July 2024

Utah Department of Health & Human Services
Integrated Healthcare

MEDICAID INFORMATION BULLETIN

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

Unless otherwise noted, all changes take effect on July 1, 2024

24-44 ARPA Enhanced Funding Update

In May of 2021, the Centers for Medicare and Medicaid Services (CMS) authorized states to make term-limited supplemental payments to certain Medicaid providers for three years (April 1, 2021, through March 31, 2024). The supplemental payments are temporary and funded with American Rescue Plan Act (ARPA), HCBS Enhanced Funding.

Information about the enhanced funding was included in the November 2021 MIB, article 21-100. In June of 2022, CMS extended the available funding period by adding an additional year, thereby extending the program through March 31, 2025.

Information about ARPA enhanced funding and how providers can take advantage of the supplemental payments, visit https://medicaid.utah.gov/arpa/.

24-45 2024 Medicaid Statewide Provider Training

Utah Medicaid will be offering the 2024 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. For each training, except UOIG, we will have a ten-minute presentation then will open it up for questions.

To register for the 2024 training, please complete the Google Form.

Previous statewide provider trainings are available on the Medicaid website. The 2024 trainings will be posted after the trainings conclude.

The following dates and times are scheduled for the 2024 Medicaid Statewide Provider Training. The duration of the training may be longer or shorter than indicated based on the number of questions asked during the training.

Date	Time (MST)	Training
Tuesday, August 13	10:00 -12:00	Claims and Billing
Wednesday, August 14	10:00 -12:00	Provider Enrollment
Thursday, August 15	12:00 -1:00	Pharmacy Program
Tuesday, August 20	10:00 - 11:30	Healthcare Policy for Hospitals, Outpatient, and Physicians
Wednesday, August 21	10:00 - 11:30	Healthcare Policy for Behavioral Health Providers
Thursday, August 22	10:00 - 11:30	Healthcare Policy for DME, Home Health, Private Duty Nursing, and Personal Care Service Providers
Tuesday, August 27	10:00 - 11:00	Managed Care
Wednesday, August 28	10:00 – 11:00	Dental Providers (Fee-for-service and Managed Care)
Thursday, August 29	10:00 – 11:00	Prior Authorization
Tuesday, September 3	10:00 – 11:30	Utah Office of Inspector General (UOIG)

24-46 Reporting Medically Unlikely Edits (MUE)

As a reminder to providers, Medicaid follows the Medicaid National Correct Coding Initiative (NCCI). According to CMS, "The Medicaid NCCI methodologies must be applied to Medicaid fee-for-service (FFS) claims which are submitted with and reimbursed on the basis of Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes." The Medicaid NCCI program has significant differences from the Medicare NCCI program. For additional guidance, please see the Medicaid NCCI Policy Manual.

24-47 Supportive Living Services

Beginning July 1, 2024, qualified Medicaid-enrolled providers may also report supportive living services for fee-for-service members, as defined by the Rehabilitative Mental Health and Substance Use Disorder Services provider manual, using code H2016, *Comprehensive Community Support Services, per diem*. Prior to this date, the service was only available to members enrolled in a managed care plan.

Chapter 2-20, *Supportive Living,* has been added to the Rehabilitative Mental Health and Substance Use Disorder Services provider manual outlining this new policy.

24-48 Social Detoxification

Section I: General Information provider manual has been updated to remove clinically managed withdrawal services (social detoxification) from Chapter 2-6, *MCE Carve-Out Services*. This service has been covered by managed care entities as of July 1, 2021, and the manual has been updated to reflect this policy.

24-49 Ambulatory Detoxification

Attention: Ambulatory Withdrawal Management Providers (ASAM Level 1 and Level 2 Withdrawal Management)

Effective July 1, 2024, ambulatory withdrawal management services, with or without extended on-site monitoring may be provided by all Medicaid enrolled and state licensed ambulatory withdrawal management providers.

