July 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 July 1, 2025

25-39 Find a Provider Online Directory Updates

Utah Medicaid's Find a Provider online directory has been updated to comply with the 21st Century Cures Act. The purpose of the directory is to help Medicaid members find a provider and improve access to care. Members can search for providers by name, type, specialty, and location.

The Find a Provider directory includes, at a minimum, the following required information for each provider:

- Provider name(s)
- Provider specialty
- Address(es) where the provider offers services*
- Provider telephone number(s)
- 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 clients (Medicaid/CHIP patients)
- ADA accommodations the provider's office or facility offers for individuals with physical disabilities
- Provider's website hyperlink
- Telehealth services offered

This provider information can be found in Utah Medicaid's Provider Reimbursement Information System (PRISM) under the state where it is located.

If providers have questions about their posted information, or want to make changes, they can contact Provider Enrollment at 1-800-662-9651, option 3, then option 4.

*The home address listed in Step 1-Basic Information, should be where the provider would like correspondence sent.

**Information on cultural competency can be found here: Cultural Competency.

25-40 2025 Medicaid Statewide Provider Training

Attention providers: If you have not already signed up, registration for the 2025 Medicaid statewide provider training is open. The training will be conducted in an online live webinar format with a variety of training courses covering specific topics. Providers can sign up to attend multiple trainings. Each training will have a short presentation then a time for questions. The Utah Office of Inspector General (UOIG) will also have a presentation then a time for questions.

To register for the 2025 training, please complete the Google Form.

Previous statewide provider trainings are available on the Medicaid website. The 2025 slides and recordings will be posted after the trainings conclude.

The following dates and times are scheduled for the 2025 Medicaid statewide provider training. The duration will be flexible based on the number of questions asked during the training.

Date	Time (MST)	Training
Tuesday, August 19	10:00 - 11:00	New Medicaid Provider Orientation
Wednesday, August 20	10:00 - 12:00	Claims and Billing
Thursday, August 21	10:00 - 12:00	Provider Enrollment
Tuesday, August 26	12:00 - 1:00	Pharmacy Program, including pharmacy prior authorization
Wednesday, August 27	10:00 - 11:00	Prior Authorization, medical services
Thursday, August 28	10:00 - 11:00	Managed Care
Tuesday, September 2	10:00 - 11:30	Healthcare Policy for Hospitals, Outpatient, and Physicians
Wednesday, September 3	10:00 - 11:30	Healthcare Policy for Behavioral Health Providers
Thursday, September 4	10:00 - 11:30	Healthcare Policy for DME, Home Health, Private Duty Nursing, and Personal Care Service Providers
Tuesday, September 9	10:00 - 11:00	Dental Providers (Fee-for-service and Managed Care)
Wednesday, September 10	10:00 – 11:00	Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
Thursday, September 11	10:00 – 11:30	Utah Office of Inspector General (UOIG)

25-41 Split or Shared Services

Split or Shared Evaluation and Management Visits for Prolonged Services and Critical Care

Medicaid follows AMA CPT guidelines for split or shared visits. As a reminder, a split or shared visit refers to an evaluation and management (E&M) visit performed in part by both a physician and other qualified healthcare professionals who are part of the same group. Medicaid considers the practitioner who spends more than half of the total time to have performed the substantive portion and can bill for the split or

shared E&M visit. When providers jointly meet with or discuss the patient, only the time of one of the practitioners may be counted. Office visits and nursing facility visits are not billable as split or shared services.

Providers cannot count time spent on the following:

- The performance of other services that are reported separately,
- Travel, or
- Teaching that is general and not limited to discussion that is required for the management of a specific patient.

Documentation for prolonged services must include:

- The start and end times of the prolonged service,
- A detailed explanation of the additional services provided during the prolonged period, and
- A clear description of the medical necessity for the prolonged service.

25-42 Reporting Surgical Sites Related to Dental Procedures

Opening Code G0330

Effective July 1, 2025, hospital outpatient departments and ambulatory surgical centers are to bill the technical, facility-fee component of dental rehabilitation services using only code G0330 *Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room*.

Historically, CPT code 41899 *Unlisted procedure, dentoalveolar structures* was used to report both dental and medical procedures. Code G0330 will now be used for reporting dental services requiring monitored anesthesia care with the use of an operating room.

Code G0330 is to be used when dental services require monitored anesthesia and the use of an operating room. It will be carved out to fee-for-service (FFS) Medicaid, meaning all claims must be submitted to Utah Medicaid. Code 41899 will no longer be considered a carve-out service. Providers who perform dentoalveolar procedures reported using CPT codes rather than CDT codes. Please submit these claims to the appropriate managed care plan when applicable.

The Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual, Chapter 8-5 *Sedation and general anesthesia,* has been updated to say, “Ambulatory surgical centers (ASC) billing for dental services shall use code G0330.”

25-43 Section I: General Information Provider Manual Updates

Effective July 1, 2025, Section I: General Information Medicaid Provider Manual has been updated to clarify that other qualified non-physician healthcare professionals, acting within their scope of practice and enrolled as Utah Medicaid providers, may render Medicaid services according to the established Medicaid policies.

25-44 School-Based Skills Development Services

Effective July 1, 2025, the School-Based Skills Development Program will expand its definition of Document of Medical Necessity (DMN), or other medical plan of care, beyond the Individualized Education Plan (IEP) only. DMNs aligning with educational rule and law may be used to demonstrate a student's medically necessary services if they address all of the following:

- Medical need
- Medical diagnosis
- Start and end date
- Scope of service
- Frequency of service
- Duration of service
- Signed and dated

Effective July 1, 2025, the School-Based Skills Development Program will cover EPSDT services not previously covered, whether or not a student possesses a DMN. These services include educationally mandated health services and screenings, which include but are not limited to the following:

- Scoliosis screening
- Vision screening
- Hearing screening
- Diabetes management
- Asthma management
- Height and weight screening

The Utah State Plan and School-Based Skills Development Provider Manual have been updated to reflect these changes.

25-45 Targeted Case Management for Early Childhood Updates

Effective July 1, 2025, the age policy for early childhood targeted case management (TCM) has been updated. The age range for these services has been expanded from birth through age three, to birth until the child turns eight years old.

These updates may be found in the TCM for Early Childhood, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services, and the TCM for Individuals with Serious Mental Illness provider manuals.

25-46 Prenatal and Postnatal Counseling

Effective July 1, 2025, prenatal and postnatal psychosocial counseling services will be reported using CPT codes for psychiatric diagnostic evaluations and psychotherapy services. Refer to the Coverage and Reimbursement Lookup Tool for the coverage of codes. Counseling services must be provided by a licensed mental health therapist. The eligible member may receive services for the duration that is medically necessary. See the Physician Services Provider Manual, Chapter 8-11.6.5, for this policy.

25-47 Inpatient Psychiatric Service Updates

Effective July 1, 2025, the Hospital Services Provider Manual, Chapter 8-11 *Mental health services*, and the Behavioral Health Services Provider Manual, Chapter 8-17 *Psychiatric specialty hospitals considered institutions for mental diseases (IMDs)*, have updated language to clarify current policies. They clarify information that no prior authorization (PA) is required for EPSDT-eligible members under 21 years old or for members aged 65 and older. See the updated manuals for further details.

25-48 Mental Health and Substance Use Disorder Residential Treatment Prior Authorization

Effective July 1, 2025, the substance use disorder residential treatment program's prior authorization (PA) documentation submission timeline has changed. A continued stay PA request must include a completed reassessment and treatment plan review using ASAM criteria and must be submitted no earlier than four (4) calendar days of (and including) the first requested date of service indicated on the PA request. The reassessment and treatment plan review must be no later than the first date of service requested on the PA request form. Refer to the Behavioral Health Services Provider Manual, Chapter 8-19.4.2.

25-49 Medication Assisted Treatment in Residential Treatment Programs

Effective July 1, 2025, licensed residential treatment programs cannot refuse to accept a member based solely on the member's use of medication-assisted treatment with the recommendation of a qualified healthcare professional. Each program must allow members to receive medication-assisted treatment.

Refer to the Behavioral Health Services Provider Manual, Chapters 8-18.2 and 8-19.2, to view the policy updates. Utah Administrative Code Rule 414-36-2 will be added which requires adherence to this policy.

25-50 Medicaid Pharmacy Contact Update

The Utah Medicaid Pharmacy telephone options have changed. Please contact us regarding pharmacy questions at (801) 538-6155, option 1, then option 1 for pharmacy prior authorizations, or option 2 for clinical outreach services. For questions, please email medicaidpharmacy@utah.gov.

25-51 DUR Board Updates

In May, the Drug Utilization Review (DUR) Board met to review new prior authorization (PA) criteria for Alhemo, Qfitlia, and Skyclarys. The DUR Board also reviewed updated PA criteria for Zepbound and Spravato.

In June, the DUR Board met for the open public meeting annual training and to review PA criteria for Tryvio, Zynteglo, and GLP-1 medications for weight loss.

