January 2026

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, 2026

26-01 Account Admin Access Enhancement in PRISM

Utah Medicaid is updating its PRISM system functionality to Identity Cloud in the summer of 2026. This change will enhance domain management capabilities to support existing external provider account administrators to directly add users to their designated domains.

The project is currently in development. More information will be provided as it becomes available.

26-02 CLIA Update

Effective for dates of service on or after February 12, 2026, only laboratories with a certification level of Certificate of Waiver are required to submit the QW modifier with CLIA waived tests. Laboratories with a CLIA level of Certification of Registration, Compliance, or Accreditation will no longer be required to submit the QW modifier.

26-03 Orthodontic Treatment Providers

Effective January 1, 2026, Medicaid will require that dental providers use the Utah Medicaid Index of Orthodontic Treatment Need (IOTN) form, a score sheet to determine medical necessity for orthodontic treatment. The IOTN form is an auto-qualified tool developed by Utah Medicaid and replaces the Salzmann Evaluation Index that has been used previously.

Prior authorization (PA) is required for orthodontic treatment. All new PA requests submitted on or after January 1, 2026, must use the IOTN form. Any PA requests that do not include the IOTN form will be denied. PA requests that were submitted before January 1, 2026, using the Salzmann Evaluation Index, are not affected by the change.

The IOTN form and the IOTN instruction form can be found on the Utah Medicaid Forms webpage.

For additional information, refer to the Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual. For code-specific information, refer to the PRISM Coverage and Reimbursement Code Lookup Tool.

26-04 Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual Updates

Effective January 1, 2026, the following revisions have been made to the Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual:

- Chapter 8-7 *Orthodontics,* has been updated to include information on the IOTN form, the auto-qualified tool to determine medical necessity for orthodontic treatment.
- Chapter 8-4.1 *Dentures,* has been reworded to clarify the policy for partial dentures.
- In Chapter 11-1 *Reporting supernumerary teeth,* and Chapter 14 *Resources*, the tables have been updated.
- General revisions have been made throughout the manual to clarify policy, correct clerical and grammatical issues, and fix invalid or broken links.

In addition, the manual has been reformatted to align with Medicaid's current style guidelines.

26-05 Chiropractic Services

Effective January 1, 2026, the Utah Medicaid provider manuals for EPSDT Services (Chapter 1-24), Physician Services (Chapter 8-20), and Section I: General Information (Chapter 2-6 and Chapter 8-4.3) have been updated to provide clarification on coverage of chiropractic services.

Coverage of chiropractic services is only open for EPSDT-eligible members ages 6 through 20 years old and pregnant members. Service is limited to spinal manipulation and visits are limited to twelve visits per rolling year per member. Additional visits will require prior authorization and will be reviewed for medical necessity. Visits must be provided by a chiropractor licensed by the State of Utah.

Chiropractors performing manual manipulation of the spine may use manual devices. However, no additional payment is available for use of the device, nor does Medicaid recognize an extra charge for the device itself. No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered.

For coverage and reimbursement information for specific procedure codes, see the PRISM Coverage and Reimbursement Code Lookup Tool.

26-06 Physical Therapy and Occupational Therapy Services Provider Manual Updated

Effective January 1, 2026, the Physical Therapy and Occupational Therapy Services Provider Manual has been updated.

The manual's format has been revised to align with standard provider manual guidelines.

HB0188 was signed into law on March 25, 2025, enacting changes to Utah State Code, Chapter 24b (Physical Therapy Practice Act) and Chapter 42a (Occupational Therapy Practice Act). In accordance with these changes, the policy found in the Physical Therapy and Occupational Therapy Services Provider Manual has been updated to clarify that a health service provider referral is not required for physical therapy and occupational therapy services.

Physical therapy and occupational therapy services are limited to twenty (20) therapy sessions per discipline per calendar year. PRISM reference groups have been updated to align with this policy.

26-07 Physician Services Provider Manual Updated and Podiatric Services Provider Manual Archived

Effective January 1, 2026, the Physician 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. All references to 'qualified physicians and non-physicians' have been updated to 'qualified healthcare professional'.

Effective January 1, 2026, the Podiatric Services Provider Manual has been archived. The applicable information has been relocated to the Physician Services Provider Manual, Chapter 8-17 *Podiatric Services*.

