

July 2023



Utah Department of
Health & Human Services
Integrated Healthcare

MEDICAID INFORMATION BULLETIN

Medicaid Information: 1-800-662-9651

medicaid.utah.gov

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Unless otherwise noted, all changes take effect on July 1, 2023

23-38 2023 Medicaid Statewide Provider Training

Utah Medicaid will be offering the 2023 Statewide Provider Training in an online live webinar format. This year we are hosting a variety of trainings covering specific topics. Providers can sign up to attend multiple trainings.

Training Sessions:

- Claims/Billing
- Provider Enrollment
- Pharmacy Program
- Prior Authorization
- Healthcare Policy
- Managed Care & Additional Specialties i.e., Dental, Applied Behavior Analysis, Durable Medical Equipment, Behavioral Health
- Utah Office of Inspector General
- Q&A Session

To register for the 2023 training, please complete the [Google Form](#). If you have already registered, please do not register again.

The 2020, 2021, and 2022 statewide provider trainings are available on the [Medicaid website](#). The 2023 trainings will be posted after the trainings conclude.

The following dates and times are scheduled for the 2023 Medicaid Statewide Provider Training.

Date	Time	Training	Description
Tuesday, August 15	10:00 - 11:00	Claims/Billing	How to process claims, electronic data interchange (EDI), corrected claims, billing modifiers, denials, appeals, coordination of benefits, and new updates.
Thursday, August 31	1:00 – 2:00		
Wednesday, August 16	10:00 - 11:00	Provider Enrollment	How to process new enrollments, retro enrollments, end dating an association, and new updates.
Tuesday, August 29	1:00 – 2:00		

Thursday, August 17 Wednesday, August 30	10:00 - 11:00 1:00 - 2:00	Pharmacy Program	Overview of coverage, billing, opioids, retro-drug utilization review (DUR), medication therapy management (MTM) services, pharmacy prior authorization, and new updates.
Tuesday, August 22 Thursday, September 7	1:00 - 2:00 10:00 - 11:00	Prior Authorization	How to submit a prior authorization, requirements, resources, and new updates.
Wednesday, August 23 Tuesday, September 5	1:00 - 2:00 10:00 - 11:00	Healthcare Policy	Overview of specific and new Medicaid policies.
Thursday, August 24 Wednesday, September 6	1:00 - 2:00 10:00 - 11:00	Managed Care & Additional Specialties (Dental, Applied Behavior Analysis, Durable Medical Equipment, Behavioral Health)	Overview of the Medicaid managed care plans, including how to process claims. This session will also cover specialty providers.
Tuesday, September 12	10:00 - 11:30	Utah Office of Inspector General	Overview of the OIG; common fraud, waste, and abuse schemes; avoiding improper Medicaid payments; and provider tips and resources.
Wednesday, September 13	10:00 - 11:00	Questions & Answers	We will have various subject matter experts on hand to answer provider questions.

23-39 P&T Committee Updates

The Pharmacy and Therapeutics (P&T) Committee reviewed weight management medications in May.

P&T Committee meeting minutes are posted on the Utah Medicaid website at <https://medicaid.utah.gov/pharmacy/pt-committee>.

23-40 DUR Board Updates

In May 2023, the Drug Utilization Review (DUR) Board met to review weight management medications approved for treating overweight and obese people. In June 2023, the DUR Board met to review Tzield (teplizumab).

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](#).

23-41 Vaccine Administration and Counseling

Beginning July 1, 2023, guidance surrounding COVID-19 vaccine counseling has changed and new codes have become available for this purpose.

The following codes have been opened for reporting stand-alone counseling for both COVID-19 and non-COVID-19 vaccines for EPSDT eligible Medicaid members: G0312, G0313, G0314, and G0315. Specific code updates are available in the code update section of the MIB and the [Coverage and Reimbursement Lookup Tool](#).