Chapter 2-20, *Ambulatory Withdrawal Management*, of the Rehabilitative Mental Health and Substance Use Disorder Services provider manual has been updated to reflect this policy change.

Prepaid Mental Health Plans (PMHPs), Utah Medicaid Integrated Care (UMIC) Plans, and Healthy Outcomes Medical Excellence (HOME) program may implement utilization review, including prior authorization (PA) of ambulatory detoxification services. For information on PMHPs', UMIC Plans', and HOME's PA and utilization review requirements and processes, programs must contact these plans. See Chapter 1-3, *Medicaid Behavioral Health Delivery System*, of the Rehabilitative Mental Health and Substance Use Disorder Services provider manual for information on managed care plans.

24-50 Behavioral Health Nurse Medication Management

Effective July 1, 2024, the Rehabilitative Mental Health and Substance Use Disorder provider manual will replace code T1001, *Nurse Evaluation and Assessment* (with CG modifier), with code 99211, *Office or other outpatient visit for the evaluation and management of an established patient that may or may not require the presence of a physician or other qualified health care professional*, with CG modifier. Use of the CG modifier indicates the service was for a behavioral health pharmacological management service as opposed to a physical health service for medical needs.

24-51 School-Based Services Time Study

Effective July 1, 2024, the Random Moment Time Study program will implement the following changes. The number of sample periods in the year will be reduced to three; there will be a period from mid-August to the end of December, a period from January 1 to June 30, and a period from July 1 to mid-August. Reporting will not happen during the summer period (June-August). The summer sample period will run from the day after the last regular school day until the day before the first regular school day for any participating LEA. An average of the two (2) previous sampling periods' time study results will be used to calculate claims for the summer sampling period. The precision level is changed from +/- 2% to +/- 5%, which will significantly reduce the overall number of moments in each period. Finally, LEAs will receive a 2-day notice prior to receiving the sampled moment request. Prior to this change, there was no notification period.

24-52 School-Based Personal Care Services

Effective July 1, 2024, a student's Individualized Education Plan (IEP) may be used as a service plan for personal care services rendered in the School-Based Skills Development program. The IEP will also retroactively cover personal care services billed from July 1, 2023, to July 1, 2024, under code T1019.

24-53 Long-Term Acute Care Hospital Billing

The Hospital Services provider manual, Chapter 14-1, *Requirements,* is updated to advise that as of July 11, 2024, LTAC providers must report revenue code 0100, *all-inclusive room and board plus ancillary services* instead of revenue code 0760 which was previously required on LTAC claims. This update will be for the date of service of the claims, not the received date.

LTAC providers must also utilize value code 80 for covered days and value code 81 for non-covered days on their LTAC claims to ensure proper adjudication.

With the transition to the Medicaid PRISM claims processing system, LTAC reporting requirements have changed to meet the new system requirements. LTAC providers are now required to submit their Utah Medicaid claims on an inpatient claim form using bill type 11X, 12X, 41X and revenue code 0100.

Medicaid will continue to require prior authorization. If Medicare is primary, prior authorization from Medicaid must be obtained at admission to the LTAC. This will ensure that, if a Medicare recipient exhausts their Medicare inpatient hospital days, their Medicaid coverage will not lapse for the continued LTAC stay. As always, for those Medicaid members who have Medicare, or any other payer as their primary payer, Medicare or the other primary payer must be billed first prior to billing Medicaid. Before submitting a claim to Medicaid, a provider must submit and secure payment from all other liable parties such as Medicare Part A and private insurance.

According to the Medicare Claims Processing Manual, Pub 100-04, Chapter 150.17, *Benefits Exhausted*, if a member who has Medicare Part A as their primary payer and will exhaust their Part A benefits before discharge from the LTAC, the LTAC provider must bill Medicare using

Occurrence Code A3-C3 to show the benefits have exhausted. The LTAC provider must bill Medicare according to Medicare policy before billing Medicaid for the LTAC services. Medicaid requires the benefit exhaust documentation, signifying that the Medicare days have been exhausted, prior to reimbursing LTAC claims that have Medicare as the primary payer.

