R414. Health and Human Services, Integrated Healthcare.
R414-1. Utah Medicaid Program.
R414-1-1. Authority and Purpose.

(1)(a) Title XIX of the Social Security Act and Sections 26B-1-213, 26B-3-102, and 26B-3-104 authorize this rule.

(b) Section 26B-3-1004 authorizes the Department of Health and Human Services to implement duties related to state claims for Medicaid payments or recovery.

(2) This rule characterizes the general scope of the Medicaid Program in Utah and defines the provisions necessary to administer the program.

R414-1-2. Definitions.

The following definitions are used throughout the rules of the Division:

(1) "Act" means the federal Social Security Act.

(2) "Applicant" means any person who requests assistance under the medical programs available through the Division.

(3) "Categorically needy" means an aged, blind or disabled individual or family or child:

(a) who is otherwise eligible for Medicaid; and

(i) who meets the financial eligibility requirements for Temporary Assistance for Needy Families as in effect in the Medicaid State Plan; or

(ii) who meets the financial eligibility requirements for Supplemental Security Income (SSI) or an optional State supplement, or is considered under Subsection 1619(b) of the Social Security Act to be an SSI recipient; or

(iii) who is a pregnant woman whose household income does not exceed 133% of the federal poverty guideline; or

(iv) is under age six and whose household income does not exceed 133% of the federal poverty guideline; or

(v) who is a child under age one born to a woman who was receiving Medicaid on the date of the child's birth and the child remains with the mother; or

(vi) who is at least six years of age, but not yet 18 years of age, or is at least six years of age, but not yet 19 years of age and was born after September 30, 1983, and whose household income does not exceed 100% of the federal poverty guideline; or

(vii) who is aged or disabled and whose household income does not exceed 100% of the federal poverty guideline; or

(viii) who is a child for whom an adoption assistance agreement with the state is in effect.

(b) whose categorical eligibility is protected by statute.

(4) "Code of Federal Regulations" (CFR) means the publication by the Office of the Federal Register, specifically Title 42, used to govern the administration of the Medicaid Program.

(5) "Member" means a person the Division or its constituted agent has determined to be eligible for assistance under the Medicaid program.

(6) "CMS" means The Centers for Medicare and Medicaid Services, a federal agency within the United States (U.S.) Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, and the Children's Health Insurance Program.

(7) "Department" means the Department of Health and Human Services (DHHS).

(8) "Director" means the director of the Division.

(9) "Division" means the Division of Integrated Healthcare within the Department.

(10) "Emergency medical condition" means a medical condition showing acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

(a) placing the patient's health in serious jeopardy;

(b) serious impairment to bodily functions;

(c) serious dysfunction of any bodily organ or part; or

(d) death.

(11) "Emergency service" means immediate medical attention and service performed to treat an emergency medical condition. Immediate medical attention is treatment given within 24 hours of the onset of symptoms or within 24 hours of diagnosis.

(12) "Emergency Services Only Program" means a health program designed to cover a specific range of emergency services.

(13) "Executive Director" means the executive director of the Department.

(14) "InterQual" means the McKesson Criteria for Inpatient Reviews, a comprehensive, clinically based, patient focused medical review criteria and system developed by McKesson Corporation.

(15) "Medicaid agency" means DHHS.

(16) "Medical assistance program" or "Medicaid program" means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act; as implemented by Title 26B, Chapter 3, Health Care -- Administration and Assistance.

(17) "Medical or hospital assistance" means the service furnished or a payment made to or on behalf of a recipient under medical programs available through the Division.

(18) "Medically necessary service" means that:

(a) it is reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap; and

(b) there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

(19) "Medically needy" means an aged, blind, or disabled individual or family or child who is otherwise eligible for Medicaid, who is not categorically needy, and whose income and resources are within limits set under the Medicaid State Plan.

(20) "Medical standards," as applied in this rule, means that an individual may receive reasonable and necessary medical services up until the time a physician makes an official determination of death.

(21)(a) "Patient liability" means the total financial amount a patient is legally obligated to pay a healthcare provider out-of-pocket for medical services rendered after the patient's health insurance company has processed the claim and paid the health insurance company's covered portion.