23-42 Pharmacy Prior Authorization Processing

Pharmacy prior authorization requests received for pharmacy services, including pharmacy related HCPCS codes, must be complete upon submission. An incomplete submission means required information is missing, which may result in the prior authorization being denied. The Utah Medicaid pharmacy team attempts to contact providers to obtain additional information for the prior authorization request at least two times. Providers and their staff are encouraged to complete the prior authorization request to include the exact medication name the member will be using, or indicate if a substitution is not permissible.

Medication Name/ Strength:	Dose:
<input type="checkbox"/> Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

If a provider's intent is for a member to use a brand product, they will check "Do Not Substitute". In the example below, the request would be reviewed for the non-preferred name brand Percocet 5/325mg.

Medication Name/ Strength: <i>Percocet 5/325mg</i>	Dose:
<input checked="" type="checkbox"/> Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

If a provider submits a prior authorization request without indicating "Do Not Substitute", the request will be processed for the preferred Generic/Brand equivalent. In the example below, the request would be reviewed for the preferred generic equivalent, Oxycodone/APAP 5/325mg.

Medication Name/ Strength: <i>Percocet 5/325mg</i>	Dose:
<input type="checkbox"/> Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless otherwise specified.	Directions for use:

In all cases, providers should submit prior authorization requests using the most current form available on the [Utah Medicaid Pharmacy Website](#), complete all fields legibly, and include all supporting documentation required for the pharmacy service requested.

23-43 Pharmacy Policy, Coverage, Prior Authorization and HCPCS Codes

The Utah Medicaid Preferred Drug List is updated monthly and is the most up-to-date source of information pertaining to drug specific pharmacy coverage, limitations, and policies, in addition to the Utah Medicaid State Plan, Utah Administrative Rule, Utah Medicaid Provider Manuals and Medicaid Information Bulletins, and Pharmacy prior authorization forms.

Pharmacy prior authorization forms and pharmacy related HCPCS codes are reviewed and updated at a minimum annually, but may be updated more frequently as drug labels are expanded.

Per the Utah Medicaid Provider Manual [Section I: General Information](#), 2-3 Member Eligibility Verification, providers who administer and bill Utah Medicaid for pharmacy related HCPCS codes shall verify member eligibility. Pharmacy related HCPCS code coverage and the HCPCS NDC Crosswalk shall be used together to verify coverage, reimbursement, and covered NDC's for pharmacy related HCPCS.

To access the most recent pharmacy resources, go to <https://medicaid.utah.gov/>, click on Healthcare Providers, Medicaid Pharmacy Program.

23-44 School Based Skills Development Policy Update

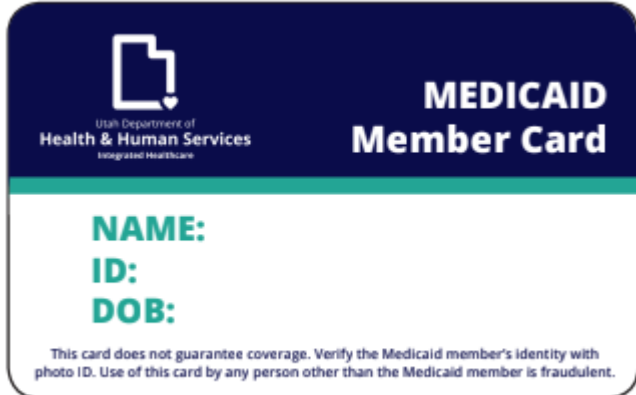
Effective July 1, 2023, the School Based Skills Development Program will no longer utilize the bundled service code T1018. A specific CPT/HCPCS code list will be used in place of code T1018. The [School Based Skills Development Provider Manual](#) will be updated to reflect information supporting the use and reporting of the listed codes. The manual will also include a separate list of applicable audiology codes. School Based Skills Development providers will use the appropriate code(s) from this list when submitting claims to Medicaid.

23-45 New Medicaid Card

On July 1, 2022, the Utah Department of Health (UDOH) and Department of Human Services consolidated and became one agency, the Department of Health and Human Services (DHHS) with a new logo and colors.

