May 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 May 1, 2026

26-40 CMS Interoperability and Prior Authorization Final Rule

The CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) aims to streamline patient care, reduce administrative burdens on clinicians, and improve data exchange. This rule mandates impacted payers to implement several new Application Programming Interfaces (APIs) to enhance patient and provider data access and streamline prior authorization processes.

Patient Access API

The Patient Access API requires impacted payers to implement and maintain a secure, standards-based Fast Healthcare Interoperability Resources (FHIR) API for its members, or a personal representative, to view their healthcare data on a mobile device using a third-party vendor software. As part of the final rule, impacted payers are required to add information about prior authorizations (excluding those for drugs) to the data available via the Patient Access API. This requirement must be implemented by January 1, 2027.

Prior Authorization API

The Prior Authorization API requires impacted payers to implement and maintain a secure, standards-based FHIR API that:

- Is populated with its list of covered items and services (excludes drugs of any type).
- Supports a prior authorization request and response.
- Sends prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests.
- Provides a specific reason for a denial, if appropriate.
- This requirement must be implemented by January 1, 2027.

Prior Authorization Metrics

Medicaid is required to report metrics, for all items and services that require prior authorization, annually on their website beginning March 31, 2026.

- The prior authorization metrics can be found at https://medicaid.utah.gov/administration-publications/.

Provider Access API

The Provider Access API requires impacted payers to implement and maintain a secure, standards-based FHIR API to:

- Share patient data with in-network providers with whom the member has a treatment relationship.
- Develop an attribution process to associate members with their providers.

- Maintain a process for members to opt out of having their health information shared.
- These requirements must be implemented by January 1, 2027.

Payer-to-Payer API

The Payer-to-Payer API requires impacted payers to implement and maintain a secure, standards-based FHIR API to:

- Make available member claims and encounter data, data classes, and data elements in the United States Core Data for Interoperability (USCDI) and information about certain prior authorizations (excluding those for drugs).
- Identify previous and concurrent payers and allow members to opt in/opt out of sharing their information.
- Exchange member data where concurrent coverage with two or more payers exists.
- These requirements must be implemented by January 1, 2027.

Provider Messaging

When developing plain language, educational resources for providers, impacted payers may wish to emphasize the following statements:

- Utah Medicaid Provider Access API allows the provider to electronically request certain data about their patients that Utah Medicaid covers. Utah Medicaid will be providing instructions on how to use the API to simplify this data retrieval.
    - These instructions will be located at https://medicaid.utah.gov/interoperability/ on or before September 30, 2026.

26-41 Prepaid Mental Health Plan Coverage Updates

Currently, most Medicaid members in Box Elder, Cache, and Rich counties are enrolled with Bear River Mental Health Services (BRMHS) as their Medicaid Prepaid Mental Health Plan (PMHP). Under the PMHP, BRMHS is responsible for inpatient mental health care and outpatient mental health services. Outpatient substance use disorder (SUD) services have not been covered under the BRMHS PMHP but instead have been covered under Medicaid fee-for-service (FFS).

Effective July 1, 2026, Medicaid members in these counties enrolled with BRMHS as their PMHP for mental health services, will also be enrolled with the BRMHS for outpatient SUD services (which include the residential treatment level of care). For dates of service on or after July 1, 2026, Medicaid will no longer pay FFS claims for outpatient SUD services.

Also, effective July 1, 2026, BRMHS will begin doing business as Bear River Behavioral Health Services (BRBHS) to reflect the coverage of both mental health and SUD services.

If you are currently providing outpatient SUD services to Medicaid members in Box Elder, Cache, or Rich counties, to ensure continuity of care, contact BRMHS to discuss provision of these services on or after July 1, 2026. Call BRMHS at 435-752-0750 or 1-800-620-0049.

This change does not affect:

- Methadone provided by opioid treatment programs (OTPs). OTPs will continue to bill the methadone code to Medicaid FFS. OTPs will need to discuss with BRMHS the provision of other services.
- Children in foster care. These children will continue to be enrolled with BRMHS only for inpatient mental health care. These children may get outpatient mental health and SUD services from any qualified Medicaid provider. Providers bill these services to Medicaid FFS.
- Children with subsidized adoption Medicaid. These children are enrolled with BRMHS for mental health services and with this change, they also will be enrolled with BRMHS for outpatient SUD services. However, they may be disenrolled (carved out) from BRMHS on a case-by-case basis for outpatient mental health and SUD services. When carved out, these children remain enrolled with BRMHS only for inpatient mental health care. They may receive outpatient mental health and SUD services from any qualified Medicaid provider. Providers bill these services to Medicaid FFS.
- SUD services provided by the Bear River Health Department providers. These providers will become part of BRMHS.
- Federally Qualified Health Centers (FQHCs). Medicaid members receiving outpatient SUD services from an FQHC may continue to do so. The FQHC will continue to bill Medicaid FFS.
- Targeted Adult Medicaid (TAM) members. TAM members are not enrolled in PMHPs. Providers will continue to bill outpatient SUD services to Medicaid FFS.

