July 2026

Utah Department of
Health & Human Services
Integrated Healthcare

Medicaid Information Bulletin (MIB)

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

26-60 SUBSTANCE USE DISORDER (SUD) PROVIDER ENROLLMENT MORATORIUM 2
26-61 RISK LEVEL ADJUSTMENT AND REVALIDATION FOR ABA AND SUD PROVIDERS 2
26-62 MID-CYCLE REVALIDATION SCHEDULED FOR HIGH-RISK BILLING PROVIDERS 3
26-63 CACHE COUNTY RECLASSIFICATION TO URBAN STATUS 4
26-64 BENEFITS OF INTEROPERABILITY FOR MEDICAID MEMBERS 5
26-65 BILLING GUIDANCE 6
26-66 TELEHEALTH MODIFIERS 7
26-67 DENTAL SERVICES FOR PREGNANT, POSTPARTUM, AND EPSDT MEMBERS 7
26-68 DUR BOARD UPDATES 8
26-69 P&T COMMITTEE UPDATES 8
26-70 QUANTITY LIMIT UPDATES 9
26-71 BEHAVIORAL HEALTH CODES RATE REBASE INFORMATION 9
26-72 BEHAVIORAL HEALTH CODE STANDARDIZATION 11
26-73 BEHAVIORAL HEALTH SERVICES PROVIDER MANUAL UPDATED 11
26-74 BEHAVIORAL HEALTH SERVICES REVENUE CODES 12
26-75 POLICY FOR CUSTOM SILICONE TRACHEOSTOMY TUBES 13
26-76 WHEELCHAIR TRANSPORTATION SECUREMENT SYSTEM CODES 13
26-77 ORTHOTICS COVERAGE IN PODIATRIC SERVICES UPDATE 13
26-78 CLARIFICATION FOR TRANSPORTATION UPON DISCHARGE FROM A SKILLED NURSING FACILITY 14
26-79 ANCILLARY SERVICES FOR NURSING HOME PROVIDERS: POLICY CHANGES FOR PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH-LANGUAGE PATHOLOGY PROVIDERS 14
26-80 NON-INVASIVE PRENATAL TESTING 15
26-81 COVERAGE OF 3D MAMMOGRAPHY 16
26-82 RURAL ENHANCEMENT MODIFIER CLARIFICATION 16
26-83 MULTIPLE MEMBERS SERVED MODIFIERS (UN, UP, UQ, UR, US) 16
26-84 HOME HEALTH SERVICES PROVIDER MANUAL UPDATED 17
26-85 DENTAL TRANSITIONS FROM MANAGED CARE ORGANIZATIONS TO FEE-FOR-SERVICE 17
26-86 2026 MEDICAID STATEWIDE PROVIDER TRAINING 19

Unless otherwise noted, all changes take effect on July 1, 2026

26-60 Substance Use Disorder (SUD) Provider Enrollment Moratorium

DHHS received approval from the Centers for Medicare and Medicaid Services (CMS) to impose a temporary moratorium on enrolling new Substance Use Disorder (SUD) and mental health rehabilitation providers into the Utah Medicaid program. The moratorium will remain in effect for an initial period of six months while we complete compliance reviews and risk assessments of existing providers. See the press release: https://mailchi.mp/utah.gov/news-release-medicaid-moratorium.

The moratorium only applies to new fee for service provider enrollments, including provider enrollments in progress. Compliant providers already in the network will continue operating normally. An exception process for new providers will be available on a case-by-case basis to ensure Medicaid members have sufficient access to care. Medicaid members currently receiving substance use disorder treatment will see no disruption to their care. We do not expect this to impact our managed care plans or local mental health authorities. However, we will continue to work closely and monitor network adequacy throughout this pause.

26-61 Risk Level Adjustment and Revalidation for ABA and SUD Providers

Effective July 1, 2026, the Utah Department of Health and Human Services (DHHS) is increasing the categorical risk level to “High Risk” for providers specializing in Applied Behavior Analysis (ABA) and Substance Use Disorder (SUD) treatment facilities.

