PROVIDER NEWSLETTER

HEALTH CHOICE UTAH

FEBRUARY 2026

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BEHAVIORAL HEALTH SUPPORT FOR PCPs — JUST A "CALL-UP" AWAY

Did you know Utah offers a statewide psychiatric phone consult service to support primary care providers (PCPs) as they treat young patients with behavioral health disorders? CALL-UP is a legislatively funded program through Huntsman Mental Health Institute (HMHI), designed to address the limited number of psychiatric services in Utah and improve access to them.

CALL-UP provides the following benefits:

- No cost to providers or patients throughout Utah
- Optimizes PCPs' ability and confidence to diagnose and treat mild to moderate mental health issues
- Improves the quality of care and health outcomes for patients through early interventions
- Improves the continuum of care by encouraging behavioral health and physical health integration
- Ensures appropriate referrals for individuals with serious health concerns

Licensed psychiatrists are immediately available to discuss medication options, treatment plans, diagnoses, and more. Call 801-587-3636 or visit CALL-UP Psychiatry Consult Service for more information. CALL-UP also offers several insightful webinars—simply scroll down the page and click on "Recent CALL-UP Webinars" or "Past Webinars" to view current and past offerings.

CALL-UP PSYCHIATRY CONSULT SERVICE >>>

BILLING REQUIREMENTS FOR PROVIDER PREVENTABLE CONDITIONS (PPCS) AND HOSPITAL-ACQUIRED CONDITIONS (HACS)

Federal and state regulations require healthcare providers to report Provider Preventable Conditions (PPCs) and Hospital-Acquired Conditions (HACs) on claims when they occur, even though these services are not reimbursable. Accurate and timely billing of these conditions supports transparency, regulatory compliance, and quality improvement efforts, while ensuring alignment with CMS and state guidelines. Proper reporting helps maintain the integrity of the healthcare system and reinforces ongoing patient safety initiatives.

GET THE DETAILS >>>

PERSONAL CARE SERVICES POLICY UPDATE: NEW BILLING REQUIREMENTS EFFECTIVE JAN. 1

As announced in the November 2025 Medicaid Information Bulletin (MIB), effective January 1, 2026, personal care services reported using HCPCS code T1019 (personal care services, per 15 minutes) are done in 15-minute increments. This represents a change from the current code units of one unit for every hour of service provided.

Also effective January 1, 2026, the multiplication rules for personal care services reported using HCPCS code T1019 (personal care services, per 15 minutes) is limited to 1.75x. Eligibility for this multiplication will be limited to claims with the TN modifier. For more information, please refer to the Personal Care Services provider manual.

MEDICAID INFORMATION BULLETINS (MIB) AND MEDICAID PROVIDER MANUALS >>>

BALANCE BILLING MEDICAID MEMBERS PROHIBITED

Utah Medicaid has reported an increase in balance billing referrals. Providers are reminded that billing Health Choice Utah members—or any Medicaid managed care organization (MCO) member—for covered services beyond allowed patient responsibilities is prohibited by federal and state law. Providers must accept plan payment as payment in full and may not bill members for denied or adjusted claims related to covered services. If a member has both Medicaid and coverage with a responsible third party, do not collect a copayment that is usually due at the time of service. Review the full article for policy details, contact requirements, and reference guidance.

VIEW FULL ARTICLE >>>

REMINDER: MEDICAID PHARMACY CHANGES EFFECTIVE JANUARY 2026

Beginning January 1, 2026, Utah Medicaid requires certain drug classes on Medicaid managed care formularies to align with the Utah Medicaid Preferred Drug List (PDL). An initial 90-day transition period applied prior to January 1, 2026 for impacted members. Moving forward, medications on the formulary will display either "Hybrid PDL Preferred" or "Hybrid PDL Non-Preferred" to support prescribing decisions. Members who are new to the plan after January 1, 2026, and are taking non-preferred medications will need to work with their prescriber to switch to a preferred option. Members who are in the plan at enrollment while the medication is transitioned to a preferred product or receives prior authorization. After January 1, 2026, requests for non-preferred products will be evaluated on a case-by-case basis for medical necessity. Updated formularies reflecting these changes were made available January 1, 2026.

MEDICAID PHARMACY CHANGES >>>

REMINDER: CHECK MEMBER ELIGIBILITY AND BENEFITS

As has always been best practice regarding Medicaid enrollees, remember to verify eligibility prior to every visit. Since Medicaid eligibility can change from month to month or during the month-verify eligibility in the month of the visit, and no more than 10 days prior to the visit. There are now three methods by which eligibility can be verified:

- PRISM portal (preferred)
- Medicaid Eligibility Lookup Tool
- Phone:
  - Salt Lake City area - 801-538-6155
  - Utah, Idaho, Wyoming, Arizona, Colorado, Nevada, and New Mexico - 800-662-9651
  - From other states - 801-538-6155

SEE A DISCREPANCY BETWEEN PRISM AND PROVIDER PORTAL OR EPIC?

If member enrollment differs between PRISM and Epic or our provider portal, please email enrollmenthealthchoiceutah.com. Our team will verify coverage and align records as needed.

QUALITY IMPROVEMENT & PATIENT CARE

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GENETIC TESTING: CONFIRMING IN-NETWORK LABS & AVOIDING UNNECESSARY DENIALS

As genetic testing becomes more integral to patient care, we have seen a parallel rise in avoidable denials and member frustration. To support timely approvals and protect patients from unexpected bills, we ask providers to take two key steps:

- Submit clear clinical documentation with each request, explaining why the specific genetic test is needed (diagnosis, family history, prior results, and how results will change management). Inadequate documentation is a leading cause of denials.
- Confirm an in-network lab (INN) provider and test availability using the Health Choice Utah Provider Directory and genetic testing resources before ordering.