26-08 Policy Manuals Aligned with PRISM System Processes

Effective January 1, 2026, the Section I: General Information, Physician Services, Hospital Services, Autism Spectrum Disorders, Dental, Oral, Maxillofacial and Orthodontia Services, Hospice Care Services, and the Pharmacy Services provider manuals, along with the Provider Instructions for Emergency Services Program for Non-Citizens Dialysis Coverage attachment have been updated to align Medicaid policies with current processes in the PRISM system. The updates affect policies related to:

- Authorizations and denials
- Hearings and administrative review
- Claims management
- Third-party liability (TPL)

26-09 Section I: General Information Exception Process Updates

Effective January 1, 2026, Section I: General Information Provider Manual has been updated to include specific requirements for requesting prior authorization for services exceeding coverage limitations, requesting prior authorization for non-covered services, and requirements for the submission of requests for state fair hearings.

The following chapters now include additional information:

- Chapter *5-4 Hearings and administrative review*
  - When an agency issues a determination on a claim for a specific item or service, the aggrieved person has 30 days to request a hearing. Adjustments to the initial claim or a claim resubmission that does not revise the initial determination shall not extend or change the appeal rights and timing of the initial determination.
  - If a provider has received a claim denial for lack of prior authorization, the claim must be rebilled with the prior authorization number for the claim to adjudicate properly.
  - For information on retroactive prior authorization, see Chapter 10-3 *Retroactive authorization*.
- Chapter 9-3.6 *Requesting exceptions for non-covered services, and services exceeding limitations*
  - New requirements for prior authorization when requesting services are now outlined including a new Prior Authorization Exception Form.
- *Chapter 12-7.1 Manual review criteria*
  - Removal of statement of unlisted codes requiring manual review.
  - The following two codes will remain on manual review:
    90999 - *Unlisted dialysis procedure*
    D5899 - *Unspecified removable prosthodontic procedure, by report*
- Chapter *12-7.5 Appealing denial*
  - Removal of documentation requirements for unlisted codes denied after manual review, documentation requirements have been moved to Chapter 9-3.6 *Requesting exceptions for non-covered services, and services exceeding limitations.*

For code specific coverage determinations, please see the PRISM Coverage and Reimbursement Code Lookup Tool.

26-10 End-Stage Renal Disease (ESRD) - Pharmacy to Hospital Services

Effective January 1, 2026, the Hospital Services Provider Manual has been updated. The term "physician" has been replaced with "qualified healthcare professional" (QHP) to reflect that services may be rendered by any practitioner operating within their scope of practice. The manual's format has also been revised to align with standard provider manual guidelines.

Policy related to End-Stage Renal Disease (ESRD) billing has been migrated from the Pharmacy Services Provider Manual Chapter VI: *Billing, Section* C: *End-Stage Renal Disease (ESRD) Billing,* into the Hospital Services Provider Manual Chapter 11-6, *End-stage renal disease (ESRD) billing*.

26-11 DUR Board Updates

The Drug Utilization Review (DUR) Board currently has four vacant positions: two pharmacists, one physician from academia, and one consumer representative. Individuals interested in joining the Utah Medicaid DUR Board may contact Luis Moreno, DUR Board Manager, at lmoreno@utah.gov for additional information.

In November, the DUR Board met to review new prior authorization (PA) criteria for the following: Avsola and biosimilars, Enbrel, Humira and biosimilars, Otezla, Pyzchiva and biosimilars, Taltz, and non-preferred immunomodulators.

In December, the DUR Board met to review new PA criteria for the following: Opzelura, Rinvoq, Tyenne and biosimilars, Xeljanz, Airsupra, and Wegovy for metabolic dysfunction-associated steatohepatitis (MASH). 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.

26-12 P&T Committee Updates

The Pharmacy and Therapeutics (P&T) Committee currently has five vacant positions: two pharmacists (academia, independent pharmacy) and three physicians (pediatrics, internal medicine, family practice). To apply for one of these positions, please contact Ngan Huynh at nganhuynh@utah.gov.

In November, the P&T Committee met to review subcutaneous, non-factor products for hemophilia prophylaxis therapy.

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

26-13 Submission Clarification Code (SCC) Update

Effective January 1, 2026, Submission Clarification Code 18 has been added to communicate specific circumstances that justify "refill too soon" overrides. Pharmacists must ensure that proper documentation is maintained to support the use of SCC codes.

18 – Facility Admission or Discharge
The pharmacist has determined that the previously dispensed supply is no longer accessible or usable. Pharmacists must document that all reasonable efforts to utilize the existing supply were exhausted, and a replacement fill is medically necessary due to the transition in care.

For a complete list of available SCC codes and additional guidance, refer to the current NCPDP Payer Sheet located in the pharmacy resource library at https://medicaid.utah.gov/pharmacy-program/resource-library.