Beginning May 1, 2023, DHHS issued a new Medicaid card to replace the existing UDOH card for new Medicaid members. The new Medicaid Member Card has the DHHS branding standards with the member's name, Medicaid ID number, and date of birth. The card will be used whenever the member is eligible for Medicaid. Each new Medicaid member will get their own card. Existing members will continue using their old UDOH Medicaid card. Please accept both DHHS and UDOH Medicaid cards.

Below is a sample of the front and back of the new Medicaid card:



23-46 Gender Dysphoria Policy Update

[S.B.16](#) Transgender Medical Treatments and Procedures Amendments, enacts Utah Code 58-1-603(3)-(5) on July 1, 2023, to require providers of hormonal treatments of minors to:

- Have a treatment history with minor patient for gender dysphoria of at least 6 months.
- Documentation that the minor was diagnosed with gender dysphoria prior to January 28, 2023.
- Identify and document any physical or mental health conditions and consider treating before treating gender dysphoria for best long-term outcome.
 - Mental health evaluation required by a mental health professional that:
 - Is different from the provider that is recommending or providing the hormonal transgender treatment.
 - Has transgender treatment certification (beginning January 1, 2024).
 - Has a history of at least 3 therapy sessions with the minor patient.
 - Documentation of all minor mental health diagnoses and any significant life events that may be contributing to the diagnoses of the minor.
 - Determine/diagnose minor gender dysphoria in accordance with the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).
- Documentation in the medical record that providing the hormonal transgender treatment will likely result in the best long-term outcome for the minor.
- Consideration of alternative treatments or behavioral intervention for minor patient gender dysphoria.
- Obtain written consent from the minor, minor's parent or guardian, unless the minor is emancipated.
- Documentation of discussion with minor, minor parent or guardian on the risk of hormonal transgender treatments, the short-term and long-term expectations that the hormonal transgender treatment will have on the minor, and the likelihood that the hormonal transgender treatment will meet the short-term and long-term expectations.
- If providing a puberty inhibition drug to the minor, the provider requires to provide information that puberty inhibition drugs are not approved by the FDA for the treatment of gender dysphoria.

Utah Medicaid has updated the Hormone Therapy for Gender Dysphoria Prior Authorization for puberty inhibition drugs and hormonal transgender treatment in accordance with the [S.B.16](#) and

Utah Code 58-1-603(3)-(5). Providers can find the prior authorization form at <https://medicaid.utah.gov/pharmacy/prior-authorization/>.

23-47 Physician Services Manual Updated

The [Physician Services Provider Manual](#) has been updated to include the policy for treating members with a gender dysphoria diagnosis. Chapter 8-20, Gender Dysphoria Treatment, has been added. This new section includes the psychotherapy, pharmacy, and surgery policies for treating members with a gender dysphoria diagnosis. After January 1, 2024, mental health professionals cited in this policy must have a transgender treatment certification as provided by the Division of Professional Licensing.

23-48 Wellness Visits

The [Physician Services Provider Manual](#) has been updated to add Chapter 8-21, Wellness Visit Services. Wellness visits are covered for a maximum of one visit annually for members over the age of 21.

The following codes will be covered for wellness visits by these providers:

- Local Health Department – 064
- Tribal Health Center – 068
- Rural Health Care Center – 067
- Group Practice – 115
- Nurse Practitioner – 062
- Physician – 033
- Physician Assistant – 140
- Federally Qualified Health Center (FQHC) - 066

99385 - *Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years.*

- Code will be open without restriction for EPSDT eligible members.

99395 - *Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years.*

- Code will be open without restriction for EPSDT eligible members.

99386 - *Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years.*

99396 - *Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years.*

99387 - *Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older.*

99397 - *Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older.*

23-49 Inpatient Hospital Intensive Physical Rehabilitation Services

The [Hospital Services Provider Manual](#), Chapter 8-6, Inpatient Hospital Intensive Physical Rehabilitation Services, has been updated. With the advent of the PRISM claims processing system, the prior authorization requirement for intensive physical rehabilitation services has been removed.

