September 2026

Department of Health & Human Services

Medicaid Information Bulletin

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

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

26-87 Interoperability Provider and Payer Registration

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. Please refer to article **26-40 in the May 2026** Medicaid Information Bulletin for more details.

To successfully follow the Centers for Medicare and Medicaid Services (CMS) rule for sharing health data and approving care faster (Interoperability and Prior Authorization Final Rule - CMS-0057-F), Utah Medicaid is registering payers and providers to participate in interoperability with Utah Medicaid Fee for Service and our contracted managed care plans.

Interoperability and Utah Medicaid Managed Care

All information provided by Utah Medicaid also applies to contracted managed care plans. Member consent is applicable to Utah Medicaid managed care plans. Utah Medicaid will be the repository for member consent and provider and payer registration to participate in Utah Medicaid's Prior Authorization Health Data Exchange, Utah Medicaid's Provider Access Health Data Exchange, and Utah Medicaid's Payer-to-Payer Health Data Exchange.

Provider and Payer Registration

For providers:

Starting September 30, 2026, please visit the Medicaid interoperability webpage, navigate to the Provider section, and submit an application to register for participation in Utah Medicaid's Prior Authorization Health Data Exchange and the Utah Medicaid's Provider Access Health Data Exchange.

You can access the registration page here: **https://medicaid.utah.gov/interoperability/**

For payers:

Starting September 30, 2026, please visit the Medicaid interoperability webpage, navigate to the Payer section, and submit your application to register for participation in Utah Medicaid's Payer-to-Payer Health Data Exchange.

The registration page can be found here: **https://medicaid.utah.gov/interoperability/**

Thank you for your continued partnership and commitment to improving health data exchange for Utah Medicaid.

26-88 New Community Engagement Requirements for Hospital Presumptive Eligibility (HPE), Adult Expansion

The passage of H.R. 1 mandates the implementation of Community Engagement (CE) requirements for the Adult Expansion (AE) and TAM populations, effective January 1, 2027. These requirements will specifically apply to the HPE Adult Expansion coverage group.

How Compliance/Eligibility is Determined

Effective January 1, 2027, individuals seeking HPE AE must be screened for CE compliance, a qualifying exclusion, or a qualifying exception. To approve HPE, the applicant must self-attest that they meet one of the following criteria:

- **Excluded status**: They meet the specified excluded individual status.
- **Exception:** They qualify for a mandatory or optional short-term exception.
- **Compliance:** They have successfully logged 80 hours of qualifying activity in the one-month look-back period.

Note: The existing self-attestation process for basic eligibility (income and household size) remains unchanged. The remaining four programs available under HPE also remain unchanged.

Training and Resources

HPE staff will be trained on these requirements and system changes to ensure accurate screening and AE determinations. Training sessions are scheduled for October and November 2026. In early September 2026, all HPE staff will receive a letter on how to sign up for the training. This link can also be found here: **https://forms.gle/6MecZZKqNrNWfFCL7**.

DHHS is committed to providing a seamless transition and supportive resources for HPE members. We are working closely with CMS to ensure the critical needs of HPE individuals continue to be met.

For HPE related questions, please email **hpepolicy@utah.gov**. For ongoing H.R. 1 updates and frequently asked questions, please visit **medicaid.utah.gov/obbba**.

26-89 Telehealth Modifiers Update

Beginning January 1, 2027, 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**, Chapter 12-7.3 *Modifiers*.

26-90 Changes to Reporting of Maternity Care

Effective January 1, 2027, maternity care reporting will transition from the current global maternity codes to unbundled, service level reporting.

In anticipation of this update, effective September 1, 2026, antepartum visits may be reported as follows, for pregnant members who are expected to deliver after December 31, 2026:

E/M Office Visit Codes (1-3 visits): Use when the patient is seen less than 4 times prior to December 31, 2026. Include modifier TH to indicate obstetrical care.

59425 (Antepartum care only): For 4-6 visits prior to December 31, 2026. Billed only once per pregnancy, per provider group.

59426 (Antepartum care only): For 7 or more visits prior to December 31, 2026. Billed only once per pregnancy, per provider group.

All antepartum visits performed after December 31, 2026, shall be reported using E/M office visit codes, per the updated **CPT Guidelines**.

