September 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 September 1, 2025

25-61 Orthodontic Treatment Codes

Effective September 1, 2025, Medicaid will cover the following orthodontic treatment codes:

D8070 - *comprehensive orthodontic treatment of the transitional dentition*
D8080 - *comprehensive orthodontic treatment of the adolescent dentition*
D8090 - *comprehensive orthodontic treatment of the adult dentition*

The age limits for these codes are as follows:

D8070 - 10 up to 14 years of age
D8080 – 10 up to 21 years of age
D8090 - 14 up to 21 years of age

Orthodontia services are covered for Medicaid members who have a handicapping malocclusion due to congenital disabilities, accidents, disease, or abnormal growth patterns, of such severity that they cannot masticate, digest, or benefit from their diet.

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

25-62 Medical Transportation Services Policy Updates

The Medical Transportation Services provider manual has been updated to encompass a comprehensive overview of the transportation services offered by Medicaid for eligible members. Policy clarifications have been made to address frequently asked questions about general eligibility for different modes of transportation, mileage reimbursement, tribal transportation, and applications for out-of-state transportation. Additionally, limitations of the transportation services have been highlighted.

25-63 DME Overlapping Dates for Medical Supplies

The Medical Supplies and Durable Medical Equipment provider manual has been updated with the following language to provide clarification regarding the shipment of disposable medical supplies in the previous month to avoid supply shortages. Please see Chapter 8-2, *Requirements for obtaining medical supplies or DME.*

Orders for equipment or supplies require:

- documentation supporting medical necessity maintained in the member's medical records
    - submission of documentation for PA, when applicable
- a physician or QHP's order including the following information:
    - member's name
    - date of the order
    - the start date, if the start date is different from the date of the order
    - diagnosis
    - a detailed description of equipment or supplies
    - duration of use
    - for items used periodically, the written order must include dosage and duration frequency of use
    - number of refills
    - refills expire 12 months from the date of initial signature
    - quantity to be dispensed
    - route of administration
    - a physician or QHP's signature following Section I: General Information, Chapter 4-6, *Signature requirements*

Medical supplies filled monthly may be refilled between the 25th day of the month and the end of the month to ensure that the member has the needed product for subsequent usage. This allowance does not permit providers to duplicate supplies for the same date(s) of service.

Example: A medical supply provider is filling an ongoing order for disposable male urinary catheters reported using HCPCS A4349. The code has a utilization restriction of 36 units per month under Medicaid policy. The provider has supplied 36 units for the current month of April but needs to ship the supplies for May to prevent a supply shortage.

Under these circumstances, the provider may ship the catheter refills for service dates beginning May 1st to the member between the dates of April 25th to the 30th. The provider must report the actual dates of service (5/1 - 5/31) on the professional claims submission rather than the shipping date of 4/26 or the delivery date. The shipping and/or delivery date must be included in the "Additional Claim Information" field of the claims submission.

In the above example, the provider would not be permitted to supply additional catheters with service dates in the month of April, since the utilization restriction for the code in April was already met.

25-64 Speech Language Qualified Healthcare Professional (QHP)

Effective September 1, 2025, the Speech Language Pathology and Audiology Services 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.

25-65 Court-Ordered Behavioral Health Services Policy

Effective September 1, 2025, the Behavioral Health Services provider manual has been updated to clarify policy on court-ordered services. It clarifies that services ordered by a court, such as psychiatric diagnostic evaluations and the provision of behavioral health services specified in the manual, are covered when they are determined to be medically necessary. It also provides a reference to the Physician Services provider manual for policy on court-ordered urine drug testing. See the Behavioral Health Services provider manual Chapters 7-1, 7-2.3, and 8 and the Physician Services provider manual Chapter 8-12.5 for more information.

25-66 Unlicensed Behavioral Health Providers

Effective September 1, 2025, unlicensed behavioral health providers will no longer enroll in PRISM as Medicaid providers, or complete the Unlicensed Mental Health and Substance Use Disorder Providers' Form.