(b) Patient liability may include a combination of copayment, deductible, or coinsurance.

(22) "Prior authorization" means the required approval for provision of a service that the provider must obtain from the Department before providing the service. Details for obtaining prior authorization are found in Section I of the Utah Medicaid Provider Manual.

(23) "Provider" means any person, individual or corporation, institution or organization that provides medical, behavioral or dental care services under the Medicaid program and who has entered into a written contract with the Medicaid program.

(24) "Recipient" means a person who has received medical or hospital assistance under the Medicaid program, or has had a premium paid to a managed care entity.

(25) "Undocumented alien" means an alien who is not recognized by Immigration and Naturalization Services as being lawfully present in the United States.

(26) "Utilization review" means the Department provides for review and evaluation of the utilization of inpatient Medicaid services provided in acute care general hospitals to patients entitled to benefits under the Medicaid plan.

(27) "Utilization Control" means the Department implements a statewide program of surveillance and utilization control that safeguards against unnecessary or inappropriate use of Medicaid services, safeguards against excess payments, and assesses the quality of services available under the plan. The program meets the requirements of 42 CFR, Part 456.

R414-1-3. Single State Agency.

DHHS is the single state agency designated to administer or supervise the administration of the Medicaid program under Title XIX of the federal Social Security Act.

R414-1-4. Medical Assistance Unit.

Within the DHHS, the Division of Integrated Healthcare has been designated as the medical assistance unit.

R414-1-5. Incorporations by Reference.

The Department incorporates by reference the:

(1) Utah Medicaid State Plan (2026), published by the Centers for Medicare and Medicaid Services, including the Coverage and Reimbursement Code Lookup Tool found at https://medicaid.utah.gov/coverage-and-reimbursement/; and

(2) Utah Medicaid Provider Manuals, published by the Division of Integrated Healthcare under the Utah Department of Health and Human Services, including:

(a) Autism Spectrum Disorder Services, version January 2026;

(b) Behavioral Health Services, version January 2026;

(c) Dental, Oral Maxillofacial, and Orthodontia Services, version January 2026;

(d) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services, version January 2026;

(e) home and community-based services waivers, including the:

(i) Home and Community-Based Services Waiver for Individuals with an Acquired Brain Injury, version September 2025;

(ii) Home and Community-Based Services Waiver for Individuals with Physical Disabilities, version September 2025;

(iii) Home and Community-Based Services Waiver for Technology Dependent, Medically Fragile Individuals, version July 2020;

(iv) Home and Community-Based Waiver Services New Choices Waiver, version July 2021;

(v) Medically Complex Children's Waiver, version July 2020;

(vi) Utah Home and Community Based Services Waiver for Individuals with Intellectual Disabilities or Other Related Condition, version November 2025; and

(vii) Utah Home and Community-Based Services Waiver for Individuals Age 65 or Older, version April 2022;

(f) Home Health Services, version January 2026, including the manual's attachment for the Private Duty Nursing Acuity Grid;

(g) Hospice Care Services, version January 2026;

(h) Hospital Services, version January 2026, including the manual's attachments;

(i) Housing Related Services and Supports, version September 2025;

(j) Indian Health Services, version November 2025;

(k) Integrated Healthcare Services, version January 2026;

(l) Long Term Care Services in Nursing Facilities, version September 2025, including the manual's attachments;

(m) Medical Supplies and Durable Medical Equipment, version November 2025, as applied in Rule R414-70, including the manual's attachment for Donor Human Milk Request Form;
(n) Medical Transportation Services, version September 2025;
(o) Personal Care Services, version January 2026;
(p) Pharmacy Services, version January 2026, including the manual's attachments;
(q) Physician Services, version January 2026, including the manual's attachments;
(r) Physical Therapy and Occupational Therapy Services, version January 2026;
(s) Rural Health Clinics and Federally Qualified Health Centers Services, version November 2025;
(t) School-Based Skills Development Services, version January 2026;
(u) Section I: General Information, version January 2026, including the general attachments;
(v) Speech-Language Pathology and Audiology Services, version September 2025;
(w) Targeted Case Management for Early Childhood, version July 2025;
(x) Targeted Case Management for Individuals with Serious Mental Illness, version July 2025;
(y) Vision Care Services, version November 2025; and
(z) Women's Services and Family Planning, version March 2026.