26-91 Home Health Modifier Update

Effective July 1, 2026, the percentage associated with the TE modifier for Licensed Practical Nurse (LPN) Private Duty Nursing (PDN) services has decreased from 78% to 58.15%. This adjustment was made in conjunction with a rate increase. The TE modifier must be reported with HCPCS T1000 and T1005, when PDN services are provided by an LPN.

For code specific rates and other information, please see the **PRISM Coverage and Reimbursement Code Lookup Tool**.

26-92 Upper Payment Limit (UPL) Project

Updates to Nursing Home Services that can be Reported Ancillary to Per Diem Rate

Medicaid is publishing this guidance to reinforce policy changes detailed in the July 2026 MIB. Please note this policy change is effective retroactively for services rendered on or after July 1, 2026. While this notice is being published in September 2026, the policy revisions outlined below are currently active.

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 has updated its coverage policy for nursing facility ancillary services.

Medicaid has aligned 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 ensures 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 alignment, PT, OT, and SLP services have transitioned from separately billable ancillary services to routine services covered under the nursing facility's daily per diem rate.

The following updates have been 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

Routine services included in the per diem rate include, but are not limited to:

- Therapy Services: Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services and evaluations provided by clinicians employed by the nursing facility.
- 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, air or water flotation mattresses, specialized mattresses/overlays

for decubitus care, Negative Pressure Wound Therapy (NPWT) pumps/cannisters/dressings, 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.

Non-Routine (Ancillary) Billable Services

Under the revised policy, services that remain billable as ancillary 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 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.

Providers are encouraged to review the CMS-approved updates to Attachment 4.19-D of the Utah State Plan for additional information concerning this policy update. Utah Medicaid will continue to provide details and clarifications through future MIB articles to assist providers with compliance.

26-93 Policy Clarification for Inpatient Medical Detoxification for Substance Use Disorders

Treatment of substance use disorders, in a general hospital or psychiatric hospital, is limited to medical detoxification services, which involves the medical treatment of withdrawal symptoms associated with drug

or alcohol dependency. Prior authorization is not required for members without a physical health managed care plan.

If the member is enrolled in an Accountable Care Organization (ACO) or a Utah Medicaid Integrated Care (UMIC) Plan, medical detoxification must be coordinated and obtained directly through the member's specific health plan.

The **Hospital Services provider manual**, Chapter 9-3, *Medical Detoxification for Substance Use Disorders,* was updated to clarify this policy. Refer to the **Behavioral Health Services provider manual** for covered outpatient behavioral health services which include substance use disorders.

26-94 Z-Code Usage for Behavioral Health Services for Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Members

This bulletin clarifies Medicaid policy regarding ICD-10-CM diagnosis coding for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) members receiving behavioral health services.

When behavioral health services are rendered and a formal diagnosis has not yet been established, providers are permitted to use Z-codes related to social determinants of health (Z55–Z60), other psychosocial and environmental circumstances (Z62–Z65), and counseling services and problems related to lifestyle (Z69–Z73). Once a definitive clinical diagnosis is established, the appropriate primary diagnosis code must be used. Furthermore, the documentation must explicitly demonstrate the medical necessity for the specific procedure code billed.

These clarifications have been added to **Section I: General Information provider manual**, Chapters 12-4 *Procedures for Children*, and 12-5 *Diagnosis and Procedure Incomplete or Not in Agreement*. Additionally, a cross-reference directing providers to these updates has been added to the **Behavioral Health Services provider manual**, Chapter 1-2.1 *Coding and Billing* under the *Early and Periodic Screening, Diagnostic, and Treatment Early and Periodic Screening, Diagnostic, and Treatment* Chapter 1-2.

26-95 Behavioral Health Code Standardization

To be compliant with National Correct Coding Initiative (NCCI) standards and federal audit oversight expectations, 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. Moving away from fractional, 15-minute incremental unit billing for these specific services addresses federal oversight concerns regarding

per-unit overpayment risks and aligns Utah with standard NCCI Medically Unlikely Edits (MUEs), which define these services as flat-rate, "single-encounter" or "per-day" procedures.