Unlicensed behavioral health providers include:

- Unlicensed individuals enrolling to provide psychosocial rehabilitative services (PRS).
- Students working toward licensure pursuant to Subsection 58-1-307(1)(b) & (c) of the Utah Code, while engaged in activities constituting the practice of a regulated profession, while in training in a recognized school approved by the Department of Commerce, Division of Occupational and Professional Licensing (DOPL).
- Unlicensed individuals accruing DOPL-required hours for licensure as a social service worker (SSW).

Unlicensed behavioral health providers do not include the following providers: targeted case managers, peer support specialists, and behavioral health technicians and coaches.

Unlicensed providers must be supervised by a licensed mental health provider and report services under the National Provider Identifier (NPI) of their supervisor with the modifier HL to indicate when an unlicensed provider performed the service.

The supervisor must ensure the completion of the Medicaid risk-based screening for every unlicensed provider before the unlicensed provider renders or reports any services for Medicaid members. To complete these screenings, request access to the DEX and PECOS system through https://portal.cms.gov/portal. The supervisor must complete a monthly check of the List of Excluded Individuals and Entities (LEIE) to guard against prohibited individuals providing services to Medicaid members. The LEIE can be searched at

https://exclusions.oig.hhs.gov/. Supervisors must keep a list of these checks and provide them if requested by the Department. See the Behavioral Health Services provider manual, Chapter 3-4, for information on unlicensed providers and supervision responsibilities.

Current unlicensed providers enrolled in PRISM will need to follow this policy as of September 1, 2025. These providers will follow the changes described in this article and as detailed in the Behavioral Health Services provider manual.

Once an unlicensed provider becomes licensed, they must complete the PRISM enrollment process to provide services to members under their own NPI.

Unlicensed providers that need to update their profile in PRISM with a current license or certification to avoid termination by November 30, 2025, must do the following:

The Account Administrator needs to login to Prism https://prism.health.utah.gov/evoBrix/CNSIControlServlet.

- If you don't see the provider's name in the drop-down Domain menu, this means that you don't have access to make any changes. You will need to work with the provider and within your organization to determine who the account administrator is, as we cannot give you that information. If you are unable to determine who that individual is, then a completed HealthCare Provider Access Agreement form will need to be emailed to providerenroll@utah.gov for review.

Step 1 will need to be updated:

- If the enrolled provider has a current applicant type of Student and Other Unlicensed Provider and the provider is no longer a student.
- Update applicant type to either an Individual/Sole Proprietor or a Rendering/Servicing Only. (If a group is billing for the provider, then choose Rendering/Servicing Only).

Step 3 will need to be updated:

- If the listed specialty/specialties are not Targeted Case Manager or Peer Specialist, add the current date as the end date for each one.
- Click the Add button, add the correct Specialty.
- If you already have the correct non-student specialty, no changes will need to be made to this step.

Step 5 will need to be updated:

- Click Add button to enter the DOPL license or Certification requirement for the specialty chosen in step 3.

All required steps within the provider's domain will need to have the status "completed". In the Upload Documents step, a copy of the DOPL license or Certification, in addition to any other required documents, must be uploaded. Be sure the modification is submitted in the Submit Modification Request for Review Step.

Student/Unlicensed providers will have until November 30, 2025, to submit a modification updating their information. After that date, the Student/Unlicensed provider will be terminated. Terminated providers can send an email to providerenroll@utah.gov requesting a 30-day re-enrollment. If the modification is submitted clean and successfully approved within the 30-day time frame, provider enrollment can approve with no gap in the provider's enrollment.

25-67 Behavioral Health Services Bundled Codes

Effective September 1, 2025, the Behavioral Health Services provider manual has been updated to include a table containing a list of codes included in the bundled reimbursement rate for services. This table is intended to provide reporting guidance for behavioral health services which cannot be reported by the same provider on the same date of service when a bundled code is reported. The table has been added as an addendum at the end of the manual.

25-68 Housing Related Services and Supports Program: Eligibility Update

The Housing Related Services and Supports (HRSS) program provides housing-related services and supports in the form of tenancy support, community transition and supportive living services to Medicaid members experiencing homelessness or at risk of homelessness. HRSS services are provided under the authority of Utah's 1115 Demonstration Waiver.

