January 2025

Utah Department of
Health & Human Services
Integrated Healthcare

Medicaid Information Bulletin (MIB)

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

Unless otherwise noted, all changes take effect on January 1, 2025

25-01 Electronic Billing in PRISM

Effective September 4, 2024, the Utah Medicaid PRISM portal accepts 5010 HIPAA compliant x12 files. To upload files, the billing agent (billing provider or designated billing staff) must log into the PRISM domain with an EXT EDI analyst profile assigned by the account administrator of an enrolled billing provider. Utah Medicaid has put into place security protocols that require the billing provider data found in the x12 transaction(s) to match the enrolled billing provider associated with the PRISM domain name at login.

Listed in the chart below are the HIPAA transactions and their required elements on the billing provider type for both loop and segment data with the corresponding qualifiers. They must be present to pass the Utah Medicaid validation process for electronic batch upload in PRISM. This list is not intended to contain all required loops and segments. Please ensure each transaction uploaded is fully HIPAA 5010 compliant.

X12 Transaction		Segment			Provider Type
All Transactions	Control Segment	ISA06			NPI or Provider ID
All Transactions	Control Segment	GS02			NPI or Provider ID
X12 Transaction	**Loop**	**Segment**	**Qualifier**	**Segment**	**Provider Type**
837 Professional, Institutional, Dental	1000A	NM101	41	NM109	NPI
837 Professional, Institutional, Dental	2010AA	NM101	85	NM109	NPI
837 Professional	1000A	NM101	41	NM109	Provider ID
837 Professional	2010BB	REF01	G2	REF02	Provider ID
270 Batch, Real Time	2100B	NM101	1P	NM109	NPI
270 Batch, Real Time	2100B	REF01	1D	REF02	Provider ID
276 Batch, Real Time	2100B	NM101	41	NM109	NPI or Provider ID
276 Batch, Real Time	2100C	NM101	1P	NM109	NPI or Provider ID
278 Batch	2010B	NM101	1P	NM109	NPI
278 Batch	2010B	REF01	ZH	REF02	Provider ID

To better understand these requirements, refer to the HIPAA 5010 Technical Reference Guide available through your billing agent/clearinghouse support, or X12.org.

Online Resources

PRISM FAQs
Electronic Batch Provider FAQ
Add staff to a domain, update or add role for staff, or review the Account Administrator Manual instructions

25-02 Find A Provider Directory

On July 1, 2025, the Utah Medicaid Find A Provider online directory will be updated to comply with the Federal 21st Century Cures Act. The purpose of the directory is to help Medicaid members find a provider and improve access to care. They will be able to search providers by name, type, specialty, and location.

Beginning July 1, 2025, the Find A Provider directory must include, at a minimum, the following required information for each provider:

- Name(s) of provider
- Specialty of provider
- Address(es) where the provider offers services
- Telephone number(s) of provider
- Provider's cultural and linguistic abilities (languages, including American Sign Language, offered by the provider or by a skilled medical interpreter who provides interpretation services at the provider's office)
- If provider is accepting new Medicaid patients
- If provider is accepting new CHIP patients
- ADA accommodations the provider's office or facility offers for individuals with physical disabilities
- Provider's website
- Telehealth services offered

In April 2025, the Utah Medicaid PRISM portal will include the required information. Providers will be encouraged to update their provider information at https://prism.health.utah.gov/.

If providers have questions about their provider information, they can contact Provider Enrollment at 1-800-662-9651, option 3, then option 4.

25-03 Denture Preparation Procedures and Periodontal Maintenance

Effective January 1, 2025, Medicaid covers the following dental codes:

- **D7310** Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant – Open coverage for members once in preparation for denture or partial denture.
- **D7311** Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant - Open coverage for members once in preparation for denture or partial denture.

- **D7340** Vestibuloplasty - ridge extension (secondary epithelialization) - Open coverage for members once in preparation for denture or partial denture.
- **D7350** Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) - Open coverage for members once in preparation for denture or partial denture.
- **D4910** Periodontal maintenance.

Alveoloplasty and vestibuloplasty will be covered in cases where these services are medically necessary for members with dental benefits in preparation for dental prosthetic placement. Periodontal maintenance will be covered for members with dental benefits who are treated for periodontal disease.