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.

25-52 P&T Committee Updates

There were no Pharmacy and Therapeutics (P&T) Committee meetings held in June and July. Previous meeting recordings can be found on the YouTube Channel @dmhf_webdohdhhs2, and meeting minutes at https://medicaid.utah.gov/pharmacy-program/pt-committee/.

25-53 Pharmacy Dispense as Written (DAW) Update

Effective July 1, 2025, per H.B.347 from the 2025 General Session, when the provider writes "dispense as written (DAW)" on the prescription, pharmacy claim's DAW-1 code will no longer override the preferred drug list for the psychotropic drugs, including (i) anti-depressant; (ii) anti-convulsant/mood stabilizer; (iii) anti-anxiety; and (iv) attention deficit hyperactivity disorder stimulant. The non-preferred psychotropic drugs will be covered if the department, based on member claims history or healthcare provider attestation, has evidence of:

- Trial and failure of a psychotropic drug on the preferred drug list that is equivalent or similar to the drug that is not on the preferred drug list in the last 365 days; or
- The member being stabilized, meaning that the enrollee has achieved a stable or steadfast medical state within the past 90 days, on the non-preferred psychotropic drug.

The DAW-1 code remains to override the non-preferred products listed on the preferred drug list for antipsychotic medications. Checked boxes or pre-printed forms that include "dispense as written" are not acceptable substitutes for the prescriber writing, "dispense as written" on the prescription.

Note: The DAW-1 code will not allow claims for the brand-name version of multi-source drugs to process, even though the brand-name version of the drug is listed as non-preferred and the prescriber writes "dispense as written" on the prescription. If a Medicaid member needs the brand-name version that is listed as non-preferred, a prior authorization request must be submitted to Utah Medicaid using the Medication Coverage Exception Request prior authorization form. For more information, refer to R414-60B and the Preferred Drug List.

References:

1) Utah State Legislature. H.B.347 Social Services Program Amendments. https://le.utah.gov/~2025/bills/static/HB0347.html

25-54 Coverage of Weight Loss Medications Policy Update

Effective July 1, 2025, select GLP-1 agonists (including Wegovy, Saxenda, and Zepbound) will be covered for fee-for-service members. The coverage criteria is for children that have BMI ≥ 95th percentile, and for adults present with a diagnosis of obesity with BMI ≥ 30 kg/m^2, or overweight with BMI 27-29.9 kg/m^2 and at least one weight-related comorbidity. Additional criteria is listed on "GLP-1 Medications for Weight Loss" Prior Authorization. These medications are not covered in ACO enrolled populations.

Providers can complete and submit the "GLP-1 Medications for Weight Loss" Prior Authorization at https://medicaid.utah.gov/pharmacy-program/prior-authorization/. Other non-GLP-1 agonist weight loss medications are not covered.

25-55 Opioid Use in Pregnancy – Limitation Update

Pregnant members are limited to a 7-day supply of opioids. Prior authorization is required to override this limit for pregnant members.

Effective July 1, 2025, if the pharmacist has verified that the member is not currently pregnant, they may use SCC 10 to override the 7-day supply limitation.

Additional information regarding pharmacy claims and processing can be found in the Utah Medicaid Payer Sheet located on the website at https://medicaid.utah.gov/pharmacy-program/resource-library/?folder=pharmacy/library/files/Payer%20Sheets/.

25-56 Medication Therapy Management (MTM) Code Update

Effective January 1, 2025, Utah Medicaid fee-for-service will utilize CPT codes 98012, 98013, and 98014 for telephone-only Medication Therapy Management (MTM) services. These codes will replace Evaluation and Management (E&M) codes 99441, 99442, and 99443, which have been discontinued by the American Medical Association (AMA).

Please refer to the table below for a current list of MTM codes available in an outpatient setting to licensed pharmacists enrolled in Utah Medicaid.

Updated billing information and rendering provider guidelines for both Medication Therapy Management (MTM) and Comprehensive Medication Management (CMM) are available on the Utah Medicaid Website https://medicaid.utah.gov/pharmacy-program/medication-therapy-management-services.

Information on code rates and limits can be found using the Utah Medicaid Coverage Lookup Tool at: https://health.utah.gov/stplan/lookup/CoverageLookup.php.

