May 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 May 1, 2024

24-28 Phone System Downtime Change

Utah Medicaid has changed its phone system downtime schedule. Effective April 8, 2024, many of the Utah Medicaid call center groups began a new schedule where phone downtime is on Tuesdays from 8 - 11 am instead of Thursdays.

The following groups have not moved to the Tuesday phone downtime schedule:

- Pharmacy Prior Authorization
- Restriction Program
- Health Program Representatives

The PRISM system is available so providers can still access this information, as well as verify member eligibility online.

24-29 2024 Medicaid Statewide Provider Training

Utah Medicaid will be offering the 2024 statewide provider training in an online live webinar format. This year we are hosting a variety of trainings covering specific topics. Providers can sign up to attend multiple trainings. For each training, except UOIG, we will have a ten-minute presentation then will open it up for questions. As applicable based on the training, staff will present in the PRISM training environment to show steps and processes.

To register for the 2024 training, please complete the Google Form.

Previous statewide provider trainings are available on the Medicaid website. The 2024 trainings will be posted after the trainings conclude.

The following dates and times are scheduled for the 2024 Medicaid Statewide Provider Training. The duration of the training may be longer or shorter than indicated based on the number of questions asked during the training.

Date	Time (MST)	Training
Tuesday, August 13	10:00 -12:00	Claims and Billing
Wednesday, August 14	10:00 -12:00	Provider Enrollment
Thursday, August 15	12:00 -1:00	Pharmacy Program
Tuesday, August 20	10:00 - 11:30	Healthcare Policy for Hospitals, Outpatient, and Physicians
Wednesday, August 21	10:00 - 11:30	Healthcare Policy for Behavioral Health Providers
Thursday, August 22	10:00 - 11:30	Healthcare Policy for DME, Home Health, Private Duty Nursing, and Personal Care Service Providers
Tuesday, August 27	10:00 - 11:00	Managed Care
Wednesday, August 28	10:00 – 11:00	Dental Providers (Fee-for-service and Managed Care)
Thursday, August 29	10:00 – 11:00	Prior Authorization
Tuesday, September 3	10:00 – 11:30	Utah Office of Inspector General (UOIG)

24-30 Balance Billing Medicaid Members Prohibited

Utah Medicaid has experienced an increase in balance billing referral cases to the Utah Office of Inspector General (UOIG). Per the Utah Medicaid Provider Agreement, Section 1, 3-4, Medicaid providers are prohibited from billing patients. A provider who accepts a member as a Medicaid patient must accept the Medicaid or state payment as reimbursement in full. A provider who accepts a member enrolled by Medicaid in an MCO must accept the payment from the plan as reimbursement in full. If a member has both Medicaid and coverage with a responsible third party, do not collect a copayment that is usually due at the time of service. The provider may not bill the member for services covered by Medicaid, Hospital Presumptive or Baby Your Baby,

or by an MCO. The payment received from Medicaid or from an MCO is intended to include any deductible, co-insurance, or copayment owed by the Medicaid member. In addition, the administrative cost of completing and submitting Medicaid claim forms are considered part of the services provided and cannot be charged to Medicaid members.

24-31 House Bill 501 Impact on Claims

HB 501 from the 2024 General Session introduces federally mandated changes to the processes health insurance entities use to handle Medicaid claims. Effective May 1, 2024, the law requires that health insurance entities "respond within 60 days to any inquiry by the department regarding a claim for payment for any health care item or service…" It also prohibits health insurance entities from denying a claim submitted by the department or its contractor for an item or service based solely on the lack of prior authorization under the third-party payer's rules.

The bill requires the Department of Health and Human Services (DHHS) to make rules to "encourage health care providers to seek prior authorization when necessary from a health insurance entity that is the primary payer before seeking third-party liability through Medicaid." DHHS is in the process of making these rules and providers should watch for updates in the State Bulletin in May or June for an anticipated July 8, 2024, effective date.

24-32 FQHC and RHC Provider Enrollment

To ensure Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are properly reimbursed, effective May 1, 2024, FQHC/RHC providers will only be allowed to enroll as an FQHC or RHC. For an FQHC/RHC that may also have other taxonomies in its current provider enrollment, the other taxonomies will be end dated effective April 30, 2024.

This will limit enrollment to the PAC, specialty and subspecialty codes listed below.

Federally Qualified Health Center (FQHC)

PAC:	066-Federally Qualified Health Center (FQHC)
Billing Taxonomy on Claim:	261QF0400X
Specialty:	B609-Clinic
Subspecialty:	C732-Federally Qualified Health Center (FQHC)

Rural Health Clinic (RHC)

PAC:	067-Rural Health Clinic (RHC)
Billing Taxonomy on Claim:	261QR1300X
Provider Specialty:	B609-Clinic
Provider Subspecialty:	C894-Rural Health

As claims are submitted, the correct taxonomy should be used for proper adjudication.