Also, revenue code 0128 will no longer be required on acute intensive physical rehabilitation service claims for them to reimburse correctly.

23-50 Autism Spectrum Disorder Services for Adults

Beginning July 1, 2023, applied behavior analysis (ABA) will be a covered benefit for eligible members of all ages with a diagnosis of autism spectrum disorder (ASD). The [Autism Spectrum Disorder Services Provider Manual](#) has been updated to remove references to these services being limited to EPSDT eligible members only.

23-51 Out-of-State Provider Telehealth Services

[Section I: General Information Provider Manual](#) has been updated to add Chapter 9-3.2.1, Non-Resident Provider Telehealth Reporting for In-State Members.

A non-resident provider may report telehealth services given to an in-state Medicaid member when the following conditions are met:

- The provider meets the licensing requirements of the Department of Professional Licensing (DOPL) as outlined in [Utah Annotated Code 58-1-302.1](#)
- The provider is enrolled as a Utah Medicaid provider as explained in [Chapter 3, Provider Participation and Requirements](#)

- Follow the policies outlined in [Chapter 8-4.2, Telehealth](#)

23-52 Telehealth Policy Updated

[Section I: General Information Provider Manual](#), Chapter 8-4.2, Telehealth, has been updated to clarify the telehealth policy as follows:

8-4.2 Telehealth

Definitions

Telehealth - is the use of electronic information and telecommunications technologies that support distant healthcare providers to deliver health assessments, diagnostics, intervention, consultations, supervision, and education.

Telemedicine – see Telehealth.

Distant site (hub site) – is where the provider delivering the service is located at the time the service is provided via telecommunications system.

Originating site (spoke site) – is the location of the Medicaid member at the time the service is being furnished via telecommunications.

Asynchronous, also called “store and forward,” is communication or information shared between providers and members that occur at different points in time.

Synchronous care is a live two-way interaction via telecommunication technology between a member at an originating site and a provider at a distant site that includes audio-visual (videoconference) or audio-only (telephone) communication.

Remote Patient Monitoring (RPM) is the deployment and use of technology to capture biometric information that is automatically shared with a remote provider. The transmission of patient data and clinical information to the provider may occur either through in-home devices or information entered and transmitted electronically by the patient.

8-4.2.1 Services

Telehealth services seek to improve an individual's health by permitting two-way communication between members and their providers and may be performed for a variety of medically necessary services. This communication often requires the use of interactive telecommunications equipment that can include both audio and video components but may also be conducted via audio-only. Audio-only telehealth is not allowed if it is solely for the sake of provider convenience. The utilization of telehealth services is dependent upon the member and their situation. As such, providers must determine the clinical appropriateness and medical necessity of the services being delivered through clinical-based decision making. Some examples of when telehealth may be appropriate are:

- Diagnostic review and discussion of results
- Evaluation and management services
- Management of chronic conditions
- Medication management
- Mental health, behavioral health, and substance use disorder services
- Telepsychiatric consultation
- Teledentistry
- Treatment counselling
- Wellness checks

There are no geographic restrictions surrounding the use of telehealth services. Medicaid covers telehealth services when performed via synchronous care. Telecommunication technologies that support synchronous care include:

- Live video two-way, face-to-face interaction between the member and the provider using audio-visual communication, including E-visits through an online patient portal.
- Audio only visits by means of telephone or other forms of communication without video.

As outlined by the Centers for Medicare and Medicaid Services (CMS), audio-only synchronous care or care that does not clinically require visual inspection, is covered for a limited number of services. Medicaid limits these services to:

- Behavioral health, including substance use disorders (SUD)
- Diabetic self-management
- Speech and hearing

- Nutritional counselling
- Tobacco cessation
- Education for chronic kidney disease
- Advanced care planning

Providers are responsible for determining the applicable CPT and HCPCS codes associated with each of the above listed services and ensure the codes are covered. The reporting requirements for services provided via telehealth are the same as those provided for services performed in-person.