24-54 Wheelchair Accessories

Beginning July 1, 2024, HCPCS code E0990, *Wheelchair Elevating Leg Rest,* will be reimbursed ancillary to the per diem rate for members residing in a nursing home. In addition, this wheelchair accessory will be available as a purchase only and may not be reported as a rental. Providers reporting this code must include either the RT or LT modifier to indicate which leg(s) requires the accessory.

Providers are encouraged to reference the Coverage and Reimbursement Lookup for additional policy information.

24-55 Magnetic Resonance Imaging (MRI) Codes

Effective May 1, 2024, the following MRI codes no longer require prior authorization:

70540 *Magnetic resonance (e.g., proton) imaging, orbit, face, and/or neck; without contrast material(s)*

70542 *Magnetic resonance (e.g., proton) imaging, orbit, face, and/or neck; with contrast material(s)*

70543 *Magnetic resonance (e.g., proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences*

73219 *Magnetic resonance (e.g., proton) imaging, upper extremity, other than joint; with contrast material(s)*

73220 *Magnetic resonance (e.g., proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences*

73221 *Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material(s)*

73222 *Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material(s)*

73223 *Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences*

73718 *Magnetic resonance (e.g., proton) imaging, lower extremity other than joint; without contrast material(s)*

73719 *Magnetic resonance (e.g., proton) imaging, lower extremity other than joint; with contrast material(s)*

73720 *Magnetic resonance (e.g., proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences*

73725 *Magnetic resonance angiography, lower extremity, with or without contrast material(s)*

75557 *Cardiac magnetic resonance imaging for morphology and function without contrast material*

75559 *Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging*

75561 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences*

75563 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging*

75565 *Cardiac magnetic resonance imaging for velocity flow mapping*

77084 *Magnetic resonance (e.g., proton) imaging, bone marrow blood supply*

Providers are encouraged to refer to the Coverage and Reimbursement Lookup for additional policy information related to these services.

24-56 Genetic Counseling Update

Effective May 1, 2024, a new provider allowable code (PAC) and specialty for genetic counseling was added to PRISM. Genetic counselors may now report services directly using PAC 174 – Genetic Counselor.

Beginning July 1, 2024, the following codes will be opened for reporting by PAC 174 - Genetic Counselor:

96040 *Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family*
S0265 *Genetic counseling, under physician supervision, each 15 minutes*

In addition, the Physician Services provider manual, Chapter 8-23 *Fertility Preservation* and the EPSDT Services provider manual, Chapter 3-10 *Fertility Preservation* will be updated to remove language that limited the reporting of genetic counseling services for fertility preservation to physicians and physician assistants.

Providers are encouraged to refer to the Physician Services provider manual, EPSDT Services provider manual, and the Coverage and Reimbursement Lookup for additional policy information regarding fertility preservation coverage.

24-57 Urine Drug Screening Clarification

The May 2024 MIB, Article 24-33 Urine Drug Screening, incorrectly stated that urine drug screening would be covered on a rolling twelve-month period beginning July 1, 2024. As a reminder, urine drug screenings are covered on a rolling 12-month period and have been since

July 2022. This was not a change to policy. For additional information, see the Physician Services provider manual, Chapter 8-12.5, *Urine Drug Screening*.

24-58 Sodium Fluoride Update

Effective June 1, 2024, Utah Medicaid will cover chewable fluoride supplements for members ages 6 to 16 years. For more information, please refer to the Preferred Drug List & Resource Document and R414-60-5.

24-59 Isotretinoin Products

Effective March 1, 2024, the Oral Acne Products PDL class has been updated to include preferred medications that were previously non-preferred. For more information, please refer to the Preferred Drug List.