If you have any questions, please contact Provider Enrollment. Contact information is found at https://medicaid.utah.gov/become-medicaid-provider/.

24-33 Urine Drug Screening

Effective July 1, 2024, urine drug screening will be covered on a rolling 12-month period instead of a calendar year. For additional information, see the Physicians Services provider manual, Chapter 8-12.5 *Urine Drug Screening*.

24-34 Wellness Visits

Effective March 1, 2024, wellness visits will be covered on a rolling 12-month period instead of a calendar year. For additional information, see the Physicians Services provider manual, Chapter 8-21 *Wellness Visits Services*.

24-35 Urban Indian Organization Clarification

Effective May 1, 2024, policy clarification has been given to Urban Indian Organizations (UIO) in Chapter 6 *Billing* of the Indian Health Services provider manual. It states that UIOs are excluded from the same reimbursement methodologies as Indian Health Service and Tribal 638 facilities.

24-36 Magnetic Resonance Imaging (MRI) Prior Authorization Removal

Beginning May 1, 2024, the following MRI codes will no longer require prior authorization:

72141 *Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material*
72142 *Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; with contrast material(s)*
72146 *Magnetic resonance (e.g., proton) imaging, spinal canal and contents, thoracic; without contrast material*
72147 *Magnetic resonance (e.g., proton) imaging, spinal canal and contents, thoracic; with contrast material(s)*
72148 *Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material*

72149 *Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; with contrast material(s)*
72156 *Magnetic resonance (e.g., proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical*
72157 *Magnetic resonance (e.g., proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic*
72158 *Magnetic resonance (e.g., proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar*

Providers are encouraged to refer to the Coverage and Reimbursement Lookup Tool for additional policy information related to these services.

24-37 Carrier Screenings and In-Vitro Fertilization

Beginning May 1, 2024, genetic screening and in-vitro fertilization will be opened for coverage as fee-for-service carve-out services for members with the following qualifying conditions:

- cystic fibrosis;
- spinal muscular atrophy;
- Morquio Syndrome;
- myotonic dystrophy; or
- sickle cell anemia

Members who qualify for genetic carrier screening and IVF services must:

- Be an enrolled Medicaid member;
- Be diagnosed by a physician as having a genetic trait associated with a qualified condition; and
- Intends to get pregnant with a partner who is also diagnosed by a physician as having a genetic trait associated with the same qualified condition as the member.

The Physician Services provider manual will be updated to include the following information:

Physician Services, Chapter 8-22 Genetic Carrier Screening and In vitro Fertilization

Genetic carrier screening and in vitro fertilization (IVF) services are available for certain Medicaid eligible individuals that meet the requirements listed below. This benefit is intended to reduce the likelihood that Medicaid beneficiaries who have a serious inherited disorder, or who carry a genetic trait associated with a serious inherited disorder, pass the disorder on to their children.

Eligibility: Genetic screening and IVF services are a covered benefit for eligible members who meet the following criteria:

- Ages 18 through 35
- Has been diagnosed, by a physician, as having a genetic trait associated with one of the following conditions:
    - cystic fibrosis;
    - spinal muscular atrophy;
    - Morquio syndrome;
    - myotonic dystrophy; or
    - sickle cell anemia
- Intends to reproduce with a partner who has been diagnosed by a physician as having a genetic trait associated with the same qualified condition as the individual, or
- One partner has been diagnosed by a physician as having myotonic dystrophy and intends to reproduce.

Genetic screening and IVF services require prior authorization. Supporting documentation of the criteria listed above is required to be submitted with each prior authorization request.

Covered Services

Carrier Screening: Carrier screening analysis for a known familial mutation may be considered medically necessary for qualifying conditions when:

- The member and/or the member's reproductive partner is considering pregnancy, and
    - The member has a close relative with a known pathogenetic or likely pathogenetic variant associated with a disorder; or
    - The member's reproductive partner is a carrier for a genetic disorder; or

    - The member or the member's reproductive partner are members of a population known to have a carrier rate of 1% or higher for a genetic condition; or
    - The member or the member's reproductive partner has a first or second degree relative who is affected with a genetic disorder, including parents, siblings, children, grandparents, aunts, uncles, nieces, nephews, grandchildren, and half siblings.
- Qualified conditions for carrier screening include:
    - cystic fibrosis;
    - spinal muscular atrophy;
    - Morquio syndrome; or
    - sickle cell anemia
- Carrier screening analysis for a known familial mutation is considered investigational for all other indications.
- Carrier screening services are a covered benefit for enrolled eligible Medicaid members only and do not extend to ineligible reproductive partners.