26-14 Continuation of Care Policy Update

Beginning January 1, 2026, members transitioning to Medicaid from other payers may encounter differences in pharmacy coverage (preferred/non-preferred status) or clinical prior authorization resulting in claim denial. Exceptions to non-preferred or clinical prior authorization may be made when a request is received for continuation of care.

Continuation of care (COC) is defined as evidence of the member being on the requested medication for a minimum of 60 out of the last 90 days (measured from when the PA is received) with a chart note providing clinical rationale to support why the preferred products cannot be used, unless the medication is used emergently.

Continuation of care may not be approved in any of the following situations:

- Non-preferred dosing when the member can reasonably use preferred dosing to make up for the non-preferred requested dosing.
- Non-preferred dosage forms (capsule/tablet or tablet/capsule) unless clinical rationale is provided by supporting documentation.
- Non-preferred brand/generic unless clinical rationale is provided by supporting documentation.

26-15 Insulin Syringes Reporting Update

Historically, the Medicaid reporting policy for HCPCS S8490 *Insulin syringes (100 syringes, any size)* has been to limit utilization to 100 units per month, with a reimbursement rate of $0.20 per unit/syringe. This policy will be revised to align with the official code description, which specifies that 1 unit represents 100 syringes.

Effective January 1, 2026, utilization restrictions for HCPCS S8490 will be changed to 1 unit/month. Each unit will represent 100 insulin syringes, per the code description. The new reimbursement rate for this code will be changed to $20.00 per unit.

Providers are encouraged to update their reporting practices to reflect this change to ensure correct reporting and reimbursement.

26-16 Durable Medical Equipment (DME) Policy for Facial Prosthetics

Effective January 1, 2026, Medicaid will open coverage for HCPCS V2627 - *Scleral Cover Shell*.

- Coverage limitations: this code is limited to one (1) unit per side every five (5) years.
- Billing requirements: providers must report HCPCS V2627 with the appropriate RT (right side) or LT (left side) modifier to denote the side for which the shell is provided.

In addition, the Medicaid payment system, PRISM, has been updated to recognize and accept the reporting of the following modifiers when billed with certain facial prosthetic codes (HCPCS L8040 – L8048):

- KM modifier: used for the replacement of a facial prosthesis that requires a new impression
- KN modifier: used for the replacement of a facial prosthesis that uses an existing master model

The reporting of modifiers KM and KN is for informational and reporting purposes only. The use of these modifiers will not affect the current Medicaid reimbursement rates for these procedures.

Providers are reminded to reference the PRISM Coverage and Reimbursement Code Lookup Tool, available on the Medicaid website, for the most current information regarding coverage criteria, limitations, and reimbursement rates for facial prosthetic services.

26-17 Personal Care Services Reporting Changes

Effective January 1, 2026, personal care services reported using HCPCS code T1019 (*personal care services, per 15 minutes)* will be done in 15-minute increments. This represents a change from the prior code units of one unit for every hour of service provided.

Effective January 1, 2026, rate multiplication for personal care services reported using HCPCS code T1019 (*personal care services, per 15 minutes*) will be limited to 1.75x. Eligibility for this multiplication will be limited to claims with the TN modifier.

For more information, please refer to the Personal Care Services Provider Manual.

26-18 School-Based Skills Development

Vision and hearing screenings in a school-based setting are not skilled nursing services. Local Education Agencies (LEAs) should not use codes T1002 and T1003 for these services. Effective January 1, 2026, these screenings will be removed from the skilled nursing activities list in the School-Based Skills Development Provider Manual.

Code 99172 is not the most accurate code for vision screenings in a school-based setting. Effective January 1, 2026, LEAs should use code 99173 instead of 99172 when submitting claims for vision screenings.

LEAs should continue to use code V5008 when submitting claims for hearing screenings.

Expansion of the School-Based Skills Development program was implemented on July 1, 2025, and allows for LEAs to include students beyond special education. Certain references to special education in the School-Based Skills Development Provider Manual are no longer appropriate and have been removed or changed.

Please refer to the School-Based Skills Development Provider Manual for updated information.