24-60 DUR Board Updates

In May 2024, the Drug Utilization Review (DUR) Board met to review Singulair (montelukast). The review consisted of the FDA boxed warning, indications, and utilization review. In June 2024, the DUR Board met to review the concurrent use of muscle relaxants and hypnotic agents with opioids. In July 2024, the DUR Board will meet to review the concurrent use of stimulants and sleep aids with benzodiazepines.

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.

24-61 P&T Committee

The Pharmacy and Therapeutics (P&T) Committee reviewed Anti-VEGF (oral) in May. The minutes for P&T Committee meetings can be found at https://medicaid.utah.gov/pharmacy/pt-committee.

24-62 Pharmacy Dispensing Fees

Effective July 15, 2024, dispensing fees for pharmacy point-of-sale claims will be updated as follows:

$11.57 for all prescriptions except hemophilia clotting factor; and

$97.53 for hemophilia clotting factor

24-63 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 about 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 NDCs for pharmacy related HCPCS.

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

24-64 Drugs to Promote Fertility Update

Beginning May 1, 2024, drugs that are required as part of an in-vitro fertilization (IVF) cycle are covered for eligible members who meet the following criteria:

- Has been diagnosed, by a physician, as having a genetic trait associated with one of the following conditions:
    - cystic fibrosis;
    - spinal muscular atrophy;
    - Morquio syndrome;
    - myotonic dystrophy; or
    - sickle cell anemia
- Intends to reproduce with a partner who has been diagnosed by a physician as having a genetic trait associated with the same qualified condition as the individual, or
- One partner has been diagnosed by a physician as having myotonic dystrophy and intends to reproduce.

Coverage of drugs that are required as part of in-vitro fertilization is limited to 3 cycles per lifetime.

Drugs that are required as part of therapy for members undergoing gonadotoxic cancer treatments or other medically necessary treatments that are expected to render them permanently infertile (excluding voluntary sterilization) either pre or post treatment are covered for qualifying members who meet the following criteria:

- The member is post-pubertal through 40 years of age.
- Diagnosis by a qualified healthcare professional (QHP) that requires treatment that may cause a substantial risk of sterility or iatrogenic infertility (infertility caused by treatment).
- The member's current state of health is sufficient to undergo fertility preservation procedures.

- The member has received infertility counseling as well as psychotherapy, when medically indicated.
- Collection and storage of embryos, eggs or sperm is consistent with established medical practices or professional guidelines published by the American Society of Reproductive Medicine (ASRM) or the American Society of Clinical Oncology (ASCO).

Coverage of drugs for fertility preservation is limited to once per lifetime.

Please refer to the Section I: General Information provider manual for additional information.

24-65 Code Coverage Updates

The following codes have been updated and effective dates may vary. Please see the Coverage and Reimbursement Lookup for code specific details.

55870 *Insertion of device to enhance semen discharge*
58970 *Removal of eggs from ovaries*
81221 *Gene analysis (cystic fibrosis transmembrane conductance regular) known familial variants*
81222 *Gene analysis (cystic fibrosis transmembrane conductance regular) duplication or deletion variants*
81223 *Gene analysis (cystic fibrosis transmembrane conductance regular) full gene sequence*
81224 *Gene analysis (cystic fibrosis transmembrane conductance regular) intron 8 poly-T*
81257 *Gene analysis (alpha globin 1 and alpha globin 2) for common deletions or variant*
81258 *Gene analysis (alpha globin 1 and alpha globin 2) for known familial variant*
81329 *Gene analysis (survival of motor neuron 1, telomeric) for dosage/deletion*
81336 *Gene analysis (survival of motor neuron 1, telomeric) of full sequence*
81337 *Gene analysis (survival of motor neuron 1, telomeric) for known familial sequence variants*
81361 *Gene analysis (hemoglobin, subunit beta) for common variant*
81362 *Gene analysis (hemoglobin, subunit beta) for known familial variant*
81363 *Gene analysis (hemoglobin, subunit beta) for duplication/deletion variant*
81364 *Gene analysis (hemoglobin, subunit beta) full sequence analysis*

