screenings performed as part of an EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) service; and
- HOME (Healthy Outcomes Medical Excellence) enrollees

Providers may refer to the following chapters of the Utah Medicaid provider manuals for additional information:

Section I: General Information

- 2-6 MCE Carve-Out Services

Autism Spectrum Disorder Services

- 8-2 General ASD Diagnostic Services
- 11-3 Mental Health Evaluations and Psychological Testing

Physician Services Manual

- 8-15.1 Evaluations and Psychological Testing

Rehabilitative Mental Health and Substance Use Disorder Services

- 1 - 3 Medicaid Behavioral Health Service Delivery System

    - Exceptions to Prepaid Mental Health Plan and UMIC Plan Coverage
        - Evaluations
- 1 - 6 Evaluation
- 4 Procedure Codes and Modifiers

24-15 Place of Service (POS) 27 Opened

Beginning October 1, 2023, CMS created a new place of service (POS) 27 for the treatment of unsheltered individuals. Per CMS, the definition of POS 27 is "Outreach Site/Street," which describes a "non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals."

Medicaid has aligned with CMS by opening POS 27 with an effective date of October 1, 2023.

24-16 Recalled Durable Medical Equipment (DME)

The Utah Medicaid Medical Supplies and Durable Medical Equipment provider manual has been revised to include coverage information for DME recalled items.

8-15.6 Medical Device Recalls

In the event of a medical device recall, the DME provider shall coordinate with the member and the manufacturer to return the defective DME and replace the item as needed.

If the medical device is a continuous rental item, the device should be replaced with a suitable device that will meet the medical needs of the member.

If the medical device has been purchased, either as a one-time purchase or after a 12-month capped rental period, the DME provider is responsible for the following actions:

• Register the device for repair or replacement

• Furnish a replacement device during the period required for the manufacturer to repair or replace the device; and

• Replace the equipment at no charge to the Medicaid program or member if the equipment doesn't last for the entire 5-year reasonable useful lifetime

24-17 Non-Emergency Medical Transportation

The Utah Medicaid Medical Transportation Services provider manual has been updated to align with the current non-emergency medical transportation contract with Modivcare. The following updates have been made:

- Remove the restriction in chapter 1-4 *Modivcare* pertaining to members being unable to utilize Modivcare NEMT for pharmaceutical trips
- Update language in chapter 1-4 *Modivcare* from "medical provider" to "primary care provider" as the individual who needs to complete the mobility evaluation for use of Modivcare services
- Update any use of ModivCare to Modivcare
- Grammatical changes as necessary to chapter 1-4 *Modivcare*

24-18 Recreational Therapy

Beginning January 1, 2024, individuals licensed to provide recreational therapy services according to Utah Code Annotated 58-40 may report recreational therapy services delivered to Medicaid members. Providers must follow the policy outlined in the Utah Medicaid Rehabilitative Mental Health and Substance Use Disorder Services provider manual, Chapter 2-

19, "Recreational Therapy" and enroll as a Medicaid provider as outlined on https://medicaid.utah.gov/become-medicaid-provider/.

Recreational therapy services are covered under the behavioral health managed care plans; Utah Medicaid Integrated Care (UMIC) plans, Prepaid Mental Health Plans (PMHP), and the Healthy Outcomes Medical Excellence (HOME) program.

For members not in managed care plans, recreational therapy services are covered under fee for service Medicaid.

Chapter 2-19 Recreational Therapy

Recreational Therapy means a treatment service designed to restore, remediate, and rehabilitate a member's level of functioning that utilizes activity-based interventions to address the assessed needs of members with illnesses and/or disabling conditions, as a means to psychological health, recovery, and well-being.

Qualified Providers:

Individuals licensed to provide recreational therapy services practicing within the scope of practice according to Utah Code Annotated 58-40, Recreational Therapy Practice Act.

Limits:

Recreational therapy services must be referred by a mental health therapist as defined in Utah Code 58-60-102 and are limited to a general acute hospital, youth residential treatment facility, behavioral health program, intermediate care facility, assisted living facility, skilled nursing facility, psychiatric hospital, and mental health agency.

Procedure Code and Unit of Service:

- H2032 - *Activity therapy, per 15 minutes* for recreational therapy interventions, assessments, and treatment plan formulation
    - Use the HQ modifier with H2032 for group interventions

Record:

Documentation must include:

1. date, start and stop time, and duration of the service,
2. setting in which the service was rendered,
3. specific service rendered (i.e., assessment),
4. signature and licensure of the individual who rendered the service

24-19 Hormone Therapy for Gender Dysphoria Prior Authorization

Effective January 1, 2024, in accordance with the S.B.16 (Transgender Medical Treatments and Procedures) and Utah Code 58-1-603(3)-(5), healthcare providers and mental health professionals who treat gender dysphoria in minors are required to complete at least 40 hours of education related to transgender healthcare for minors from an approved organization and receive the Transgender Treatment Certification issued by the Utah Division of Professional Licensing (DOPL).

As a result, Utah Medicaid has updated the Hormone Therapy for Gender Dysphoria Prior Authorization criteria for the treatment of a minor. Providers can find the prior authorization at https://medicaid.utah.gov/pharmacy/prior-authorization/.

24-20 Whole Genome Sequencing (WGS)

Whole Genome Sequencing (WGS) services align with the emergency criteria outlined in Section I: General Information provider manual, chapter 10-3.3 *Medical Emergency* and R414-1-2(10). Consequently, these services are eligible for retroactive authorization, provided they comply with the policy defined in the Physician Services Manual, chapter 8-12.10.4 *Next Generation Sequencing (NGS)*.

Prior authorization requests for emergency services must comply with retroactive prior authorization policy requirements as detailed in Section I: General Information provider manual, Chapter 10-3 *Retroactive Authorization*, which includes the following guidance:

Services provided must meet all Medicaid criteria for coverage and providers must:

- Complete the appropriate prior authorization request form,
- Provide documentation supporting the medical necessity of the services; and
- Include documentation describing why the provider delivered the service(s) without authorization

A provider must request retroactive authorization within 180 days following delivery of services, or Medicaid will deny coverage of the services.

Providers should request authorization, whenever possible, prior to the service being rendered.

24-21 Associate Physician

The Physician Services provider manual has been updated to add subchapter 1-1.1, Associate Physician, which states the following:

An associate physician, as defined in Utah Code 58-67-302.8 *Restricted licensing of an associate physician*, may enroll as a Medicaid provider.

The associate physician may provide medically necessary primary care services, consistent with the clinician's skill, training, education, and competence, to Medicaid members. Associate physician services must be performed under the direction of a collaborating physician as defined in Utah Code 58-67-807, *Collaborative practice arrangement*.