All existing ABA and SUD providers must revalidate their enrollment within the next 18 months. Revalidation notices will be mailed in phases beginning September 2026. To maintain active enrollment, providers must complete the following "High Risk" screening criteria within 60 days of the date on their notification letter to avoid closure:

- Report all individuals or corporations with a 5% or greater direct or indirect ownership interest.
- Required for individual owners with 5% more direct or indirect. Providers may obtain information on how to obtain the mandated FCBC by logging onto MY FBI Report at www.myfbireport.com click on “FINGERPRINTING”, then click on applicable state residence. A list of locations throughout your state will populate, where you may be fingerprinted to begin the process for obtaining and mailing your FCBC card. You may also go to www.fbi.gov/services/cjis/identity-history-summary-checks/list-of-fbi-approved-channelers-for-departmental-order-submissions to obtain the live scan the results within 24 hours.

- Pre-enrollment or post-enrollment unannounced site visits may be conducted by DHHS or its designee.
- Providers must pay the 2026 federally mandated enrollment fee ($750), unless they can provide proof of active enrollment and fee payment to Medicare or another state's Medicaid program.

Note: Failure to complete the revalidation process by the specified deadline may result in termination from the Utah Medicaid program. For assistance, contact the Provider Enrollment team at (800) 662-9651 option 3, and then option 4.

26-62 Mid-Cycle Revalidation Scheduled for High-Risk Billing Providers

In accordance with federal regulations under 42 CFR 424.515 and Utah Administrative Code R414-23-3, Utah Medicaid requires all enrolled providers to regularly revalidate their enrollment information.

To support enhanced program integrity, transparency, and operational efficiency, the Utah Department of Health and Human Services (DHHS) is aligning with federal directives issued by the Centers for Medicare and Medicaid Services (CMS) under the leadership of Administrator Dr. Mehmet Oz. In coordination with these state and federal priorities, Utah Medicaid will be conducting a comprehensive mid-cycle revalidation initiative over the next two years.

This mid-cycle revalidation is mandatory and applies to all billing providers categorized under high categorical risk levels that have not revalidated after July 1, 2025.

Implementation Timeline

The mid-cycle revalidation process will be rolled out in phases based on the provider's designated categorical risk level:

Provider Categorical Risk Level	Revalidation Timeline
High Risk	Revalidation letters will begin going out on July 15, 2026, and revalidation must be completed within 90 days of the initial notification letter.

Providers will receive official notification when it is their specific time to revalidate. All revalidations must be completed electronically through the Provider Reimbursement Information System for Medicaid (PRISM) portal.

1. Utah Medicaid will send a physical notification letter to the "Pay-To" address on file in your PRISM account when your revalidation window opens.
2. In accordance with the state rule, providers must complete and submit the revalidation process within 90 days from the date of the letter.
3. Failure to complete revalidation within 90 days of the initial letter will result in the termination of your Utah Medicaid enrollment.

To ensure a smooth revalidation process and avoid any disruptions to claims payments, providers should take the following steps immediately:

- Log into the PRISM Portal and verify that your "Pay-To" and correspondence addresses, email addresses, and contact phone numbers are completely accurate and up to date.
- Ensure your credentialing and billing staff are actively looking for Utah Medicaid revalidation notices.
- Ensure all licensing, certifications, and required provider disclosures (pursuant to 42 CFR 455.104) are current so they can be readily verified during your revalidation cycle.
    - You can view a list of required documents by clicking on the “required credentials” button in the “upload document” step in PRISM.

For questions regarding your risk category or the revalidation process, please contact Utah Medicaid Provider Enrollment via email at providerenroll@utah.gov.

26-63 Cache County Reclassification to Urban Status

Effective July 1, 2026, Cache County will be reclassified as an urban county for Medicaid provider reimbursement purposes. Please note that this change applies to physician services, dental services, and other licensed providers whose reimbursement rates are tied directly to the physician fee schedule under the State Plan. Specifically, this transition impacts the following provider types:

- Anesthesiologist services
- Physician assistant services
- Dental services
- Licensed certified registered nurse-midwife services
- Nurse practitioner services

- Other physician services and services that pay the same as physician services according to the State Plan

Rural county reimbursement methodologies will no longer apply to these specific provider types. However, unrelated service types will remain unaffected. This transition may result in rate differences for affected providers. To ensure clarity, the policy is being rolled out in a multi-phased approach with key dates highlighted:

July 1, 2026
Reimbursement changes take effect. On this date, the policy will be formally integrated into the Utah State Plan, and new urban reimbursement rates for the physician, dental, and associated practitioner services listed above will begin.