Before providing outpatient mental health or SUD services, providers must check to determine if the Medicaid member is enrolled with BRMHS as their mental health and substance use disorder plans. If the member is enrolled with BRMHS, the provider must refer the member to BRMHS for services. Please refer to Section I of the Utah Medicaid Provider Manual, Chapter 1-6, *Medicaid Member Card*, and Chapter 6-1, *Verifying Medicaid Eligibility*, for information on verifying Medicaid coverage and enrollment in managed care plans.

26-42 2026 Medicaid Statewide Provider Training

Join Utah Medicaid for the 2026 statewide provider training, offered through virtual webinars. This year features a variety of sessions covering specific, focused topics, and providers are welcome to register for and attend multiple trainings. Each session will follow a format of a short presentation followed by an open Q&A, with the exception of the UOIG training.

To register for the 2026 training, please complete the Google Form.

Previous statewide provider trainings are available on the Medicaid website. The 2026 slides and recordings will be posted after the trainings conclude.

The following dates and times are scheduled for the 2026 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	Description
Tuesday, August 11	10:00 - 11:00	New Medicaid Providers Only	Training is geared towards newly enrolled Medicaid providers. Overview of resources, how to access PRISM and the different tools available.
Tuesday, August 18	10:00 - 12:00	Claims and Billing (remits, filters, how to adjust a claim)	Training will cover the following topics: 1. Claims 2. Third Party Liability / Coordination of Benefits 3. Remittance Advice 4. Medical Documentation Submissions 5. Timely Filing 6. New SPOTs
Wednesday, August 19	10:00 - 11:00	Third Party Liability	Overview of third party liability claims.
Thursday, August 20	10:00 - 11:00	Provider Enrollment	Training will cover the following topics: 1. Revalidation Cycle - what documents are needed to complete the revalidation 2. Re-enrollment - what documents are needed to complete the re-enrollment 3. Application/Modification Checklist when it shows incomplete is anything needed 4. Account Administration - new process flow 5. Healthcare User Access Agreement - what are the required fields
Tuesday, August 25	10:00 - 11:00	Pharmacy Program	Overview of the pharmacy program and policy updates from the last year.

Wednesday, August 26	10:00 - 11:00	Prior Authorization	General prior authorization team overview, PRISM entry tip and tricks, recent policy and criteria related changes impacting FFS Prior Authorizations and resources.
Thursday, August 27	9:00 - 10:00	Managed Care	Overview of Managed Care programs and plans including updates and policy changes.
Tuesday, September 1	10:00 - 11:00	Healthcare Policy for Hospitals, Outpatient, and Physicians	Overview of Medical Policy Team; Updates to Hospital, Outpatient, and Physician Policy.
Wednesday, September 2	10:00 - 11:00	Healthcare Policy for Behavioral Health Providers	Overview of Medical Policy Team; Updates to Behavioral Health Policy.
Thursday, September 3	10:00 - 11:00	Healthcare Policy for DME, Home Health, Private Duty Nursing, and Personal Care Service Providers	Overview of Medical Policy Team; Updates to DME, Home Health, Private Duty Nursing, and Personal Care Service Policy.
Tuesday, September 8	10:00 - 11:00	Dental Providers (Fee-for-service and Managed Care)	Overview of Medical Policy; Overview of Managed Care Structure; Updates to Dental Policy
Wednesday, September 9	10:00 – 11:00	Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services	Overview of the Medical Policy Team; Updates to EPSDT Policy.
Thursday, September 10	10:00 – 11:30	Utah Office of Inspector General (UOIG)	Overview of the OIG; common fraud, waste, and abuse schemes; avoiding improper Medicaid payments; emerging fraud trends; The False Claims Act; how to report; and provider tips and resources.
Thursday, September 17	10:00 - 11:00	Federal H.R. 1/ One Big Beautiful Bill Act (OBBBA) Updates	Overview of the OBBBA provisions that impact Utah Medicaid and the changes that are coming as a result of the bill.

26-43 Section I: General Information Provider Manual Updated

Effective May 1, 2026, the Section I: General Information provider manual has been updated to include specific requirements for requesting prior authorization for services exceeding coverage limitations and requesting prior authorization for non-covered services.

Chapter 9-3.6, *Requesting exceptions for non-covered services, and services exceeding limitations*

- Providers must obtain prior authorization for non-covered services and services exceeding limitations prior to performing services, except as outlined in Section I: General Information, Chapter 10-3*, Retroactive authorization*.
- All documentation submitted must be in alignment with HIPAA guidelines and only be related to the requested services or items. Excessive documentation will not be reviewed for medical necessity and will be returned to the requestor for correction.
- We are removing the requirement for the Prior Authorization Exception Form.