R414-1-6. Services Available.

(1) Medical or hospital services available under the Medical Assistance Program are generally limited by federal guidelines as set forth under Title XIX, Social Security Act and Chapter IV, Subchapter C, 42 CFR (2024).

(2) The following services provided in the Medicaid State Plan are available to both categorically needy and medically needy individuals:

(a) inpatient hospital services, with the exception of those services provided in an institution for mental diseases;
(b) outpatient hospital services and rural health clinic services;
(c) other laboratory and x-ray services;
(d) skilled nursing facility services, other than services in an institution for mental diseases, for individuals 21 years of age or older;
(e) early and periodic screening and diagnoses of individuals under 21 years of age, and treatment of conditions found, are provided in accordance with federal requirements;
(f) family planning services and supplies for individuals of child-bearing age;
(g) physician services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere;
(h) podiatrist services;
(i) optometrist services;
(j) psychologist services;
(k) interpreter services;
(l) home health services, including:
(i) intermittent or part-time nursing services provided by a home health agency;
(ii) home health aide services by a home health agency; and
(iii) medical supplies, equipment, and appliances;
(m) private duty nursing services for children under 21 years of age;
(n) clinic services;
(o) dental services;
(p) physical therapy and related services;
(q) services for individuals with speech, hearing, and language disorders furnished by or under the supervision of a speech pathologist or audiologist;
(r) prescribed drugs, dentures, and prosthetic devices and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist;
(s) other diagnostic, screening, preventive, and rehabilitative services other than those provided elsewhere in the Utah Medicaid State Plan;
(t) services for individuals 65 years of age or older in institutions for mental diseases, including:
(i) inpatient hospital services for individuals 65 years of age or older in institutions for mental diseases;
(ii) skilled nursing services for individuals 65 years of age or older in institutions for mental diseases; and
(iii) intermediate care facility services for individuals 65 years of age or older in institutions for mental diseases;
(u) intermediate care facility services, other than services in an institution for mental diseases. These services are for individuals determined, in accordance with Subsection 1902(a)(31)(A), Social Security Act, to be in need of this care, including those services furnished in a public institution for the mentally retarded or for individuals with related conditions;
(v) inpatient psychiatric facility services for individuals under 22 years of age;
(w) nurse-midwife services;
(x) family or pediatric nurse practitioner services;
(y) physician assistant services;
(z) hospice care in accordance with Subsection 1905(o), Social Security Act;
(aa) case management services in accordance with Subsection 1905(a)(19) or Subsection 1915(g), Social Security Act;

(bb) extended services to pregnant women, pregnancy-related services, postpartum services for 12 months, and additional services for any other medical conditions that may complicate pregnancy;

(cc) ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider in accordance with Section 1920, Social Security Act; and

(dd) other medical care and other types of remedial care recognized under state law, specified by the Secretary of the United States Department of Health and Human Services, pursuant to 42 CFR 440.60 and 440.170 (2024), including:

(i) medical or remedial services provided by licensed practitioners, other than physician services, within the scope of practice as defined by state law;

(ii) transportation services;

(iii) skilled nursing facility services for patients under 21 years of age;

(iv) emergency hospital services; and

(v) personal care services in the recipient's home, prescribed in a plan of treatment and provided by a qualified person, under the supervision of a registered nurse; and

(ee) other medical care, medical supplies, and medical equipment not otherwise a Medicaid service if the division determines that it meets both of the following criteria:

(i) it is medically necessary and more appropriate than any Medicaid-covered service; and

(ii) it is more cost effective than any Medicaid-covered service.

R414-1-7. Aliens.

Certain qualified aliens described in 8 U.S.C. Sec. 1612, may be eligible for the Medicaid program. Other aliens are prohibited from receiving non-emergency services as described in Subsection 1903(v) of the Social Security Act.