September 1, 2026
Provider manuals will be updated. Relevant manuals will be officially revised to reflect the urban county designation for these specific services.

Providers rendering services in Cache County are encouraged to review the updates to understand how these changes may impact their payments.

26-64 Benefits of Interoperability for Medicaid Members

As the implementation of the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) approaches, member awareness has been identified as a primary concern for Utah Medicaid, managed care plans, payers, and providers.

We encourage you to share the benefits of interoperability with members and invite them to create an account on the MyBenefits website: https://medicaid.utah.gov/mybenefits-login/.

The benefits of interoperability for members include:

- **Real-time coverage information:** Quickly verify your eligibility dates and health plan to make sure you are covered before an appointment
- **Track approvals:** Monitor the status of your prior authorizations
- **Faster decisions and access to care:** Get prior authorization decisions within 72 hours for expedited (urgent) requests and seven calendar days for standard (non-urgent) requests
- **Improved patient outcomes:** Increased automation reduces delays in care for patients waiting for approval of medical items, services, and eventually, prescription drugs
- **Reduced administrative burden:** Electronic, EHR-integrated workflows reduce the need for manual, fax-based, or portal-based requests, saving significant time for providers

- **Care continuity:** Eliminates coverage-transition disruptions so active care plans remain intact
- **Data portability:** Empowers members to securely carry their historical medical records across insurance networks
- **Reduced administrative friction:** Decreases the time spent tracking down historical charts, faxing, and pulling external records
- **Elimination of duplicative testing:** Prevents re-ordering expensive lab or diagnostic workups because historical results are visible
- **Mitigation of medical errors:** Minimizes dangerous prescription or diagnostic errors caused by incomplete data sets

26-65 Billing Guidance

Parent and Add-On Codes

Parent codes and add-on codes must be billed on the same claim. For proper claims adjudication, the parent code must be billed sequentially prior to the add-on code.

Separate and Distinct Services

Any service or procedure that is separate and distinct that occurs on the same date of service must be billed with the appropriate modifier. For example:

59: Distinct procedural service
XE: Separate encounter
XS: Separate structure
XP: Separate practitioner
XU: Unusual non-overlapping service

All services must be appropriately documented. Medical records may be requested to support medical necessity and the distinct nature of both services.

CMS Resources

APMA Coding Resources

26-66 Telehealth Modifiers

Beginning October 1, 2026, providers will be required to append modifier 93 *Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System*, or modifier 95 *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System* when providing services via telehealth.

For additional information, see the Section I: General Information provider manual.

26-67 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 more information, refer to the Medicaid website.

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.

Administrative rule R414-49. Dental, Oral, and Maxillofacial Surgeons and Orthodontia and the provider manuals have been updated to reflect these changes.

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.

26-68 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 May, the DUR Board met to review new prior authorization forms for Pivya (pivmecillinam), and Zolgensma (onasemnogene abeparvovec-xioi) and Itvisma (onasemnogene abeparvovec-brve).

In June, the DUR Board met to discuss Single Maintenance and Reliever Therapy (SMART) for Asthma Management, a topic by the University of Utah's Drug Regimen Review Center. The DUR Board also reviewed new prior authorization forms for Imaavy (nipocalimab-aahu), Rystiggo (rozanolixizumab-noli), Vyvgart (efgartigimod alfa-fcab), and Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc); Vykat XR (diazoxide choline); and Verquvo (vericiguat).

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.

26-69 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.

In May, the P&T Committee met to review opioid overdose reversal agents.

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.

26-70 Quantity Limit Updates

Effective July 1, 2026, Utah Medicaid will implement a Quantity Limit (QL) for several medication classes including diabetic supplies, antidiabetics, HIV antiretroviral, hepatitis C, respiratory, and atopic dermatitis.