Medicaid does not cover telehealth services when performed by means of asynchronous communication. Examples of asynchronous communication include:

- Email communication
- Text messaging
- Other forms of messaging with follow-up instructions or confirmations
- Mobile Health (mHealth)
 - Fitness tracker
 - Phone applications that record a patient's exercise
 - Automatic reminders such as when to take medicine.
 - Storing information or educational materials such as discharge instructions
- Remote patient monitoring (RPM)
 - Blood pressure monitors
 - Pacemakers
 - Glucose meters
 - Oximeters
 - Wireless scales
 - Heart rate monitors
- Store-and-forward imaging
- Transmission of lab or other diagnostic/screening results

Telepsychiatry

When psychiatrists consult with a physician regarding a member's possible need for telepsychiatry, they must report the following CPT codes to receive payment for services:

99446 Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting

physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review

99447 - 11-20 minutes of medical consultative discussion and review

99448 - 21-30 minutes of medical consultative discussion and review

99449 - 31 minutes or more of medical consultative discussion and review

The treating physician, consulting with the psychiatrist, reports CPT code 99358- *Prolonged evaluation and management services before and/or after direct patient care.*

Teledentistry

Teledentistry services are covered for eligible members statewide.

Providers must report one of the following CPT codes to receive reimbursement for services:

D0140 – Limited oral evaluation - problem focused; An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

D0170 - Re-evaluation - limited, problem focused (established patient; not post-operative visit); Assessing the status of a previously existing condition. For example: - a traumatic injury where no treatment was rendered but patient needs follow-up monitoring; - evaluation for undiagnosed continuing pain; - soft tissue lesion requiring follow-up evaluation.

D0171 – Re-evaluation - post-operative office visit.

The dentist, to receive reimbursement, must report CPT code D9995- *teledentistry - synchronous; real-time encounter; reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service* to denote that services were rendered via teledentistry. Rates for approved teledentistry are the same as rates for in-person dental services.

8-4.2.1 Billing

Refer to the following when billing for services provided through telehealth:

Distant providers:

- CMS 1500 Professional Claims- Provider must indicate that the service(s) was provided via telehealth by indicating Place of Service (POS) 02 – Telehealth Provided Other than in Patient’s Home, or POS 10 – Telehealth Provided in Patient’s Home on the CMS 1500 claim form with the service’s usual billing codes.
- UB-04 Institutional Claims- Providers must indicate that the service(s) was provided via telehealth by appending the GT modifier to the UB-04 institutional claim form with the service’s usual billing codes.
 - o GT - Via interactive audio and video telecommunication systems
- Services provided via telehealth have the same service thresholds, authorization requirements, and reimbursement rates as services delivered face-to-face.

8-4.2.3 Limitations

Telehealth encounters must comply with HIPAA privacy and security measures and the Health Information Technology for Economic and Clinical Health Act, Pub. L. No.111-5, 123 Stat. 226, 467, as amended to ensure that all member communications and records, including recordings of telehealth encounters, are secure and remain confidential. The provider is responsible for ensuring the encounter is HIPAA compliant. Security measures for transmission may include password protection, encryption, and other reliable authentication techniques. Compliance with the Utah Health Information Network (UHIN) Standards for Telehealth must be maintained. These standards provide a uniform standard of billing for claims and encounters delivered via telehealth.

Services not otherwise covered by Utah Medicaid are not covered when delivered via telehealth.

The provider, if the member is in a facility i.e., the originating site, receives no additional reimbursement for the use of telehealth services.

23-53 Home Health Private Duty Nursing Hours

Effective July 1, 2023, private duty nursing (PDN) maximum daily hours have been increased from 2-3 days to 14 days in the [Home Health Services Provider Manual](#) and PDN Acuity Grid forms.