26-19 Behavioral Health Code Standardization

To be compliant with National Correct Coding Initiative (NCCI) standards, Utah Medicaid will be making updates to the PRISM system in July 2026 for some behavioral health codes using 15-minute units for claims submissions. This announcement is meant to inform all providers of the upcoming code changes to adjust claims submissions and systems as necessary. The following codes will no longer use a 15-minute unit submission as of July 2026, and will instead follow NCCI standards as listed below:

CPT and Code Description	NCCI Submission Requirements
90791, Psychiatric diagnostic evaluation	Evaluation based service
90792, Psychiatric diagnostic evaluation with medical services	Evaluation based service
90846, Family psychotherapy (without patient present)	50 minutes (*excludes service time less than 26 minutes)
90847, Family psychotherapy (conjoint psychotherapy) (with patient present)	50 minutes (*excludes service time less than 26 minutes)
90849, Multiple-family group psychotherapy	50 minutes (*excludes service time less than 26 minutes)
90853, Group psychotherapy (other than of a multiple-family group)	Evaluation based (no time requirements)

26-20 Integrated Healthcare Services Provider Manual Update

The Integrated Healthcare Services Provider Manual, Chapter 8-8.4 *General Behavioral Health Integration (BHI)*, Coding and Billing General Behavioral Health Integration has been updated to include peer support services as a separate reportable service that may be delivered on the same day as a general BHI service.

26-21 Medically Managed Outpatient Treatment/Ambulatory Detoxification

Effective March 1, 2026, medically managed outpatient treatment programs will no longer be required to be licensed through the Utah Office of Licensing as a medically managed outpatient treatment facility.

Current providers who report this service with HCPCS code H0014, *Alcohol and/or drug services-ambulatory detoxification (with or without extended on-site monitoring),* must update their PRISM account and follow the steps below before February 14, 2026, for claims to continue processing correctly:

1. The account administrator must submit a 'modification' through PRISM for the facility to add a new Specialty (PT/SP/SSP) to their enrollment profile.

    a. The new Specialty (PT/SP/SSP) that must be chosen is: A330-Ambulatory Health Care Facilities/B609-Clinic/C796-Multi-Specialty.

    b. If you currently provide services that require facility licensure from the Office of Licensing, continue to report these with the correct PT/SP/SSP. Providers may have more than one PT/SP/SSP to report services to Medicaid.

    c. In the future, should you provide services that require a facility licensure from the Office of Licensing, the account administrator must submit a 'modification' through PRISM for the facility to add a new Specialty (PT/SP/SSP) to their enrollment profile. Depending on the services reported, use the appropriate specialty.

2. All individual providers who will be providing services will need to be associated to the facility. A 'modification' will need to be submitted in the individual's domain "associating the billing provider".

3. After these steps are completed, report services under the PT/SP/SSP: A330-Ambulatory Health Care Facilities/B609-Clinic/C796-Multi-Specialty using the facility NPI as the billing provider and the individual NPI as the rendering provider.

As of March 1, 2026, claims for medically managed outpatient treatment must be submitted under the PT/SP/SSP, A330-Ambulatory Health Care Facilities/B609-Clinic/C796-Multi-Specialty or A180-Groups/B562-Single-Specialty/C999-No Subspecialty, or the claim will be denied.

As of March 1, 2026, all new Medicaid providers enrolling to provide this service will need to enroll as a Facility with the Specialty (PT/SP/SSP) A330-Ambulatory Health Care Facilities/B609-Clinic/C796-Multi-Specialty or a Group Practice with the Specialty (PT/SP/SSP) A180-Groups/B562-Single-Specialty/C999-No Subspecialty.

26-22 Billing for Mental Health and Substance Use Disorder Treatment

Effective July 1, 2026, the following services will be reported using an updated methodology:

- Behavioral Health Residential Treatment (mental health and substance use disorder)
- Partial Hospitalization Program (mental health and substance use disorder)
- Intensive Outpatient Program (mental health and substance use disorder)

When reporting these services to Medicaid, providers will be required to submit claims via the 837I (institutional) transaction (the electronic equivalent of a UB-04 form). When submitting claims for residential services, facilities must submit the appropriate revenue code with the supporting CPT/HCPCS code appended to each revenue code reported. Multiple CPT/HCPCS codes can be used to support a single revenue code. The revenue codes are as follows:

Service	Revenue Code	Required Corresponding HCPCS Code
Substance Use Disorder Residential Treatment (IMD Facility)	1002	H0018
Substance Use Disorder Residential Treatment (Non-IMD Facility)	1002	H2036
Mental Health Residential Treatment (IMD Facility)	1001	H0017
Mental Health Residential Treatment (Non-IMD Facility)	1001	H2013
Partial Hospitalization (Intensive)	0913	Submit all required HCPCS/CPT Codes
Partial Hospitalization (Less Intensive)	0912	Submit all required HCPCS/CPT Codes
Intensive Outpatient Services (Chemical Dependency)	0906	Submit all required HCPCS/CPT Codes
Intensive Outpatient Services (Psychiatric)	0905	Submit all required HCPCS/CPT Codes

Questions may be submitted to dmhfmedicalpolicy@utah.gov.