PROVIDER NEWSLETTER

HEALTH CHOICE UTAH

MAY 2026

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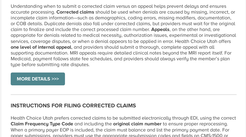
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GENERAL NEWS

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UTAH 2026 LEGISLATIVE SESSION: KEY HEALTH POLICY UPDATES FOR PROVIDERS

Several new state laws passed in the 2026 General Session will impact provider directories, insurance coverage, autism reporting, physical therapy licensing, and prior authorization processes.

H.B. 71 – Provider Directory & Access Requirements
Strengthens directory accuracy rules and requires timely behavioral health access support. Providers will see increased requests to verify practice details.

H.B. 258 – Coverage Parity for Gender Transition & Reversal Procedures
Beginning in 2027, plans that cover gender transition treatments must also cover related reversal procedures.

H.B. 468 – Mobile Mammography Coverage
Beginning in 2027, plans that cover mammography must also cover screenings performed by FDA-accredited mobile units in rural areas, reimbursed at the standard in-network rate.

S.B. 175 – Autism Coverage Reporting
Updates autism-related definitions and creates new reporting requirements for health plans.

S.B. 204 – Physical Therapy Cost-Sharing
Physical therapy services must use primary care cost-sharing levels, likely reducing patient costs and increasing completion of treatment plans.

S.B. 319 – Prior Authorization Reforms
New rules require posted criteria, stricter timelines (7 days standard, 72 hours urgent). At use disclosure, longer authorization validity (6–12 months), and continuity-of-care protections.

SEE FULL LEGISLATIVE SUMMARY >>>

APPEALS VS. CORRECTED CLAIMS: HOW TO KNOW THE DIFFERENCE

Understanding when to submit a corrected claim versus an appeal helps prevent delays and ensures accurate processing. **Corrected claims** should be used when denials are caused by missing, incorrect, or incomplete claim information—such as demographics, coding errors, missing modifiers, documentation, or COB details. Duplicate denials also fall under corrected claims, but providers must wait for the original claim to finalize and include the correct processed claim number. **Appeals**, on the other hand, are appropriate for denials related to medical necessity, authorization issues, experimental or investigational services, coverage disputes, or when a denial appears to be applied in error. Health Choice Utah offers both a standard and expedited appeal process, and providers may submit supporting documents or supporting documentation. MRI appeals require detailed clinical notes beyond the MRI report itself. At Medicaid, payment follows state fee schedules, and providers should always verify the member's plan type before submitting rate disputes.

MORE DETAILS >>>

INSTRUCTIONS FOR FILING CORRECTED CLAIMS

Health Choice Utah prefers corrected claims to be submitted electronically through EDI, using the correct **Claim Frequency Type Code** and including the **original claim number** to ensure proper reprocessing. When a primary payer EOP is included, the claim must balance and list the primary payment date. For paper submissions, providers must use the appropriate resubmission codes and fields on CMS-1500 or UB-04 forms, ensuring the original claim number is reported correctly. These steps help prevent delays and ensure accurate claim handling.

MORE INFORMATION >>>

BILLING REMINDER: ONE CMS-1500 PER PLACE OF SERVICE (POS)

When a patient is seen in more than one place of service (POS)—such as home, office, or telehealth (non-home)—providers must submit a separate CMS-1500 claim form for each POS. Submitting multiple POS codes on a single claim will result in a denied claim.

KEY POINTS FOR PROVIDERS:

- Submit one CMS-1500 claim per POS
- Do not combine different POS codes on the same claim
- Claims with multiple POS will be denied and require resubmission
- Denial codes include CO16 (missing information) and M77 (invalid/missing POS)

FULL DETAILS HERE >>>

TWO-FACTOR AUTHENTICATION (2FA) FOR PROVIDER PORTAL USERS

Beginning March 4, 2026, two-factor authentication (2FA) became a required security step for all users of the Health Choice Utah Provider Portal, adding an essential layer of protection for PHI and strengthening compliance with HIPAA and CMS standards. After entering your username and password, you'll receive a one-time passcode or authentication method—email (required), text message, or an authenticator app—after which a 6-digit verification code is needed to complete sign-in. Providers can update their contact details within the portal's communication preferences, and the Portal Support team is available for assistance at **801-213-0506** or provider.portal@healthchoiceutah.com.

LEARN MORE >>>

NEW TOOL TO CHECK PRIOR AUTHORIZATION STATUS

RealRx, the Pharmacy Benefit Manager for Health Choice Utah, has introduced a new online tool that allows providers to check the status of prior authorization requests and formulary exception requests by entering basic member and prescription details such as member ID, date of birth, NPI, drug name, and request date. The tool is available at realrxhealth.com/status, and providers can contact the RealRx Pharmacy Service team at **385-429-4042** or **855-859-4892** for assistance.

MORE INFORMATION >>>

OBTAINING UTILIZATION MANAGEMENT CRITERIA

Health Choice Utah makes every effort to ensure that the services provided to our members meet nationally recognized guidelines, are delivered in the appropriate setting (treatment or equipment), and that the length of stay is supported by medical indications. We reference InterQual, the Medicaid Manual, and our coverage policies to help determine medical necessity.

Our coverage policies provide guidelines for determining coverage criteria for specific medical, behavioral health, and pharmaceutical technologies, including procedures, equipment, and services. We would be happy to provide you with a copy of the criteria used to make a specific utilization management decision. Please call the Utilization Management team at **877-358-8789, option 2**, for additional information or email your request to hcuue@healthchoiceutah.com.