HRSS services are available to Medicaid members, ages 19 through 64, who are members of the Targeted Adult Medicaid (TAM) and the Medicaid Adult Expansion (AE) population and meet the clinical and social risk factors criteria.

The social risk factors criteria include homelessness or at risk of homelessness, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except the annual income requirement in 24 CFR 91.5 (1)(i).

The clinical risk factors include:

1. Complex behavioral health need: Requires improvement stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a diagnosable substance use disorder, serious mental illness, developmental disability, cognitive impairment or behavioral impairment resulting from dementia, brain injury or other medically-based behavior condition/disorder.

2. Needs assistance with one or more activities of daily living (ADLs), instrumental activities of daily living (IADLs) or eligible for long term services and supports (LTSS). One of which may be body care, verbal queuing, or hands-on assistance.
3. Recent hospitalization for a chronic health condition (within the last 12 months), at least 1 inpatient claim for one of the following:

   Cancer, diabetes, hypertension, heart disease, heart failure, kidney disease, kidney transplant failure, liver disease, multiple sclerosis, necrotizing fasciitis, renal failure.
   *Utah Medicaid's Medical Director may approve additional chronic conditions on a case-by-case basis.

25-69 Home and Community-Based Services Waiver Provider Manual Updates

The provider manuals for home and community-based waivers operated by the Division of Services for People with Disabilities (DSPD) have been updated, including the Home and Community-Based Services Waiver for Individuals with Intellectual Disabilities or other Related Conditions, Home and Community-Based Services Waiver for Individuals with Physical Disabilities, and Home and Community-Based Services Waiver for Individuals with an Acquired Brain Injury. Previously there was a disparity between how the state and federal government referred to intermediate care facilities for people with intellectual disabilities. As a result, the manuals have now clarified this distinction. Now the state and federal government are more closely aligned in their terminology, and references have been updated accordingly with appropriate references to the Code of Federal Regulations. If providers have questions about these updates, please contact jambrena@utah.gov.

Intellectual Disabilities or Related Conditions Provider Manual Changes

Page 4 - Altered last sentence of the second paragraph which previously read, "The term ICF/ID, which is used in this document, is equivalent to intermediate care facility for persons with mental retardation (ICF/MR) under federal law." It now reads as, "The term ICF/ID, which is used in this document, is equivalent to intermediate care facility for individuals with intellectual disabilities (ICF/IID) as defined in 42 CFR §440.150."

Page 5 - Altered starred sentence in the ICF/ID definition which previously read, "This is equivalent to intermediate care facility for persons with mental retardation (ICF/MR) under federal law." It now reads as, "This is equivalent to intermediate care facility for individuals with intellectual disabilities (ICF/IID) as defined in 42 CFR §440.150."

Page 6 - Altered starred sentence in the QIDP definition which previously read, "This is equivalent to Qualified Mental retardation Professional (QMrP) under federal law." It now reads as, "This is equivalent to Qualified Intellectual Disability Professional (QIDP) as defined in 42 CFR §483.430."

Physical Disabilities Provider Manual Change

Page 11 - Altered last sentence of the second paragraph which previously read, "The term intermediate care facilities for people with intellectual disabilities, which is used in this document, is equivalent to intermediate care facilities for persons with mental retardation (ICFs/MR) under federal law." It now reads as, “The term intermediate care facilities for people with intellectual disabilities, which is used in this document, is equivalent to intermediate care facilities for individuals with intellectual disabilities (ICF/IID) as defined in 42 CFR §440.150.”

Acquired Brain Injury Provider Manual Change

Page 7 - Altered last sentence of bullet point 6 which previously read, "The term intermediate care facilities for people with intellectual disabilities, which is used in this document, is equivalent to intermediate care facilities for persons with mental retardation (ICFs/MR) under federal law." It now reads as, “The term intermediate care facilities for people with intellectual disabilities, which is used in this document, is equivalent to intermediate care facilities for individuals with intellectual disabilities (ICF/IID) as defined in 42 CFR §440.150.”

25-70 CHIP Program Benefit Changes

Removal of Annual and Lifetime Dollar Limits on CHIP Benefits

Effective June 3, 2025, the Utah Children’s Health Insurance Program (CHIP) removed all annual and lifetime dollar limits on CHIP benefits. This benefit change was done in accordance with the requirements in the final eligibility rule, streamlining the Medicaid, CHIP, and basic health program application, eligibility determination, enrollment, and renewal processes.

https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health.