Quantity limits are listed on the Utah Medicaid Preferred Drug List. Providers may submit a prior authorization to request an exception to the limits.

26-71 Behavioral Health Codes Rate Rebase Information

As part of the National Correct Coding Initiative standardization project, Utah Medicaid has developed rates for the five unique codes that required a 15-minute time submission. This process required a rebase of all behavioral health codes and we have provided an update of the rebased codes including the current rate, the July 2026 rate, and the January 2027 rates.

Code	Description	7/1/25 Rate	7/1/26 Rate	1/1/27 Rate
90832	PSYTX PT&/FAMILY 30 MINUTES	$70.41	$71.69	$83.67
90833	PSYTX PT&/FAM W/E&M 30 MIN	$70.41	$71.69	$79.10
90834	PSYTX PT&/FAMILY 45 MINUTES	$125.66	$127.95	$127.95
90836	PSYTX PT&/FAM W/E&M 45 MIN	$105.61	$107.53	$107.53
90837	PSYTX PT&/FAMILY 60 MINUTES	$156.38	$159.23	$162.81
90838	PSYTX PT&/FAM W/E&M 60 MIN	$140.80	$143.36	$143.36
90839	PSYTX CRISIS INITIAL 60 MIN	$140.80	$143.36	$156.19
90840	PSYTX CRISIS EA ADDL 30 MIN	$70.41	$71.69	$75.13
90870	ELECTROCONVULSIVE THERAPY	$110.10	$112.10	$174.16
96116	NEUROBEHAVIORAL STATUS EXAM	$171.46	$174.58	$174.58
96121	NUBHVL XM PHY/QHP EA ADDL HR	$171.46	$174.58	$174.58
96130	PSYCL TST EVAL PHYS/QHP 1ST	$171.46	$174.58	$174.58
96131	PSYCL TST EVAL PHYS/QHP EA	$171.46	$174.58	$174.58
96132	NRPSYC TST EVAL PHYS/QHP 1ST	$171.46	$174.58	$174.58
96133	NRPSYC TST EVAL PHYS/QHP EA	$171.46	$174.58	$174.58
96136	PSYCL/NRPSYC TST PHY/QHP 1ST	$85.72	$87.28	$87.28
96137	PSYCL/NRPSYC TST PHY/QHP EA	$85.72	$87.28	$87.28
96138	PSYCL/NRPSYC TECH 1ST	$28.51	$29.03	$35.09
96139	PSYCL/NRPSYC TST TECH EA	$28.51	$29.03	$32.93
96146	PSYCL/NRPSYC TST AUTO RESULT	$1.56	$1.59	$2.16