This bulletin message is meant to inform all providers of the upcoming code changes to adjust claims submissions and systems as necessary. While providers are expected to continue delivering full clinical sessions, the entire encounter must be submitted as one single unit on the claim form.

The following codes will no longer use a 15-minute unit submission as of January 2027 and will instead follow NCCI standards as follows:

CPT Code	Description	New Maximum Units (MUE)	Minimum Time Required for 1 Unit
90791	Psychiatric diagnostic evaluation	**1 Unit Per Day**	16 Minutes Minimum
90792	Psychiatric diagnostic evaluation with medical services	**1 Unit Per Day**	16 Minutes Minimum
90846	Family psychotherapy (without patient present)	**1 Unit Per Day**	26 Minutes Minimum
90847	Family psychotherapy (conjoint) (with patient present)	**1 Unit Per Day**	26 Minutes Minimum
90849	Multiple-family group psychotherapy	**1 Unit Per Day**	50-60 Minutes Minimum
90853	Group psychotherapy (other than multiple-family)	**1 Unit Per Day (Per Patient)**	45-60 Minutes Minimum

26-96 Behavioral Health Revenue Code Updates

Effective January 1, 2027, the following services will be reported using an updated methodology per diem (daily):

- 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). Claims must be billed with one unit per day, representing the per diem rate. 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 and corresponding HCPCS codes are as follows:

Service	Revenue Code	Required Corresponding HCPCS Code	Billing Basis
Mental Health Residential Treatment (IMD Facility)	1001	H0017	Per Diem (1 Unit = 1 Day)
Mental Health Residential Treatment (Non-IMD Facility)	1001	H2013	Per Diem (1 Unit = 1 Day)
Substance Use Disorder Residential Treatment (IMD Facility)	1002	H0018	Per Diem (1 Unit = 1 Day)
Substance Use Disorder Residential Treatment (Non-IMD Facility)	1002	H2036	Per Diem (1 Unit = 1 Day)
Partial Hospitalization (Less Intensive)	0912	H0035	Per Diem (1 Unit = 1 Day)
Partial Hospitalization (Intensive)	0913	H0037	Per Diem (1 Unit = 1 Day)
Intensive Outpatient Services (Psychiatric)	0905	S9480	Per Diem (1 Unit = 1 Day)
Intensive Outpatient Services (Chemical Dependency)	0906	H0015	Per Diem (1 Unit = 1 Day)

Questions can be submitted to **dmhfmedicalpolicy@utah.gov**.

26-97 Street Medicine Resource Guide

Per the 2026 Utah Legislative Session HB 339, the Division of Integrated Healthcare has published the Street Medicine Resource Guide on the Medicaid website to provide guidelines, standards, and best-practice for

street medicine services in the State of Utah. Please refer to the **Utah Medicaid website** for more information.

26-98 Spravato Observation Billing Update

Effective July 1, 2026, providers should bill prolonged post-administration observation services associated with Spravato (Esketamine) using CPT codes 99415 and 99416 when the observation is performed by clinical staff under the direction of a physician or other qualified healthcare professional.

99415 – Prolonged clinical staff service (first hour) in the office or other outpatient setting.

99416 – Each additional 30 minutes of prolonged clinical staff service (listed separately in addition to code for primary service).

Providers should report 99415 for the first hour of clinical staff observation and 99416 for each additional 30 minutes of medically necessary observation time. These codes more accurately reflect the clinical staff monitoring typically provided during the required post-administration observation period following Spravato treatment.

Providers should discontinue billing CPT codes 99417 and 99418 for Spravato post-administration observation services when those services are rendered by clinical staff. CPT codes 99417 and 99418 are intended for prolonged services personally performed by a physician or other qualified health care professional and are not appropriate when the observation is conducted by clinical staff.

26-99 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 July, the DUR Board met to review new prior authorization forms for Ryoncil (remestemcel-L-rknd), Miebo (perfluorohexyloctane), Hemady (dexamethasone), and Dojolvi (triheptanoin).

In August, the DUR Board met to discuss Esketamine (Spravato) for the treatment of bipolar depression, a topic by the University of Utah's Drug Regimen Review Center.

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**.

26-100 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 September, the P&T Committee met to review prophylaxis immunosuppressive therapy to prevent transplant rejection 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**.