R414-1-8. Statewide Basis.

The medical assistance program is state-administered and operates on a statewide basis in accordance with 42 CFR 431.50.

R414-1-9. Medicaid Advisory Committee.

In accordance with 42 CFR 431.12, the Division establishes the Medicaid Advisory Committee to advise the Medicaid agency director on health and medical care services.

R414-1-10. Discrimination Prohibited.

In accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d Sec et seq., Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Sec 70b, and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subjected to discrimination under the plan on the grounds of race, color, gender, national origin, or handicap.

R414-1-11. Administrative Hearings.

The Department has a system of administrative hearings for any medical provider, dissatisfied applicant, or member that meets the requirements of 42 CFR Part 431 Subpart E.

R414-1-12. Utilization Review.

(1) The Department shall conduct hospital utilization reviews as outlined in the Hospital Services Utah Medicaid Provider Manual. The Department shall use the Hospital Services Utah Medicaid Provider Manual in effect at the time the service is rendered.

(2) The Department shall determine medical necessity and appropriateness of inpatient admissions through utilization reviews. Utilization reviews shall use an evidence-based criteria tool determined by the Department through the state's procurement process.

(3) The Department shall seek a contract implemented through a competitive solicitation process in accordance with Title 63G, Chapter 6a, Utah Procurement Code.

(4) The standards in the evidence-based criteria may not apply to services in which a determination has been made to utilize the following criteria:

(a) criteria customized by the Department;

(b) criteria excluded as a Medicaid benefit by rule or contract; or

(c) criteria for organ transplant services as described in Rule R414-10A.

(5) The Department shall approve or deny services based upon administrative rules or its own criteria set forth in the Medicaid provider manuals when the exceptions in Subsection (4) exist.

R414-1-13. Provider and Member Agreements.

(1) To meet the requirements of 42 CFR 431.107, the Department contracts with each provider who furnishes services under the Utah Medicaid Program.

(2) By signing a provider agreement with the Department, the provider agrees to follow the terms incorporated into the provider agreements, including policies and procedures, provider manuals, Medicaid Information Bulletins, and provider letters.

(3) By signing an application for Medicaid coverage, the member agrees that the Department's obligation to reimburse for services is governed by contract between the Department and the provider.

R414-1-14. Utilization Control.

(1) In order to control utilization, and in accordance with 42 CFR 440 Subpart B, services, equipment, or supplies not specifically identified by the Department as covered services under the Medicaid program are not a covered benefit. In addition, the Department will also use prior authorization for utilization control. Necessary and appropriate medical record documentation for prior approvals must be submitted with the request. If the provider has not obtained prior authorization for a service as outlined in the Medicaid provider manual, the Department shall deny coverage of the service.

(2) The Department may request records that support provider claims for payment under programs funded through the Department. These requests must be in writing and identify the records to be reviewed. Responses to requests must be returned within 30 days of the date of the request. Responses must include the complete record of services for which reimbursement is claimed and supporting services. If there is no response within the 30-day period, the Department will close the record and will evaluate the payment based on the records available.

(3)(a) If the Department pays for a service which is later determined not to be a benefit of the Utah Medicaid program or does not comply with state or federal policies and regulations, the provider shall refund the payment upon written request from the Department.

(b) If services cannot be properly verified or when a provider refuses to provide or grant access to records, the provider shall refund to the Department funds for services rendered. Otherwise, the Department may deduct an equal amount from future reimbursements.

(c) Unless appealed, the refund must be made to Medicaid within 30 days of written notification. An appeal of this determination must be filed within 30 days of written notification as specified in Rule R410-14.

(d) A provider shall reimburse the Department for overpayments regardless of the reason for the overpayment.

(e) Provider appeals of action for recovery or withholding of money initiated by the Office of Inspector General of Medicaid Services (OIG) shall be governed by the OIG Administrative Hearings Procedures Manual incorporated by reference in Section R414-1-5.

R414-1-15. Medicaid Fraud.