99211	OFC,OUTPAT VISIT E/M EST MAY NOT REQUIRE PHYSICIA	$52.72	$53.68	$53.68
99213	OFFICE / OUTPAT VISIT ESTAB. 2/3 H:EP E:EP D:LC	$120.59	$122.78	$122.78
99214	OFFICE / OUTPAT VISIT ESTAB. 2/3 H:DT E:DT D:MC	$155.10	$157.92	$157.92
99308	NURSING FAC CARE,E&M REQ 2 OF 3:HISTORY;EXAM;LOW C	$120.59	$122.78	$122.78
99309	NURSING FAC CARE,E&M REQ 2 OF 3:HISTORY;EXAM;MOD C	$120.59	$122.78	$122.78
99310	NURSING FAC CARE,E&M REQ 2 OF 3:HISTORY;EXAM;HIGH	$120.59	$122.78	$157.19
99348	HOME VISIT FOR E&M OF ESTABLISHED PATIENT, 25 MIN.	$120.59	$122.78	$122.78
99349	HOME VISIT FOR E&M OF ESTABLISHED PATIENT, 40 MIN.	$120.59	$122.78	$127.65
90791	PSYCH DIAGNOSTIC EVALUATION	$42.94	$43.72	$214.70
90792	PSYCH DIAG EVAL W/MED SRVCS	$42.94	$43.72	$247.30
90846	FAMILY PSYCHOTHERAPY (WITHOUT PATIENT PRESENT)	$35.21	$35.85	$117.37
90847	FAMILY PSYCHOTHERAPY (CONJOINT)(W PATIENT PRESENT)	$35.21	$35.85	$122.37
90849	MULTIPLE-FAMILY GROUP PSYCHOTHERAPY	$8.20	$8.35	$63.18
90853	GROUP PSYCHOTHERAPY (OTHER THAN MULTI-FAM GROUP)	$10.53	$10.72	$73.71
0905	BEHAVIORAL HEALTH TREATMENT/SERVICES (ALSO SEE 091X, AN EXTENSION OF 090X) - INTENSIVE OUTPATIENT SERVICES – PSYCHIATRIC (HCPCS Code S9480)	N/A	N/A	$293.38
0906	BEHAVIORAL HEALTH TREATMENT/SERVICES (ALSO SEE 091X, AN EXTENSION OF 090X) - INTENSIVE OUTPATIENT SERVICES - CHEMICAL DEPENDENCY (HCPCS Code H0015)	N/A	N/A	$293.38
0912	BEHAVIORAL HEALTH TREATMENT/SERVICES - EXTENSION OF 090X - PARTIAL HOSPITALIZATION - LESS INTENSIVE (HCPCS Code H0035)	N/A	N/A	$445.94

0913	BEHAVIORAL HEALTH TREATMENT/SERVICES - EXTENSION OF 090X - PARTIAL HOSPITALIZATION – INTENSIVE (HCPCS Code H0037)	N/A	N/A	$551.55

26-72 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)

26-73 Behavioral Health Services Provider Manual Updated

Effective July 1, 2026, the Behavioral Health Services provider manual, Chapter 7-21, *Recreational Therapy*, has been updated to include, “licensed residential support program accredited by the American Camp Association” as an allowed provider setting for recreational therapy services. Providers offering recreational therapy services in this setting must be licensed through the Office of Licensing as a Residential Support Program and must be accredited through the American Camp Association. When enrolling under the

recreational therapy provider type, providers must complete the appropriate attestation form to confirm accreditation by the American Camp Association.

26-74 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	H0037
Partial Hospitalization (Less Intensive)	0912	H0035
Intensive Outpatient Services (Chemical Dependency)	0906	H0015
Intensive Outpatient Services (Psychiatric)	0905	S9480

Questions may be submitted to dmhfmedicalpolicy@utah.gov.

26-75 Policy for Custom Silicone Tracheostomy Tubes

To address concerns regarding inadequate reimbursement for high-cost tracheostomy supplies and to ensure continued member access to care, Medicaid is updating its billing policy for custom silicone tracheostomy tubes.

Beginning July 1, 2026, enrolled Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers should continue to report standard PVC and silicone tubes under HCPCS codes A7520 and A7521 at the current published fee schedule reimbursement rate. Providers should utilize HCPCS code S8189 (Tracheostomy supply, not otherwise classified) to report custom silicone tracheostomy tubes.

Claims that include S8189 will be manually priced at 120% of the Actual Acquisition Cost (AAC) plus shipping. Medicaid defines AAC as the invoice price paid by the provider, representing the true cost of the purchase from the manufacturer or the direct cost of manufacturing the custom tracheostomy tube. Please be advised that AAC does not represent the manufacturer's suggested retail price (MSRP), list price, or any other estimated retail value.

Providers are required to submit documentation of the acquisition and shipping costs with their claims to ensure accurate reimbursement.

26-76 Wheelchair Transportation Securement System Codes

Effective May 1, 2026, Medicaid will open coverage for HCPCS codes E1022 (Wheelchair transportation securement system, any type, includes all components and accessories) and E1023 (Wheelchair transit securement system).

Coverage of these codes requires prior authorization and is considered an "add-on" to base equipment coverage, as detailed in the Medical Supplies and Durable Medical Equipment provider manual, Chapter 8-14.5, *Accessories, Attachments, Components, and Options*, Table A.

Providers should consult the PRISM Coverage and Reimbursement Code Lookup Tool "Special Notes" for further information regarding specific requirements for these codes.