81400 *Molecular pathology procedure level 1*
81403 *Molecular pathology procedure level 4 genetic analysis*
81405 *Molecular pathology procedure level 6 genetic analysis*
89250 *Culture of eggs or embryos, less than 4 days*
89251 *Culture of eggs or embryos, less than 4 days, with co-culture of eggs or embryos*
89253 *Assisted embryo hatching (fertility procedure)*
89254 *Egg identification from ovarian fluid*
89257 *Sperm identification from aspiration*
89258 *Frozen preservation of embryos*
89259 *Frozen preservation of sperm*
89264 *Sperm identification from testis tissue*
89272 *Extended culture of eggs or embryos, 4-7 days*
89337 *Frozen preservation of mature eggs*
89342 *Storage of embryos, per year*
89343 *Storage of sperm or semen per year*
89344 *Storage of reproductive tissue, testicular or ovarian per year*
89346 *Storage of eggs, per year*
89398 *Reproductive medicine laboratory procedure*
96040 *Counseling for genetic testing*
A2026 *Restrata minimatrix, 5 mg*
A4564 *Pessary, disposable, any type*
C9166 *Injection, secukinumab, intravenous, 1 mg*
C9167 *Injection, apadamtase alfa, 10 units*
C9168 *Injection, mirikizumab-mrkz, 1 mg*
C9796 *Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis])*
C9797 *Vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction*
E0152 *Walker, battery powered, wheeled, folding, adjustable or fixed height*
E0468 *Home ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions*
J0177 *Injection, aflibercept hd, 1 mg*
J0209 *Injection, sodium thiosulfate (hope), 100 mg*

J0577	*Injection, buprenorphine extended release (brixadi), less than or equal to 7 days of therapy*
J0578	*Injection, buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy*
J0589	*Injection, daxibotulinumtoxina-lanm, 1 unit*
J0650	*Injection, Calscorbate, up to 100 mg*
J0651	*Injection, levothyroxine sodium (fresenius kabi) not therapeutically equivalent to j0650, 10 mcg*
J0652	*Injection, levothyroxine sodium (hikma) not therapeutically equivalent to j0650, 10 mcg*
J1010	*Injection, methylprednisolone acetate, 1 mg*
J1202	*Miglustat, oral, 65 mg*
J1203	*Injection, cipaglucosidase alfa-atga, 5 mg*
J1323	*Injection, elranatamab-bcmm, 1 mg*
J1434	*Injection, fosaprepitant (focinvez), 1 mg*
J2277	*Injection, motixafortide, 0.25 mg*
J2782	*Injection, avacincaptad pegol, 0.1 mg*
J2801	*Injection, risperidone (rykindo), 0.5 mg*
J2919	*Injection, methylprednisolone sodium succinate, 5 mg*
J3055	*Injection, talquetamab-tgvs, 0.25 mg*
J3424	*Injection, hydroxocobalamin, intravenous, 25 mg*
J7165	*Injection, prothrombin complex concentrate, human-lans, per i.u. of factor ix activity*
J7354	*Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)*
J9073	*Injection, cyclophosphamide (ingenus), 5 mg*
J9074	*Injection, cyclophosphamide (sandoz), 5 mg*
J9075	*Injection, cyclophosphamide, not otherwise specified, 5 mg*
J9248	*Injection, melphalan (hepzato), 1 mg*
J9249	*Injection, melphalan (apotex), 1 mg*
J9376	*Injection, pozelimab-bbfg, 1 mg*
L5783	*Addition to lower extremity, user adjustable, mechanical, residual limb volume management system*
L5841	*Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control*
Q4305	*American amnion ac tri-layer, per square centimeter*
Q4306	*American amnion ac, per square centimeter*
Q4307	*American amnion, per square centimeter*