The Department has established and will maintain methods, criteria, and procedures in accordance with 42 CFR 455.13 through 455.21 for prevention and control of program fraud and abuse.

R414-1-16. Confidentiality.

Title 63G, Chapter 2, Government Records Access and Management Act and Section 26B-1-212 impose legal sanctions and provide safeguards that restrict the use or disclosure of information concerning an applicant, a member, and a recipient to purposes directly connected with the administration of the plan. Additionally, the requirements of 42 CFR 431 Subpart F apply to the restricted use or disclosure of protected information.

R414-1-17. Eligibility Determinations.

The determination of Medicaid eligibility is made by the Department and the Department of Workforce Services. There is a written agreement between the Department and the Department of Workforce Services. The agreement defines the relationships and respective responsibilities of the agencies.

R414-1-18. Professional Standards Review Organization.

The Medicaid agency or its agents shall administer the Medicaid State Plan according to written contract, except for those functions for which final authority has been granted to a Professional Standards Review Organization under Title XI of the Act.

R414-1-19. Timeliness in Eligibility Determinations.

The Medicaid agency shall adhere to the timeliness requirements found in 42 CFR 435.911, for processing applications, determining eligibility, and approving Medicaid requests. If these requirements are not completed within the defined time limits, members may notify the Division.

R414-1-20. Residency.

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403.

R414-1-21. Out-of-state Services.

Medicaid services shall be made available to eligible residents of the state who are temporarily in another state. Reimbursement for out-of-state services shall be provided in accordance with 42 CFR 431.52.

R414-1-22. Retroactive Coverage.

Individuals are entitled to Medicaid services under the plan during the 90 days preceding the month of application if they were, or would have been, eligible at that time.

R414-1-23. Freedom of Choice of Provider.

Unless an exception under 42 CFR 431.55 applies, any individual eligible under the plan may obtain Medicaid services from any institution, pharmacy, person, or organization that is qualified to perform the services and has entered into a Medicaid provider contract, including an organization that provides these services or arranges for their availability on a prepayment basis.

R414-1-24. Availability of Program Manuals and Policy Issuances.

In accordance with 42 CFR 431.18, the state office, local offices, and district offices of the Department maintain program manuals and other policy issuances that affect recipients, providers, and the public. These offices also maintain the Medicaid agency's rules governing eligibility, need, amount of assistance, recipient rights and responsibilities, and services. These manuals, policy issuances, and rules are available for examination and, upon request, are available to individuals for review, study, or reproduction.

R414-1-25. Billing Codes.

In submitting claims to the Department, every provider shall use billing codes compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements as found in 45 CFR Part 162.

R414-1-26. General Rule Format.

The following format is used generally throughout the rules of the Division. Section headings as indicated and the following general definitions are for guidance only. The section headings are not part of the rule content itself. In certain instances, this format may not be appropriate and will not be implemented due to the nature of the subject matter of a specific rule.

(1) A concise statement as to what Medicaid service is covered by the rule, and a listing of specific federal statutes and regulations and state statutes that authorize or require the rule.

(2) Definitions that have special meaning to the particular rule.

(3) Categories of Medicaid members eligible for the service covered by the rule that include categorically needy members, medically needy members, or both. Conditions precedent to the member's obtaining coverage such as age limitations or otherwise.

(4) Program access requirements that include conditions external to the member obtaining service, such as type of certification needed from attending physician, whether available only in an inpatient setting or otherwise.

(5) Service coverage that details specific services available under the rule, including limitations, such as number of procedures in a given period or otherwise.

(6) As necessary, a description of the procedures for obtaining prior authorization for services available under the particular rule. Prior authorization, however, may not be used as a substitute for regulatory practice that should be in rule.

(7) As necessary under the particular rule, additional sections may be indicated. Other sections include regulatory language that does not fit into Subsections (1) through (5).

R414-1-27. Determination of Death.

(1) In accordance with Section 26B-8-132, the fiduciary responsibility for medically necessary care on behalf of the member ceases upon the determination of death.