26-77 Orthotics Coverage in Podiatric Services Update

Effective July 1, 2026, the Physician Services provider manual has been updated to clarify policy regarding orthotics coverage in podiatric services.

26-78 Clarification for Transportation Upon Discharge from a Skilled Nursing Facility

Effective July 1, 2026, the Medical Transportation Services provider manual, Chapter 8-2.12, will clarify the transportation responsibilities for a skilled nursing facility. It clarifies that the skilled nursing facility is responsible for transportation while the member is admitted to the facility, while Medicaid's transportation broker is responsible for transportation upon discharge.

26-79 Ancillary Services for Nursing Home Providers: Policy Changes for Physical Therapy, Occupational Therapy and Speech-Language Pathology Providers

Medicaid is reissuing previously published guidance to reinforce upcoming policy changes detailed in the May 2026 MIB. Please note this policy change will have a substantial impact to Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) providers who will no longer report services as ancillary under the proposed policy change.

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.

Important Notice for Therapy Providers: Under this proposed alignment, PT, OT, and SLP services will transition from separately billable ancillary services to routine services covered under the nursing facility's daily per diem rate.

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 (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services.
- Medical Supplies and Equipment: Routine supplies including, but not limited to, syringes, ostomy supplies, catheters, IV set-ups, and routine dressings (e.g., gauze, bandages).

- Durable Medical Equipment (DME): Standard equipment such as canes, crutches, walkers, wheelchairs, traction equipment, floatation mattresses, and CPAP/Bi-PAP equipment/supplies.
- Transportation: Non-emergency medical transportation.
- Dietary and Hygiene: Standard dietary supplements, laundry services, and personal hygiene items (e.g., shampoo, toothpaste, disposable briefs) as specified in 42 CFR 483.10.

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

- Prescription Drugs and Enteral Formula: Prescription medications and enteral nutrition formulas remain categorized as non-routine.
- Specialized Mobility Equipment: Customized wheelchairs (measured, fitted, or adapted to an individual's body size and disability) and power wheelchairs.
- Oxygen: Oxygen gas, liquid oxygen, oxygen concentrators, and associated supplies remain non-routine, billable services.
- Professional and Diagnostic Services: Direct resident care provided by qualified healthcare professionals practicing within their scope, including physicians, physician assistants, nurse practitioners, psychologists, podiatrists, optometrists, and audiologists (note: this explicitly excludes PT, OT, and SLP). Laboratory and radiology services also remain non-routine.
- Dental: Dental services (except for ICF/IID annual exams).
- Prosthetic Devices: Artificial limbs/eyes and special braces for the leg, arm, back, and neck (note: urinary collection/catheter systems are explicitly excluded from this definition and are covered in the routine per diem).
- Emergency Transportation: Emergency ambulance transportation.
- Other Specialized Therapies: Hyperbaric oxygen therapy and recreational therapy when providing prescribed mental health services.

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.

26-80 Non-Invasive Prenatal Testing

Effective July 1, 2026, coverage for Non-Invasive Prenatal Testing (NIPT, CPT code 81420) is open to all pregnant members. To ensure accurate results, standard practice requires that testing be conducted at or after 10 weeks gestation. Coverage is currently limited to Fiscal Year 2027.

26-81 Coverage of 3D Mammography

Effective July 1, 2026, digital breast tomosynthesis (DBT), also known as 3D mammography, is a covered service for the screening of breast cancer. This service is reported using CPT code 77063 *Screening digital breast tomosynthesis, bilateral*.

The Women's Services and Family Planning provider manual has been updated accordingly.

26-82 Rural Enhancement Modifier Clarification

Effective July 1, 2026, the Home Health Services and Personal Care Services provider manuals have been updated to clarify language regarding geographical criteria for the rural enhancement modifier.

26-83 Multiple Members Served Modifiers (UN, UP, UQ, UR, US)

Home Health Services Provider Manual Changes

Effective July 1, 2026, the Home Health Services provider manual has been updated to clarify policy regarding modifiers for multiple members served. *Chapter 8-11.10 Billing PDN* and *Chapter 11-1 Calculating the number of units billed to each beneficiary* have been updated to provide direction on utilization of these modifiers.