What changed:

No more $1000 annual dental maximum
Removal of the annual $1000 dental benefit limit. Standard copays and deductibles still apply.

No more $1,000 lifetime orthodontia maximum
The $1,000 lifetime benefit limit for orthodontia was eliminated. Copays remain the same, and braces will continue to be covered only once per lifetime.

No more $35,000 lifetime cochlear implant maximum

The $35,000 lifetime benefit limit for cochlear implants was removed. These services will still require prior authorization, and the member copay still applies.

For general inquires, contact the CHIP Program Director Jennifer Wiser at jwiser@utah.gov.

25-71 DUR Board Updates

In July, the Drug Utilization Review (DUR) Board met to review the new antipsychotic, Cobenfy (xanomeline and trospium chloride). It is listed as non-preferred on the Preferred Drug List (PDL) and is covered by Utah Medicaid fee for service with prior authorization (PA). The DUR Board also reviewed new PA criteria for Kebilidi and updated PA criteria for Spravato.

In August, the DUR Board reviewed Journavx (suzetrigine) for acute pain, finalized PA criteria for Kebilidi, and reviewed PA criteria for the ultra-high-cost drugs (UHCD) Beqvez and Skysona.

PA forms can be found at https://medicaid.utah.gov/pharmacy-program/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.

25-72 P&T Committee Updates

There were no Pharmacy and Therapeutics (P&T) Committee meetings held in July and August. The P&T Committee will meet in September to review the botulinum toxins class including Botox, Dysport, and Xeomin.

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.

25-73 Hybrid Unified Preferred Drug List

The S.B. 2 New Fiscal Year Supplemental Appropriations Act (2025 General Session) was passed to require the Department of Health and Human Services to establish a unified Medicaid preferred drug list for identified drug classes for Accountable Care Organizations (ACOs) and fee for service (FFS).

Effective January 1, 2026, ACOs and FFS will share the below unified drug classes:

- Continuous glucose monitors/diabetic supplies
- Non-insulin antidiabetic (DPP4-inhibitors, DPP4 inhibitor combinations, GLP-1 agonists, SGLT-2 inhibitors, SGLT-2 inhibitors combinations, sulfonylurea combinations)
- Insulin antidiabetic (insulin mixtures, intermediate acting insulin, long acting insulin, short acting insulin)
- HIV antiretroviral (combination products, entry/fusion inhibitors, integrase inhibitors, non-nucleoside reverse transcriptase inhibitors, nucleoside/nucleotide reverse transcriptase inhibitors)
- Hepatitis C - direct acting antivirals
- Asthma and bronchodilator inhaled (anticholinergics, combination products, corticosteroids, LABA/LAMA combinations, long acting beta agonists, short acting beta agonists)
- Atopic dermatitis (non-steroidal)

The ACOs will align coverage with FFS for the hybrid PDL's classes with any utilization management designed by FFS including quantity limits, day supply limits, and prior authorization criteria.

Additionally, the ACOs will reimburse Medicaid pharmacy providers at the same reimbursement rates and using the same methodologies as FFS for all point of sale claims.

The ACOs still maintain their PDL that includes the hybrid PDL selected drug class on their websites.

Additional information and FAQs will be available on the Utah Medicaid website later this year.

Resources:

1) S.B. 2 New Fiscal Year Supplemental Appropriations Act. https://le.utah.gov/~2025/bills/static/SB0002.html

25-74 Medication Therapy Management (MTM) Correction

This article is a clarification to the Medication Therapy Management (MTM) services code, 98013, for telephone-only consultations. The rate in the July MIB was displayed incorrectly. Please see the correct rate for 98013 on the table below.

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.	44.06	
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	

25-75 Section I: General Information Provider Manual

Section I: General Information provider manual has been reformatted, and the style guide has been updated. Please note, Chapter 9-2, *Non-covered services*, has been updated to reflect policy changes to weight loss medications consistent with the policy update in the July 2025 MIB.