These simple checks help prevent delays in care and post-service out-of-network (OON) fees.

For more information, please contact Customer Service at 877-358-8797.

PROVIDER DIRECTORY >>>

APPOINTMENT ACCESS STANDARDS: ENSURING TIMELY CARE FOR MEMBERS

The Appointment Access Standards outline provider expectations for ensuring members receive timely, appropriate care in accordance with CMS, State of Utah, and federal Qualified Health Plan requirements. Providers must meet defined wait-time standards for urgent, routine, behavioral health, after-hours, and emergency-related care, while maintaining effective scheduling and telephone systems to support access. Adhering to these standards helps promote consistent access to care, regulatory compliance, and high-quality service for all members.

VIEW APPOINTMENT ACCESS STANDARDS >>>

CLARIFYING COVERAGE FOR ROUTINE VACCINATIONS AMID FEDERAL GUIDANCE CHANGES

Recent updates to federal childhood vaccination guidance have prompted questions about how these changes affect coverage. Health Choice Utah wants to reassure providers and members that vaccines previously included in the routine immunization schedule remain covered when administered according to medically appropriate indications. Coverage continues without interruption even when current federal recommendations emphasize shared clinical decision-making—ensuring members have ongoing access to important preventive vaccines as guidance evolves.

READ THE FULL VACCINATION COVERAGE UPDATE >>>

CERVICAL CANCER SCREENING (CCS) HEDIS MEASURE TRANSITIONS TO ELECTRONIC CLINICAL DATA SYSTEMS (ECDS): WHAT CLINICIANS NEED TO KNOW

Starting in 2025, NCQA transitioned the HEDIS® Cervical Cancer Screening (CCS) measure to the Electronic Clinical Data Systems (ECDS) reporting method. This change means screenings documented in EHRs, health information exchanges, and clinical registries will count toward performance—even without a claim. For clinicians, this shift offers more accurate measurement, improved care visibility, reduced administrative burden, and better alignment with clinical workflows. Accurate and timely documentation in structured EHR fields is essential to ensure compliance and quality reporting.

READ THE ARTICLE >>>

PHARMACY NEWS

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ANNUAL NOTICE OF PHARMACY RESOURCES FOR PRESCRIBERS

Health Choice Utah regularly updates medication and pharmacy information to ensure prescribers have the most current details. Providers are encouraged to visit the pharmacy website at least quarterly for updates on formulary changes, prior authorization requirements, and other important resources. These updates help maintain compliance and support safe, effective prescribing practices.

Click the link below for resources on medical and retail pharmacy medications.

These include prior authorization forms, formulary exception requests, and links to searchable directories. Providers can submit requests online or by fax and should review upcoming formulary changes posted on the website. For assistance, dedicated customer service teams are available for each plan type, with 24/7 support for retail pharmacy inquiries.

VIEW FULL PHARMACY RESOURCES >>>

REDUCING THE PHARMACY PRIOR AUTHORIZATION BURDEN

Our Pharmacy team proactively reviews medication prior authorizations (PAs) that are set to expire within the next one to two months. If there is sufficient information to renew the PA (e.g., member adherence, treatment efficacy, and whether the member has seen their provider during the plan year), we will extend the PA for you. This eases your PA burden and prevents access-to-care issues for your patients. We will notify you whenever an authorization is extended. Certain medications always require provider submission of the PA request, so always check the formulary.

We're updating our pharmacy PA policies to make them simpler and more efficient—reducing unnecessary steps and improving clarity for providers and members.

We continue to focus on ways to make the PA process easier for you. Updates will be shared in future Provider Newsletter editions. If you haven't yet, subscribe today so you don't miss a quarterly edition.

CODING CORNER

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CODES REQUIRING PRIOR AUTHORIZATION

We regularly review our list of Codes Requiring Prior Authorization and update it as changes occur, including removing codes no longer requiring authorization. Please search this list before scheduling procedures or prescribing durable medical equipment to determine if prior authorization is required.

Also, take a moment to view Upcoming Changes to Codes Requiring Prior Authorization to ensure your authorizations for future procedures are also compliant.

PREVENTIVE CODING UPDATES FOR COLORECTAL CANCER SCREENING

To improve access and reduce claim denials, Health Choice Utah has updated preventive screening billing and diagnosis requirements for members ages 45–75. These changes align with statewide initiatives and help ensure accurate reimbursement for routine screenings.

KEY HIGHLIGHTS:

- Use appropriate CPT/HCPCS codes and include either a screening diagnosis code (Z12.10, Z12.11, Z12.12) or Modifier 33.
- Preventive benefits vary by test type (e.g., FIT: 1 per year; Colloguard: 1 per 3 years)

FULL DETAILS HERE >>>

PRIOR AUTHORIZATION LIST: REMOVING NON-COVERED CODES FOR GREATER CLARITY

Health Choice Utah is updating its prior authorization list to improve clarity by removing codes that are not covered under member's benefits. This change is intended to help providers more easily identify which outpatient services require prior authorization, reduce confusion, and prevent avoidable denials. While most coverage determinations will be reflected in the updated list, individual plan benefits or member circumstances may result in exceptions.

VIEW FULL ARTICLE >>>

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