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

25-04 Dental Code for Reporting Extended Care Facility Calls

Effective January 1, 2025, reporting extended care facility calls under CDT code D9410 *house/extended care facility call* is open for coverage for the following Provider Allowable Codes (PACs):

- 115-Group Practice
- 028-Dental
- 007-Maxillofacial Surgery
- 169-Dental Hygienist

The code is limited to the following places of service (POS):

- 13-Assisted Living Facilities
- 31-Skilled Nursing Facilities
- 32-Nursing Facilities
- 54-Intermediate Care Facility/ Individuals with Intellectual Disabilities

Please see the Coverage and Reimbursement Lookup Tool for more code-specific information.

25-05 CLIA Waived Tests

As a reminder, Chapter 8-12.7, Billing, of the Physicians Services Provider Manual states, "Waived tests must be billed with a QW modifier. Refer to the Tests Granted Waived Status Under CLIA document for a list of CLIA waived tests". Per this manual, it is a Utah Medicaid requirement that these tests be billed with the QW modifier.

If a test is classified as CLIA waived, it requires the QW modifier regardless of your level of certification. Your certification level states that you can perform higher levels of testing in addition to the waived tests.

25-06 School-Based Skills Development Manual Updated

Beginning January 1, 2025, the following definition for paraprofessionals will be used in the School-Based Skills Development Program: "An individual who is not a licensed healthcare provider; however, has been trained to perform certain healthcare tasks under the supervision of a licensed medical or behavioral professional". The term paraeducator has been replaced by the term paraprofessional.

Special education teachers will be allowed to act in the same capacity as a paraprofessional in the School-Based Skills Development Program. The School-Based Skills Development Provider Manual and the Supervision and Licensure Appendix have been updated with this information.

25-07 Code Updates

The following codes have been updated, effective October 1, 2024, to a Medicaid covered status. For code and provider-specific coverage, please see the Coverage and Reimbursement Lookup Tool.

90624 Menb-4c&menacwy vacc im
90684 Pcv21 vaccine im
A2027 Matriderm per sq cm
A2028 Micromatrix flex per mg
A2029 Mirotract matrix sheet
A9610 Xe129 xenon, diagnostic
C9169 Inj, nogapendekin pmln 1 mcg

C9170 Inj, tarlatamab-dlle, 1 mg
C9171 Inj, pegulicianine, 1 mg
C9172 Inj, beqvez, per tx dose
E0469 Lung expans high oscil neb
E0683 Non pneu peristalic comp pmp
E2513 Sgd accessory, emg sensor
J0138 Injection, acetaminoph 10 mg
J0175 Inj, donanemab-azbt, 2 mg
J1171 Inj, hydromorphone, 0.1 mg
J1749 Inj, iloprost, 0.1 mcg
J2002 Inj, lidocaine in d5w, 1 mg
J2003 Inj, lidocaine hcl, 1 mg
J2004 Inj, lidocaine w epinephrine
J2252 Inj midazolam in 0.8% nacl
J2253 Inj midazolam (seizalam)
J2601 Inj, vasopressin (baxter)
J8522 Capecitabine, oral, 50 mg
J8541 Oral, hemady, 0.25 mg
J9329 Inj, tislelizumab-jsgr
L1006 Scoliosis orth sag/ cor
L1653 Ho abduction static ots
L1821 Ko elas w/ condyle pads otf
P9027 Rbc o2 co2 reduced
Q0519 Supply fee hiv prep inj 30
Q0520 Supply fee hiv prep inj 60
Q4334 Amnioplast 1, per sq cm
Q4335 Amnioplast 2, per sq cm
Q4336 Artecent c, per sq cm
Q4337 Artecent trident, per sq cm
Q4338 Artacent velos, per sq cm
Q4339 Artacent vericlen, per sq cm
Q4340 Simpligraft, per sq cm
Q4341 Simplimax, per sq cm
Q4342 Theramend, per sq cm
Q4343 Dermacyte ac matrx per sq cm
Q4344 Tri membrane wrap, per sq cm
Q4345 Matrix hd allogrft per sq cm
Q5135 Inj, tyenne, 1 mg
Q5136 Inj, denosumab-bbdz, 1 mg

25-08 Reporting Obstetrical Care for RHCs and FQHCs

Effective as of May 1, 2024, Utah Medicaid has updated its policy on reporting obstetrical services by Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC). RHCs/FQHCs will no longer report these services using all-inclusive antepartum, labor and delivery (L&D), and postpartum codes. Instead, antepartum and postpartum services will be reported using an appropriate E&M code with the TH modifier (*Obstetrical treatment/services, prenatal and postpartum*) appended to the appropriate line. The TH modifier indicates the service was related to obstetrical care. For L&D, report the appropriate non-all-inclusive CPT code describing the mode of delivery.