The [Home Health Services Provider Manual](#), 8-11.6 PDN Acuity Grid Score and PDN Hours have been updated as follows:

8-11.6 PDN Acuity Grid Score and PDN Hours

Score	Maximum allowable covered hours per day
21-35	12
36-45	14
46-51	16
56+ and over	18

Chapter 11.8 Guidelines for an Increase in the Quantity of PDN Services Over Time

An increased number of hours of PDN services may be authorized when acute exacerbations of illness require a temporary increase in skilled care. Additional documentation may be requested to support the request for increased hours. The member may receive up to 20-24 hours of PDN care daily, if authorized, only under the following circumstances:

- After initial hospital discharge, for up to 14 days to enable the caregiver (s) to become trained on procedures.
- After a subsequent hospitalization, for up to 14 days to allow caregiver (s) training in any new procedures or changes in care.

23-54 Specialty Services Provided to Members in Residential Substance Use Disorder Treatment Programs

Beginning July 1, 2023, opioid treatment programs, domestic violence treatment providers, and providers delivering psychological testing to members receiving care in a residential substance use disorder program will be able to report and receive reimbursement for those services when provided to members who are also involved in a residential substance use disorder program.

23-55 Targeted Case Management for Early Childhood Providers

The [Targeted Case Management – Early Childhood Provider Manual](#) has been updated. The following reflects the changes made to the manual:

- Updates to align with Division of Integrated Healthcare provider manual style template.
 - Rearrange text under new headings and subheadings.
- Insert standard template language, where applicable.
- Remove redundant text and consolidate sections, where appropriate.
- Remove language directly lifted from State Plan and contracts.
 - Where applicable, direct the reader back to relevant sections of State Plan and contracts between Division and local health departments for most accurate, up-to-date information.
- Clarify conflicting language between sections.
- Remove all references to CHEC program.
- Clarify eligible member population with language agreed upon by TCM workgroup (“ages 0 to four” instead of “ages 0 through three”)
- Remove out of date references to “pricing updates.”

Additionally, the codes used for reimbursement within the Targeted Case Management – Early Childhood program have been updated to reflect the following:

- Update reimbursement for code T1017 from \$20.24 to \$22.16
- Update reimbursement for code T1023 from \$251.98 to \$306.17

23-56 Dental Hygienist Amendment – Senate Bill 237

Effective July 1, 2023, dental hygienists may receive payment for dental services performed independently in a public health setting without a written agreement or general supervision of a dentist. Dental services performed must comply with Utah Administrative code [58-69-801](#):

A dental hygienist licensed under this chapter may only practice dental hygiene:

- (1) in an accredited dental or dental hygienist school to teach and demonstrate the practice of dental hygiene;
- (2) for a public health agency;
- (3) under the supervision of a dentist, for an employee leasing company or temporary personnel service company providing employees to a dentist or other person lawfully providing dental services:
 - (a) under the indirect supervision of a dentist licensed under this chapter at any time the dental hygienist is administering an anesthetic or analgesia as permitted under this chapter or division rules made under this chapter;
 - (b) under the general supervision of a dentist licensed under this chapter within the office of the supervising dentist and upon patients of record of the supervising dentist; and
 - (c) under the general supervision of a dentist licensed under this chapter, and the practice is conducted outside of the office of the supervising dentist, if:
 - (i) the dental hygiene work performed is authorized by the supervising dentist as a part of and in accordance with the supervising dentist's current treatment plan for the patient;