MEMBER RIGHTS AND RESPONSIBILITIES

Health Choice Utah is committed to ensuring that every member receives high-quality, respectful, and timely care. As part of that commitment, members are informed of their rights and responsibilities at enrollment.

LEARN MORE >>>

REMINDER: CHECK MEMBER ELIGIBILITY AND BENEFITS

Before every visit, coverage should be confirmed as active — eligibility can change month to month or even mid-month. Verification should occur no more than 10 days before the appointment.

Medicaid members can be verified through the PRISM portal (preferred), the Medicaid Eligibility Lookup Tool, or by phone. If a discrepancy is noticed between PRISM and Epic or the provider portal, contact enrollment@healthchoiceutah.com.

READ THE FULL ARTICLE HERE >>>

STAY UPDATED: SUBSCRIBE TO MEDICAID INFORMATION BULLETINS (MIB)

The Division of Integrated Healthcare publishes Medicaid Information Bulletins every other month on the first Tuesday. The MIB is the official communication for policy changes, system updates, new and existing policies, updates to policies and procedures, and other important information for Medicaid providers. Please subscribe to stay informed about the latest Medicaid updates, including those that may also apply to Health Choice Utah.

SUBSCRIBE HERE >>>

LAST REMINDER: MEDICAID PHARMACY CHANGES EFFECTIVE JANUARY 2026

This is your last reminder. 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 PDL was implemented on January 1, 2025, with a grace period 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 not receive a grace period. Instead, prior authorization will be required at the point of service. For any enrollment while the medication is transitioned to a preferred product or reviewed, 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 >>>

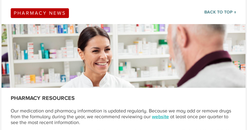
DOULA SERVICES NOW COVERED: WHAT PROVIDERS NEED TO KNOW

Our recent webinar provided an overview of Utah Medicaid's upcoming expansion of doula services, effective April 1, 2026, for Health Choice Utah members. The presentation covered eligibility criteria, billing requirements, the required training and certification steps, and detailed billing guidance for T1032 and T1033, including benefit limits and place-of-service rules. Attendees also received expectations for claim submission and denial payment processes, as well as key distinctions among labor, prenatal, and postpartum support.

VIEW TRAINING PRESENTATION >>>

QUALITY IMPROVEMENT & PATIENT CARE

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UNDERSTANDING THE DIFFERENCE: PROVIDER DEMOGRAPHIC INFORMATION FOR CLAIMS VS. PROVIDER DIRECTORIES

"Provider demographics" means different things depending on where the information is used — and mixing them up can cause delays and compliance issues.

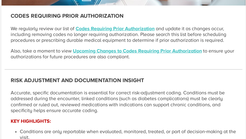
- **For billing claims**, the key details are the legal entity name, TIN, Group NPI, billing address, and rendering provider NPI. Health Choice Utah uses the TIN and Group NPI to process payments, so a separate entry is not needed for each service location when those identifiers remain the same.
- **For provider directories**, the focus is on what members need to find and access care — practice addresses, scheduling phone numbers, accepting-new-patients status, languages spoken, and telehealth availability.

Changes should be reported within 30 days. The Provider Information Update Form is available on the Health Choice Utah website, and roster submissions can be sent to providers@healthchoiceutah.com.

READ THE FULL ARTICLE >>>

PHARMACY NEWS

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PHARMACY RESOURCES

Our medication and pharmacy information is updated regularly. Because we may add or remove drugs from the formulary during the year, we recommend reviewing our website at least once per quarter to see the most recent information.

To help you know when to go, we compiled a webpage of pharmacy resources that might be helpful to you, including a link to our formularies, prior authorization forms, and more.

CHECK OUT THE RESOURCES >>>

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.

RISK ADJUSTMENT AND DOCUMENTATION INSIGHT

Accurate, specific documentation is essential for correct risk-adjustment coding. Conditions must be addressed during the encounter, linked conditions (such as diabetes complications) must be clearly confirmed or ruled out, reviewed medications with indications can support chronic conditions, and specificity helps ensure accurate coding.

KEY HIGHLIGHTS:

- Conditions are only reportable when evaluated, monitored, treated, or part of decision-making at the visit.
- Chronic conditions listed as stable/ongoing remain reportable.
- Diabetes-related conditions are presumed linked unless documentation states otherwise.
- Medication lists help only when reviewed and include indications.
- Document stage, severity, and status when known to ensure coding accuracy.

FULL DETAILS HERE >>>

CORRECT BILLING REQUIREMENTS WHEN USING POS 99 (OTHER PLACE OF SERVICE)

POS 99 is reserved for service locations that don't fit any other established place-of-service code — think community settings, pop-up events, or mobile units. Because the code is broad, additional documentation is required to ensure claims are processed correctly.

When billing POS 99, the name and physical address of where services were actually rendered must be included. For paper claims (CMS-1500), this goes in Box 32. For electronic claims (837P), Loop 2310C should be populated with the service facility location.

Missing or incomplete location information can result in claims being returned, pended, or denied.

VIEW FULL ARTICLE >>>

Please share this newsletter with providers and staff in your office, and encourage them to subscribe to receive notifications when new editions are available. Past newsletters can be viewed here.

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