RHCs/FQHCs must report services using the correct taxonomy in order to receive reimbursement in accordance with the Utah State Plan.

25-09 DUR Board Updates

In December 2024, the Drug Utilization Review (DUR) Board met to review Chimeric antigen receptor (CAR) T-cell therapies. In January 2025, the DUR Board will meet to review various proposed prior authorization forms.

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.

25-10 P&T Committee Updates

The Pharmacy and Therapeutics (P&T) Committee will not meet in January 2025. The next meeting will be held February 20, 2025.

The minutes for P&T Committee meetings can be found at https://medicaid.utah.gov/pharmacy/pt-committee/. P&T Committee meeting recordings can be found on the YouTube Channel @dmhf_webdohdhhs2.

25-11 Pharmacy Point of Sale Claim Submission Clarification Codes

Effective December 1, 2024, the following submission clarification codes may be used on pharmacy point-of-sale claims NCPDP Field 420-DK:

- "2" Mandatory 90-day supply exception: The pharmacist is indicating that in their professional judgment or otherwise inappropriate as directed by the provider to have a 90-day supply. (Please note: Pharmacy claims will be closely monitored to ensure that 90-day supply claims are being processed when appropriate.)
- "3" Vacation supply: The pharmacist is indicating that the cardholder has requested a vacation supply of the medicine
- "4" Lost/damaged prescription: The pharmacist is indicating that the cardholder has requested a replacement of medication that has been damaged or lost.

For additional information, please refer to the Utah Medicaid NCPDP Payer Sheet on the Resource Library, or contact the Utah Medicaid pharmacy team at (801) 538-6155, options 3, 2, 2.

25-12 GLP-1 Agonists Updates

Prescriptions for Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists indicated for type 2 diabetes require a diagnosis code to be submitted with the claim. Additionally, concurrent use of more than one GLP-1 Agonist is restricted. All GLP-1 Agonists are mutually exclusive with each other. Only one GLP-1 per month may be covered.

For more information, please refer to the preferred drug list here: https://medicaid.utah.gov/pharmacy/preferred-drug-list.

25-13 Leave of Absence Days in Intermediate Care Facilities for Individuals with Intellectual Disabilities

PRISM programming has been updated regarding Leave of Absence (LOA) days for residents of an Intermediate Care Facility for Individuals with Intellectual Disabilities (IICF/IID). The update is as follows:

1. Payment for therapeutic or rehabilitative leave of absence shall be limited to 100 days per calendar year for residents of an Intermediate Care Facility for Individuals with Intellectual Disabilities.

2. Payment for additional leave of absence days may be authorized only with prior approval from the Division of Integrated Healthcare. The facility's request for prior approval must be accompanied by appropriate and adequate documentation and must include written approval of the additional leave days by the resident's attending physician and/or the interdisciplinary team as appropriate to meet and support the individual resident's plan of care.

(See Prior Authorization for Additional Leave of Absence Days)

Billing for Allowable Leave of Absence Days in PRISM

For claims payment, when submitting a claim for LOA days for each Medicaid resident residing in any Nursing Facility (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), providers must bill for the allowable LOA days (12 for NF and 100 for ICF/IID) by using occurrence span code 74.

Prior Authorization for Additional Leave of Absence Days

When the allowable LOA days for any NF or ICF/IID are exhausted, more LOA days for therapeutic or rehabilitative purposes may be requested through the prior authorization (PA) process. Providers must contact their Resident Assessment nurse to request additional LOA days. Providers are required to submit appropriate and adequate documentation, which must also include approval of the additional leave days by the resident's attending physician and/or the interdisciplinary team as appropriate, to meet and support the resident's plan of care. HCPCS code A9270 will be used for prior authorization purposes for the request of the extension of LOA days.

(See Billing for Prior Authorized Additional Leave of Absence Days)

Contact the Resident Assessment nurses by calling the main Medicaid line at (801) 538-6155, or 1-800-662-9651, choose option 3, option 3 again, then choose the correct nurse from those mentioned.

Billing for Prior Authorized Additional Leave of Absence Days

When billing for the additional, prior authorized, LOA days for residents of a NF or ICF/IID, providers must submit the claim appending the following codes:

1. Occurrence span code 74,
2. Revenue code 0183,
3. HCPCS code A9270,
4. The prior authorization number.

Submitting the claim this way will allow for proper adjudication and payment of the claim.