- (ii) no anesthetic or analgesia is used;
 - (iii) the supervising dentist has determined the patient's general health and oral health are so that the dental hygiene work can be performed under general supervision and with an acceptable level of risk or injury as determined by the supervising dentist;
 - (iv) the supervising dentist accepts responsibility for the dental hygiene work performed under general supervision; and
 - (v) (A) the dental hygienist's work is performed on a patient who is homebound or within a hospital, nursing home, or public health agency or institution; and
 - (B) the patient is the supervising dentist's patient of record and the dentist has examined the patient within six months prior to the patient's receiving treatment from a dental hygienist under this Subsection [\(3\)](#);
- (4) under a written agreement with a dentist who is licensed under this chapter and who is a Utah resident if:
 - (a) the dental hygienist practices in a public health setting;
 - (b) the dentist is available in person, by phone, or by electronic communication;
 - (c) the agreement provides that the dental hygienist shall refer a patient with a dental need beyond the dental hygienist's scope of practice to a licensed dentist; and
 - (d) the dental hygienist obtains from each patient an informed consent form that provides that treatment by a dental hygienist is not a substitute for a dental examination by a dentist; or
- (5) notwithstanding any other provision of this chapter, without general supervision and without a collaborative practice agreement with a dentist if:

- (a) the dental hygienist engages in the practice of dental hygiene in a public health setting;
- (b) prior to engaging in the practice of dental hygiene in a public health setting, the dental hygienist notifies the division on a one-time basis in accordance with rules made by the division in accordance with [Title 63G, Chapter 3, Utah Administrative Rulemaking Act](#), that the dental hygienist will engage in the practice of dental hygiene in a public health setting;
- (c) the dental hygienist assumes liability for the work done by the dental hygienist while engaging in the practice of dental hygiene in a public health setting;
- (d) the dental hygienist has liability insurance for the work done by the dental hygienist while engaging in the practice of dental hygiene in a public health setting; and
- (e) the dental hygienist:
 - (i) refers to a licensed dentist any patient with a dental need beyond the dental hygienist's scope of practice encountered while engaging in the practice of dental hygiene in a public health setting; and
 - (ii) sends to the licensed dentist all dental records for the patient generated by the dental hygienist.

Dental services that may be reported directly by a hygienist are limited. Refer to the [Coverage and Reimbursement Lookup Tool](#) for additional information concerning CDT code coverage for dental hygienists.

23-57 Code Updates

The following codes will be open as of July 1, 2023. Please see the [Coverage and Reimbursement Lookup Tool](#) for code specific changes.

G0312 - Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 5-15 minutes time (This code is used for Medicaid billing purposes)

G0313 - Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16-30 minutes time (This code is used for Medicaid billing purposes)

G0314 - Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 16-30 minutes time (This code is used for the Medicaid Early and Periodic Screening, Diagnostic, and Treatment Benefit [EPSDT])

G0315 - Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 5-15 minutes time (This code is used for the Medicaid Early and Periodic Screening, Diagnostic, and Treatment Benefit [EPSDT])

97151 - Behavior identification assessment

97153 - Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes

97154 - Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes

97155 - Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes

H0032 - Mental health service plan development by non-physician

97156 - Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes

97157 - Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes

97158 - Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes

23-58 Ultra High-Cost Medications

Effective July 1, 2023, ultra high-cost medications greater than \$1 million per dose will be carved out from MCE coverage and are part of the FFS Medicaid benefit. Please refer to the [Medicaid Pharmacy Manual](#) for more details.

See current rebateable FDA-approved therapies with costs greater than \$1M per dose:

HCPCS	Brand Name	Generic Name	Date	Indication	Rebate Status	Cost
J1411	Hemgenix	Etranacogene dezeparvovec (Etranadez)	11/22/2022	Adults with Hemophilia B (congenital Factor IX deficiency) Dx Code: D67	Rebateable	\$3.5M (WAC)
J3399	Zolgensma	Onasemnogene abeparvovec-xioi	5/24/2019	Children <2yrs of age with Spinal Muscular Atrophy (SMA) Dx Codes: G12.0, G12.1, G12.25, G12.8, G12.9	Rebateable	\$2.1M (WAC)

23-59 Updated Medical Prior Authorization PRISM Submissions

Effective August 1, 2023, providers must submit all prior authorization requests, modifications, and additional documentation directly through the PRISM portal. Any request received via fax, email, or mail on August 1, 2023, or after will not be accepted or reviewed.

If you do not have access to PRISM PA, please contact your office administrator or reach out to provider enrollment at providerenroll@utah.gov for assistance in registration.