CPT	Description	Rate	Limits
99605	Medication therapy management service(s) provided by a pharmacist for a new patient, individual, with assessment and intervention if provided; initial 15 minutes, in-person only	53.48	Face-to-Face: Four consults per patient per year, including one new patient service and three established patient services.
99606	Medication therapy management service(s) provided by a pharmacist for an established patient, individual, with assessment and intervention if provided; initial 15 minutes, in-person or audio-video only	32.94	
99607	Medication therapy management service(s) provided by a pharmacist, individual, with assessment and intervention if provided; each additional 15 minutes, in-person or audio-video only	16.68	
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.	32.94	Audio-Only: Four consults per patient per year.
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	44.6	
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	55.18	

25-57 340B Ceiling Price

The 340B program is a drug pricing program established by the Veterans Health Care Act of 1992, which is Section 340B of the Public Health Service Act (PHSA). Section 340B of the PHSA (42 U.S.C. 256b) limits the cost of covered outpatient drugs to certain federal grantees, federally qualified health center look-alikes, and qualified hospitals. These providers purchase, dispense and/or administer pharmaceuticals at significantly discounted prices. The significant discount applied to the cost of drugs purchased through the 340B program makes them ineligible for the Medicaid drug rebate. State Medicaid programs are mandated to ensure rebates are not claimed on 340B purchased drugs, preventing duplicate discounts.

States have an obligation to collect Medicaid rebates for covered outpatient drugs (including primary, supplemental, and value-based rebates), unless the drug was subject to a 340B drug discount program discount (42 U.S.C. § 1396r-8(j)(1)) and indicated as such per the state's policies. The 340B covered entities are responsible for ensuring duplicate discounts do not occur, and they can be sanctioned for causing duplicate discounts (42 U.S.C. § 256B). Therefore, the 340B program compliance rests entirely on the covered entity.

As outlined in the Utah Medicaid State Plan (Attachment 4.19-B, page 19, a(2)), for covered outpatient drugs purchased through the 340B program, claims are required to be submitted with the 340B actual acquisition cost (AAC), also known as the 340B ceiling price. Claims will be reimbursed at the lesser of the AAC plus the professional dispensing fee*, as applicable, or the billed charges.

Effective July 1, 2025, Utah Medicaid will monitor 340B claims to ensure providers are appropriately billing and not submitting more than the 340B AAC. Utah Medicaid will compare the submitted AAC to the calculated 340B ceiling price, as available, to identify non-compliant claims submitted by providers.

Providers will be required to submit a copy of their 340B invoice upon request to justify the AAC submitted. If Medicaid determines fraud or abuse is occurring, providers will be referred to the Utah Office of the Inspector General (UOIG) for a preliminary investigation. Claims may be subject to recovery and/or further audit proceedings if they are not compliant.

Please refer to the Pharmacy Services Provider Manual for 340B billing guidelines.

*Professional dispensing fee applies to pharmacy claims only; provider-administered drugs do not receive a professional dispensing fee.

25-58 Medical Transportation Services – Ambulance Update

Effective July 1, 2025, the Medical Transportation Services Provider Manual has been amended to comply with the recent legislative changes and clarify existing policy.

Providers may only bill for ambulance transport when the member is transported via ambulance. Ambulance response and treatment, no transport (HCPCS code A0998) may be used in situations when member transport is not necessary. The ambulance base rate includes medical supplies, interventions, and oxygen, which should not be billed separately.

25-59 Integrated Healthcare Provider Manual Updates

The Integrated Healthcare Services Provider Manual was updated to include clarifying information related to member responsibilities and use of CPT code 99484. Updates have been made to the definition of "qualified healthcare professional (QHP)". Manual references to "physicians" have been updated to include QHP and clarification added regarding reimbursement of covered QHP services. The following reflects the updates made to the manual:

- Chapter 7, *Member responsibilities* updated to include reference and link to Section I: General Information provider manual.
- Chapter 8-12.1, *Reporting -coding and billing, Reference table* added for code 99484 (care management services for behavioral health conditions).
- The definition of "Qualified healthcare provider (QHP)" has been modified to the standard definition of "an individual who is qualified by education, training, licensure and regulation who performs a professional medical service within their scope of practice and is enrolled with Medicaid as a provider." References throughout the manual have been changed to reflect this updated definition.
- Chapter 8-2, *Integrated healthcare and care management* updated to include clarification of Medicaid reimbursement of covered QHP services.

25-60 Attention Out-of-State Medicaid Providers

If you received a letter from Utah Medicaid indicating your license is expiring, please check your PRISM provider enrollment domain account as the expiration notice may be linked to your out-of-state license.

Please contact the provider enrollment team at (801) 538-6155, or 1-800-662-9651, option 3, then option 4 for any questions.