26-44 Dental Services for Pregnant, Postpartum, and EPSDT Members

Effective July 1, 2026, dental services for members receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits, as well as pregnant and postpartum members, will transition from Managed Care Entity (MCE) dental plans (Premier Access and MCNA Dental) to Medicaid Fee for Service (FFS). Members will be transitioned to FFS automatically.

For information about dental services, refer to the Dental, Oral Maxillofacial, and Orthodontia provider manual. For information about covered services and procedure codes, refer to the PRISM Coverage and Reimbursement Code Lookup Tool. To download the Provider Allowable Code (PAC) fee schedule, refer to the PRISM Coverage and Reimbursement Fee Schedule Download Tool.

To receive reimbursement for dental services rendered to any Medicaid member, providers must meet both of the following requirements:

1. Medicaid enrollment: Providers must be actively enrolled as Medicaid providers.
2. University of Utah School of Dentistry (UUSOD) Network enrollment: Providers must be enrolled in the UUSOD Medicaid Associated Provider Program.

Providers who have not yet enrolled in the UUSOD Medicaid Associated Provider Program need to contact the UUSOD Associated Provider Team:

- Phone: (801) 646-7401
- Email: dental.network@hsc.utah.edu

For more information, refer to the UUSOD Medicaid Associated Provider Program webpage.

26-45 GLP-1 Agonists for Weight Loss

Effective June 30, 2026, Utah Medicaid fee-for-service (FFS) will no longer cover GLP-1 agonists, including Wegovy, Saxenda, and Zepbound for weight loss for FFS members.

Utah Medicaid will continue to cover GLP-1 agonists for other FDA-approved indications, including major adverse cardiovascular events, metabolic dysfunction-associated steatohepatitis, and severe obstructive sleep apnea.

26-46 Pharmacy Submission Clarification Codes

Effective January 1, 2026, Submission Clarification Code (SCC) 04 has been updated to communicate specific circumstances that justify *refill to soon* overrides. Pharmacists must ensure that proper documentation is maintained to support the use of SCC codes.

- 04 Lost/Damaged/Stolen Prescription
  The pharmacist is indicating that the cardholder has requested a replacement of medication that has been lost, damaged, or stolen.

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.

26-47 DUR Board Updates

The Drug Utilization Review (DUR) Board currently has one vacant pharmacist position. Individuals interested in joining the Utah Medicaid DUR Board may contact Luis Moreno, DUR Board Manager, lmoreno@utah.gov, for additional information.

In March, the DUR Board met to discuss *GLP-1 Receptor Agonists for the Treatment of Obesity: Long-Term Benefits and Discontinuation After Ongoing Treatment*, topic by the University of Utah's Drug Regimen Review Center. The DUR Board reviewed new prior authorization criteria for Kisunla (donanemab-azbt) and Pompe Disease.

In April, the DUR Board met to discuss the *Economic Value of GLP-1 Receptor Agonists Approved for the Treatment of Obesity*, topic by the University of Utah's Drug Regimen Review Center. The DUR Board also re-reviewed updates to the prior authorization criteria for Kisunla (donanemab-azbt), as well as new prior authorization forms: Agamree, IBAT inhibitors, and iDose TR.

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.

26-48 P&T Committee Updates

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

There were no P&T Committee meetings in March and April.

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.

26-49 Buprenorphine Quantity Limit Update

Effective January 1, 2026, quantity limits for buprenorphine/naloxone tablets and films have been updated. The maximum allowable daily dose remains 24 mg/day.

Updated quantity limits:

- 2/0.5 mg and 4/1 mg: Increased to 4 units per day.
- 8/2 mg: Remains at 3 units per day.
- 12/3 mg: Remains at 2 units per day.

Additional information can be found at Utah Medicaid Preferred Drug List.

26-50 Anti-VEGF Prior Authorization Update

Effective March 1, 2026, fee-for-service (FFS) Medicaid no longer requires prior authorization for anti-VEGF (vascular endothelial growth factor) injections.

Providers must check the PRISM Coverage and Reimbursement Code Lookup Tool every time services are provided.

26-51 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 January 2027 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 January 2027, 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)

26-52 Behavioral Health Services Provider Manual Updated

Effective May 1, 2026, the Behavioral Health Services provider manual, Chapter 4, *Record Keeping*, has been reorganized for better clarity and easier reference. No policy changes have been made. Please see the updated chapter in the revised provider manual.

26-53 Behavioral Health Services Revenue Codes

Effective January 2027, 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.