(2) Reimbursement for the determination of death by acceptable medical standards must be in accordance with Medicaid coverage and billing policies in place on the date the physician renders services.

R414-1-28. Provider-Preventable Conditions.

(1) In accordance with 42 CFR 447.26, Medicaid will not reimburse providers or contractors for provider-preventable conditions as noted therein. Please see Utah Medicaid State Plan Attachments 4.19-A and 4.19-B for detail.

(2) Medicaid providers who treat Medicaid eligible patients must report provider-preventable conditions whether or not reimbursement for the services is sought. Medicaid providers shall meet this requirement by complying with existing state reporting requirements of these events that include:

(a) Rule R380-200;

(b) Rule R386-705;

(c) Rule R428-10; and

(d) Section 26B-7-221.

(3) Utilizing the reporting mechanism from one of the rules noted above may not impact confidentiality and privacy protections for reporting entities as noted in Title 26B, Chapter 1 Department of Health and Human Services.

R414-1-29. Medicaid Policy for Reconstructive and Cosmetic Procedures.

(1) Reconstructive or restorative services are medically necessary; and

(a) performed on abnormal structures of the body to improve and restore bodily function; or

(b) performed to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention.

(2) Medicaid does not cover cosmetic procedures performed with the primary intent to improve appearance, nor does it cover non-medically necessary procedures performed in the same episode as a covered procedure.

(3) Coverage for reconstructive breast procedures related to cancer includes:

(a) reconstruction of the breast on which the procedure is performed; and

(b) reconstruction of the breast on which the procedure is not performed to produce a symmetrical appearance and prostheses.

(4) Medicaid limits reconstructive breast surgeries to initial occurrences that may include multi-step procedures.

(5) Medicaid does not cover repeat reconstructive breast procedures.

R414-1-30. Face-to-Face Requirements for Home Health Services.

(1) Orders for home health services and certain durable medical equipment (DME) must be in accordance with 42 CFR 440.70.

(2) DME that requires face-to-face shall be the same as DME items required by Medicare.

(3) No home health agency or DME supplier may report services for reimbursement until they meet the face-to-face requirement.

R414-1-31. Withholding of Payments.

(1) In addition to other remedies allowed by law and unless specified otherwise, the Department may withhold payments to a provider or contractor if:

(a) the provider or contractor fails to provide the requested information within 30 calendar days from the date of a written request for information;

(b) the provider or contractor has an outstanding balance owing the Department for any reason; or

(c) the provider or contractor receives more than $5,000,000 in reimbursement annually from the Department and fails to comply with 42 U.S.C. 1396a(a)(68).

(2) The Department or the Office of the Inspector General of Medicaid Services may determine a provider or contractor to be noncompliant if the provider or contractor cannot submit, upon request:

(a) an attestation of compliance with the Social Security Act, 42 U.S.C. 1396a(a)(68); and

(b) an attestation of compliance with the False Claims Act, 31 U.S.C. Sections 3729 through 3733.

(3) The Department shall provide written notice before withholding payments.

(4) When the Department rescinds withholding of payments to a provider or contractor, it will, without notice, resume payments according to the regular claims payment cycle.

R414-1-32. Prior Authorization from Primary Payers First.

(1) Health care providers are encouraged to seek prior authorization, when necessary, from a health insurance entity that is the primary payer before seeking third-party liability (TPL) through Medicaid.

(2) A health insurance entity may not deny a claim submitted by the Office of Recovery Services, the Office of Inspector General of Medicaid Services, Medicaid, or an authorized contractor for an item or service based solely on a lack of prior authorization.

R414-1-33. Reimbursement for Claims with Coordination of Benefits.

(1) Except as otherwise noted in Attachment 4.19-B of the Utah Medicaid State Plan:

(a) Medicaid reimbursement is limited to patient liability for a claim with TPL; and

(b) Medicaid payment for a coordination of benefits claim is the lower of:

(i) the allowed Medicaid rate minus any TPL payment; or

(ii) patient liability.

(2) It is fraudulent for a Medicaid service provider to note patient liability based on Medicaid's reimbursement structure rather than the primary payor's reimbursement structure.

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