Q4308 *Sanopellis, per square centimeter*
Q4309 *Via matrix, per square centimeter*
Q4310 *Procenta, per 100 mg*
Q5133 *Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg*
Q5134 *Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg*
S0265 *Genetic counseling, under physician supervision, each 15 minutes*
S4011 *In vitro fertilization; including but not limited to identification and embryo(s), and subsequent visualization for determination of development incubation of mature oocytes, fertilization with sperm, incubation*
S4016 *Frozen in vitro fertilization cycle, case rate*
S4017 *Incomplete cycle, treatment cancelled prior to stimulation, case rate*
S4018 *Frozen embryo transfer procedure cancelled before transfer, case rate*
S4020 *In vitro fertilization procedure cancelled before aspiration, case rate*
S4021 *In vitro fertilization procedure cancelled after aspiration, case rate*
S4028 *Microsurgical epididymal sperm aspiration (mesa)*
S4042 *Management of ovulation induction (interpretation of diagnostic tests and studies, non-face-to-face medical management of the patient), per cycle*
S9002 *Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device*

24-66 Utah Medicaid Integrated Care (UMIC) Policies

Utah Medicaid Integrated Care (UMIC) Behavioral Health Treatment Prior Authorization/Service Authorization Request Processes

UMIC plans are managed care plans that provide integrated medical and behavioral health services for Utah Adult Medicaid Expansion members. Currently, UMIC plans are offered in Weber, Davis, Salt Lake, Utah and Washington counties.

Behavioral Health Residential Treatment - UMIC

In an effort to simplify the prior authorization/service authorization request process for behavioral health residential treatment providers, the UMIC plans agreed to a single process for

prior authorizations/service authorization for behavioral health residential treatment requests, effective July 1, 2024. These standardized policies apply to requests for substance use disorder residential treatment and mental health residential treatment.

If a provider does not yet have access to the updated policies, effective July 1, 2024, the provider should contact each UMIC plan directly to obtain the policies.

Inpatient Psychiatric Hospital Services – UMIC

- Due to 1115 waiver requirements, admissions to a psychiatric hospital that qualifies as an IMD requires a prior authorization/service authorization request. The UMIC plans each have an individual policy for this service.
- Individual UMIC plans may also require a prior authorization/service authorization request for inpatient psychiatric hospital services that are provided in an acute care hospital or general hospital.

If a provider does not have access to each UMIC plan's policies, the provider should contact each UMIC plan directly to obtain the policies.

No Other UMIC Prior Authorization/Service Authorization Requirements for Outpatient Behavioral Health Treatment

The UMIC plans confirm that no other prior authorization/service authorization requests, or notifications, are currently required or will be required on any mental health and/or substance use disorder outpatient services, unless otherwise required under Utah Medicaid policy or unless the provider is Out of Network.

Utah Medicaid Fee-for-Service Policies

Please note that the UMIC policies indicated above do have some differentiation from the Utah Medicaid policies. For members who have fee-for-service coverage for behavioral health treatment, service authorization/prior authorization is required for the following:

- Substance use residential treatment and mental health residential treatment. These policies are located in the Utah Medicaid Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual.
- Inpatient psychiatric services that are provided in an IMD. This policy is located in the Utah Medicaid Hospital Services Provider Manual.

For questions regarding UMIC policies, please contact:

Utah Medicaid Integrated Care Plans	
Health Choice Utah: 1-877-358-8797 healthchoiceutah.com	Healthy U: 1-833-981-0212 uhealthplan.utah.edu/medicaid
Molina Healthcare: 1-888-483-0760 molinahealthcare.com	SelectHealth Community Care: 1-800-538-5038 selecthealth.org/plans/medicaid

If a provider has questions regarding Utah Medicaid policies, an email may be sent to dmhfmedicalpolicy@utah.gov. If a managed care plan has questions regarding Utah Medicaid policies, the plan should contact their Utah Medicaid program manager.