26-54 PA Removal from Negative Pressure Wound Therapy Supply Codes

Effective April 1, 2026, Medicaid will no longer require a separate prior authorization for the following negative pressure wound therapy (NPWT) HCPCS supply codes when used in conjunction with an authorized NPWT pump (HCPCS code E2402):

- A7000 (canister, disposable)
- A6550 (Wound care set)

While a separate PA is no longer required for these supplies, coverage remains contingent upon the approval of the primary NPWT device. Providers should consult the PRISM Coverage and Reimbursement Code Lookup Tool "Special Notes" for information regarding updated quantity limits and documentation requirements for these codes.

26-55 Dyadic Services

Dyadic services continue to be a covered benefit for Early and Periodic Screening Diagnostic and Treatment (EPSDT) members. This is a preventative care model that treats the child and their parent or caregiver together as a single unit. Because these services are designed to provide a direct benefit to the child's health and development, the services are billed entirely under the EPSDT member's benefit.

This comprehensive coverage includes dyadic behavioral health (DBH) visits, community support services, psychoeducational services, and family training along with counseling focused on child development. These services help families navigate and access vital community supports.

Information regarding dyadic services has been added to the EPSDT website.

26-56 Doula Services

Effective April 1, 2026, doula services became a covered benefit through Utah Medicaid. The Women's Services and Family Planning provider manual has been updated to reflect these changes. See Chapter 8-5.8*, Doula Services*, for more information.

26-57 Medicaid Canopie Pregnancy App

Utah Medicaid has contracted with Canopie to provide pregnant and postpartum Medicaid members with access to the Canopie App. The Canopie App is a mobile and web application for expecting and new mothers that provides virtual support and education.

Effective May 15, 2026, members will have full access to the Canopie App. The app will also provide Medicaid-specific resources and information. To access this resource, Medicaid members only need to download the application to their mobile device and follow the prompts. Additional information and enrollment instructions can be found on the Utah Medicaid-Canopie website. To learn more about the Canopie App, visit the Canopie website.

26-58 Ancillary Services for Nursing Home Providers

To comply with guidance from the Centers for Medicare and Medicaid Services (CMS) and to preserve the long-term viability of the Upper Payment Limit (UPL) program, Utah Medicaid is proposing updates to its coverage policy for nursing facility ancillary services.

Subject to CMS approval of the State Plan Amendment (SPA), Medicaid plans to align its "routine" and "non-routine" service definitions with the Medicare Patient Driven Payment Model (PDPM) with some exceptions (e.g., medications, laboratory, radiology, oxygen). This transition is intended to ensure a more accurate comparison between Medicaid and Medicare services—a federal requirement for maintaining the supplemental UPL payments that support Non-State Government Owned (NSGO) facilities.

If approved, the following updates will be made to the State Plan Attachment 4.19-D regarding services included in the daily per diem rate versus those that may be billed as ancillary (non-routine).

Routine (non-ancillary) services will include, but are not limited to:

- **Therapy Services:** Physical therapy, occupational therapy, speech-language pathology, and audiology examinations.
- **Medical Supplies and Equipment:** Routine supplies including, but not limited to, syringes, ostomy supplies, catheters, IV set-ups, and oxygen tubing/masks.
- **Durable Medical Equipment (DME):** Standard equipment such as canes, crutches, walkers, wheelchairs, traction equipment, floatation mattresses, and CPAP/Bi-PAP supplies.
- **Transportation:** Non-emergency medical transportation.

- **Dietary and Hygiene:** Special dietary supplements (tube or oral feeding), laundry services, and personal hygiene items (shampoo, toothpaste, etc.).

Under the proposed policy revision, services that would remain billable as ancillary (non-routine) include:

- **Prescription Drugs:** Prescription medications remain categorized as non-routine.
- **Customized and Power Wheelchairs:** Specialized mobility equipment, including power wheelchairs and custom-configured wheelchairs.
- **Oxygen:** Oxygen and oxygen concentrators remain a non-routine, billable service (note: delivery equipment like tubing/masks is considered routine).
- **Professional and Diagnostic Services:** Direct resident care provided by physicians, psychologists, podiatrists, optometrists, and audiologists, as well as laboratory and radiology services.
- **Dental and Prosthetics:** Dental services (except for ICF/IID annual exams) and prosthetic devices.
- **Emergency Transportation:** Emergency ambulance transportation.

As this policy is currently pending federal approval, the approved State Plan language is not yet available. Utah Medicaid will continue to provide updates through future MIB articles. Once CMS grants approval, formal policy language will be published to assist providers with needed policy details.

26-59 School-Based Skills Development Services

The School-Based Skills Development provider manual currently defines a *Document of Medical Necessity* (DMN) as requiring both a medical diagnosis and a medical need.

The DMN definition is being amended to state that it must include either a medical diagnosis or a medical need. This change will be retroactive back to August 1, 2025.