IVF Services

IVF services may include the following:

- Stimulation of ovulation
- Monitoring of ovulation stimulation
- Oocyte retrieval
- Laboratory studies, including pre-implantation genetic diagnosis testing for genetic disorders
- Genetic counseling
- Embryo assessment and transfer
- Luteal phase support
- Thawing of cryopreserved embryos

All services which are provided as part of an IVF cycle are covered under the global reimbursement rate for the IVF procedure. This can include, but is not limited to:

- Ovarian stimulation
    - excludes ovarian stimulation medications which are reported separately.
- Egg retrieval

- Insemination
- Fertilization
- Embryo culture
- Labs, including pre-implantation genetic diagnosis testing.
- Genetic counseling
- Pathology
- Surgical procedures
- Radiology (ultrasound)
- Cryopreservation and storage of sperm, ova, and embryos in connection with in vitro fertilization

Current American Society for Reproductive Medicine (ASRM) and Society for Assisted Reproductive Technology (SART) guidelines regarding limits to the number of embryos transferred must be followed.

Limitations

- Qualified Medicaid members may receive three (3) cycles of IVF per lifetime.
- Genetic screening services are limited to one (1) per lifetime.
- Reimbursement for genetic counseling services is limited to physicians and physician assistants with the training and qualifications to offer genetic counseling services.

For additional code specific policy information, providers may refer to the Coverage and Reimbursement Code Lookup.

24-38 Fertility Preservation

Beginning May 1, 2024, fertility preservation services will be opened for coverage as fee-for-service carve-out services for members.

The Physician Services and EPSDT Services provider manuals will be updated to include the following policy information:

Physician Services Manual, Chapter 8-23 Fertility Preservation and EPSDT Services Manual, Chapter 3-10 Fertility Preservation

Fertility preservation services are covered for members undergoing gonadotoxic cancer treatments or other medically necessary treatment that are expected to render them permanently infertile (excluding voluntary sterilization) either pre or post treatment. Qualifying members must meet the following criteria:

- The member is post-pubertal through 40 years of age.
- Diagnosis by a qualified healthcare professional (QHP) of a condition requiring treatment which, in the QHP's professional judgment, may pose a substantial risk of sterility or iatrogenic infertility (infertility caused by treatment).
- The member's current state of health is sufficient to undergo fertility preservation procedures.
- The member has received infertility counseling as well as psychotherapy, when medically indicated.
    - Counselors may include physicians and physician assistants qualified to provide genetic counseling services according to their training and scope of practice.
- Collection and storage of embryos, eggs or sperm is consistent with established medical practices or professional guidelines published by the American Society of Reproductive Medicine (ASRM) or the American Society of Clinical Oncology (ASCO).

Coverage

Collection and storage of embryos, reproductive tissues, eggs, and sperm must use collection and storage processes that are consistent with established medical practices or professional guidelines published by the ASRM or the ASCO.

Coverage includes the following fertility preservation services:

- Mature oocyte cryopreservation
- Ovarian tissue cryopreservation
- Ejaculated/surgically extracted sperm cryopreservation
- Embryo cryopreservation

Limitations

- Reimbursement for cryopreservation storage is covered as a single payment and includes up to a five-year storage increment.
    - Post cryopreservation procedures for use of eggs, sperm, or embryos are not covered.
    - Additional five-year storage increments may only be requested for member's that retain Medicaid eligibility.

Non-Covered Services

- Cryopreservation of embryos or eggs or sperm for fertility preservation purposes other than chemotherapy or other treatments that may render an individual infertile.
- Cryopreservation of embryos or eggs or sperm for reciprocal IVF.
- Sperm storage/banking for males requesting this service for convenience or "back-up" for a fresh specimen.

Section I: General Information provider manual, Chapter 2-6 MCE *Carve-Out Services* will also be updated to include Fertility Preservation to the list of carve-out services.

Providers may find additional code specific policy information using the Coverage and Reimbursement Lookup.

24-39 Updates to Section I: General Information and Home Health Provider Manuals

Section I: General Information provider manual, Chapter 1-9 *Definitions* is updated to add the definition of a "Qualified Healthcare Professional" as follows:

- Qualified Healthcare Professional (QHP): An individual who by way of education, training, and licensure performs a professional service within their scope of practice and independently reports that professional service.

Section I: General Information provider manual, Chapter 9-1 *Limited Abortion Services* is also updated as follows:

- In the professional judgment of the physician overseeing the pregnant woman's care, abortion is necessary because the life of the mother would be endangered if the fetus were carried to term; and all requirements of 42 CFR 441 Subpart E have been satisfied; or

Also, Chapter 11-3.1 *Attending Provider* will be added to Section I: General Information provider manual as follows:

> 11-3.1 Attending Provider
>
> When reporting for facility services, the attending provider is a physician or other qualified healthcare professional who has the overall responsibility for the member's medical care.