Home health services performed for multiple members in the same location shall be billed with the appropriate informational modifier as noted below.

Number of Members Served	Applied Modifier
2	UN
3	UP
4	UQ
5	UR
6+	US

Transportation of Portable X-ray Equipment Service Code

Effective July 1, 2026, rates have been updated for HCPCS code R0075 (*Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen*) to correspond with the appropriate modifier for the number of members served at the same location.

Applied Behavior Analysis Codes Associated with Modifier UN, UP, UQ, UR, and US

Policy regarding the use of these modifiers with Applied Behavior Analysis (ABA) codes will remain the same. Refer to the Autism Spectrum Disorder Services provider manual, *Chapter 12-3 Group Treatment Codes,* for more information.

26-84 Home Health Services Provider Manual Updated

Effective July 1, 2026, the Home Health Services provider manual was 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.

In addition, the following updates were made to the Home Health Services provider manual to clarify policy:

- Wording was revised throughout manual.
- Additional information and resources were added where needed.
- Tables were updated as needed.
- Clerical and grammatical issues were corrected.
- Invalid or broken links were fixed.
- Formatting was updated to align with Medicaid's current style guidelines.

26-85 Dental Transitions from Managed Care Organizations to Fee-for-Service

As Utah Medicaid transitions dental coverage from managed care organizations to fee-for-service, providers should review the following operational requirements for a seamless transition:

Learn how to submit claims in PRISM: Information guide found here: Direct Data Entry (DDE) for Dental claim submissions.

- For help with DDE claim questions email: dih_csu@utah.gov.

Verify Trading Partner Numbers (TPN): Ensure your Trading Partner Numbers (TPNs) are accurate for claim submissions and response receipts (837D, 835).

- For help with the Business Process Wizard steps check out the Business Process Wizard (BPW) – Step Remark Guide document.
- For help with the EDI specific steps (8, 9, and 13) check out the EDI FAQ.
- For questions regarding enrollment email: providerenroll@utah.gov

Update Third-Party Liability (TPL) Settings: Verify your Practice Management software correctly transmits Other Payer information. You must use the qualifier **CI** for commercial insurance or **MA** or **MB** as appropriate for all Medicare/Advantage plans in Loop 2320, Segment SBR09.

- For help with electronic claim submissions (EDI) email: hcf_osd@utah.gov.
- PRISM Submitting Payment Other Information Dental Guide

Bill with a Group Billing NPI: You must bill using a Group NPI whenever provider affiliations exist.

- Verify rendering providers are correctly associated in step 12 of the Provider Enrollment Business Process Wizard (BPW).

Adhere to HIPAA 5010 Taxonomy and NPI Rules: Taxonomy is required at the Billing Loop (2000A) only when the billing provider is the same as the rendering provider. If it is not required, do not send it.

- If a rendering provider NPI is present, the taxonomy code must be submitted in the Rendering loop (2310B).
- Do not send the rendering provider loop (2310B) information when it is identical to the Billing loop (2010AA).
- More information can be found at X12.org and within the 005010X224 (837D) implementation guide. The Utah Medicaid Companion guide can be found here: 837D - Health Care Claim: Dental (ensure update has been added to website.)

Streamline Documentation: Supporting documentation such as dental films or exam notes is not required unless explicitly stated by a specific dental/medical code or a Prior Authorization (PA) policy. Refer to reason (CARC) and remark (RARC) codes or PA guidelines for exact requirements for claim submissions.

- Claim Denial Codes List (CARC_RARC)

If there are concerns regarding this transition or other issues, please call:

- From the Salt Lake City area, call (801) 538-6155
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free (800) 662-9651
- From all other states, call (801) 538-6155

26-86 2026 Medicaid Statewide Provider Training

If you have not already signed up, the registration for the 2026 Utah Medicaid Statewide Provider Training is open. Training will be 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, please complete the Google Form.

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

Below are the dates and times the sessions are offered. 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	Medicaid as Secondary (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.