The Home Health Services provider manual is also updated as follows:

> Chapter 8-1 *Definitions*
> Plan of Care: A written plan developed and prescribed by the member's ordering practitioner in cooperation with the home health agency staff. The plan is designed for the agency to adequately meet the specific needs of the member in their place of residence. The approved plan must be retained in the agency's permanent record for the member.
>
> Chapter 8-3.2 *Plan of Care*
> The plan of care is a written plan developed and prescribed by the member's ordering practitioner in cooperation with the home health agency staff. The plan is designed for the agency to adequately meet the specific needs of the member in their place of residence. The approved plan must be retained in the agency's permanent record for the member.
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> Chapter 8-4 *Physical Therapy*
> The plan of care and progress toward goals must be reviewed by the nurse reviewer every 60 days and reviewed and recertified by the ordering practitioner every 6 months. Requests for continued service will be evaluated by consultants and nursing staff on a case-by-case basis. A new plan of care must be submitted with a prior authorization request, and must include the following information:

Chapter 8-5 *Occupational Therapy*
The plan of care and progress toward goals must be reviewed by the nurse reviewer every 60 days and reviewed and recertified by the ordering practitioner every 6 months. Requests for continued service will be evaluated by consultants and nursing staff on a case-by-case basis. A new plan of care must be submitted with a prior authorization request, and must include the following information:

Chapter 8-6 *Speech-Language Pathology and Audiology Services*
The plan of care and progress toward goals must be reviewed by the nurse reviewer every 60 days and reviewed and recertified by the ordering practitioner every 6 months. Requests for continued service will be evaluated by consultants and nursing staff on a case-by-case basis. A new plan of care must be submitted with a prior authorization request, and must include the following information:

24-40 Folic Acid for Women

Utah Medicaid covers folic acid for all women and prenatal vitamins for pregnant women with prescriptions from providers. Refer to Utah Medicaid's Preferred Drug List for covered products.

The Centers for Disease Control and Prevention recommends all women of reproductive age receive 400 micrograms (mcg) of folic acid every day from supplements, in addition to consuming folate from their diet to prevent neural tube defects (NTDs). For women who have already had an NTD-affected pregnancy, the recommendations are 4,000 mcg of folic acid daily beginning one month before becoming pregnant and through the first three months of pregnancy.

Reference:

1) Centers for Disease Control and Prevention. Folic Acid Recommendations. September 19, 2023. https://www.cdc.gov/ncbddd/folicacid/recommendations.html#:~:text=The%20current%20recommendations%20are%20that,of%20folic%20acid%20each%20day.

24-41 PRISM Provider-Administered Drug Claim Requirements and Billing Guidelines

Effective February 29, 2024, the PRISM system will adjudicate claims for physician-administered drugs using HCPCS codes and HCPCS units. This coding change will take effect for all claims submitted in PRISM. The Office of Medicaid Operations will work to reprocess denied claims and will bypass timely filing edits. Providers may contact (801) 538-6188, option 3, 2, 2 for additional information on claims reprocessing.

Providers are encouraged to review the following guidelines which apply to claims submitted for physician-administered drugs:

- Review the PRISM Coverage and Reimbursement Code Lookup for current coverage status and the PRISM Coverage and Reimbursement Fee Schedule Download for current NDCs (National Drug Codes) cross-walked to specific HCPCS codes.
    - A valid HCPCS (Healthcare Common Procedure Coding System), and
    - HCPCS units for the drug being administered are required, and
        - The HCPCS unit submitted on the claim shall reflect the actual dosage administered, not the package size.
    - A valid NDC for the drug being administered is required.
        - Claims are accepted when they contain a valid HCPCS and NDC combination.
    - Physician-administered drugs shall be administered by a qualified healthcare professional.
        - self-administered drugs shall not be billed as a provider-administered drug.
    - Provider-administered drugs that do not require payment, such as samples or those previously billed at a pharmacy, should report the appropriate HCPCS and $0.0 or $0.1 charge.
    - NOC (Not Otherwise Classified) HCPCS codes should only be reported for drugs that do not have a drug-specific HCPCS code (e.g., J3490, J3590).

- Reimbursement shall be based on the submitted HCPCS code and units administered, using the lesser of logic as stated in the Utah Medicaid State Plan 4.19-B.

24-42 DUR Board Updates

In January 2024, the Drug Utilization Review (DUR) Board met to review Lantidra (donislecel), the first cellular therapy to treat patients with type 1 diabetes. In February 2024, the DUR Board met to review Sublocade utilization among Medicaid patients. In March 2024, the DUR Board met to review gene therapy for sickle cell disease. In April 2024, the DUR Board met to review Short Acting Beta 2-Agonists (SABA) utilization.

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.

24-43 P&T Committee

The Pharmacy and Therapeutics (P&T) Committee reviewed Anti-VEGF (IV) in February. The minutes for P&T Committee meetings can be found at https://medicaid.utah.gov/pharmacy/pt-committee.