2025 Medicaid Statewide Provider Training

Healthcare Policy for Hospitals, Outpatient, and Physicians

Utah Department of Health & Human Services

Agenda

- Fertility preservation
- Genetic counseling
- Medical transportation
- Modifiers
- Telehealth
- Integrated healthcare services provider manual
- Women’s health updates

Fertility Preservation Services

- Fertility preservation services are available for members undergoing gonadotoxic cancer treatments, or other medically necessary treatment, that is expected to render them permanently infertile.
- Effective February 1, 2025, the coverage age range for fertility preservation services was extended to cover eligible members through 50 years of age.
- Ovarian tissue cryopreservation services for pre-pubescent females is now a covered service.

Genetic counseling

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 for fertility preservation services.**

The following codes are open for reporting by PAC 174 – Genetic Counselor:

- **96041 Medical genetics and genetic counseling services**, each 30 minutes of total time provided by the genetic counselor on the date of the encounter
- **S0265 Genetic counseling**, under physician supervision, each 15 minutes
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Medical transportation

Non-Emergency Medical Transportation (NEMT)

- Medicaid members are served by different Non-Emergency Medical Transportation (NEMT) providers according to their circumstance.
- More information can be found here: https://medicaid-documents.dhhs.utah.gov/Documents/pdfs/NEMT%20flyer1.2024.pdf

Transportation over 75-miles with Modivcare

- All non-emergent medical transportation (NEMT) must be to the nearest appropriate Medicaid provider or facility that can provide the service.
- Members requesting trips above 75 miles (one-way) must provide a medical necessity form signed by their provider indicating that closer providers are unsuitable for the member.
- The Medical Necessity Certification form can be found on the Modivcare website and must be filed with Modivcare to request that those rides be authorized.
- The form is provider-specific and not location specific; each provider further than 75 miles will require a separate medical necessity form.
- When denied transportation due to excessive provider distance, members may receive transportation for **up to 4 weeks** allowing for the filling of the form or the transition of care to a closer provider.

Ambulance transportation updates

- Coverage for ground ambulance is limited to:
  - Base rate billed with the appropriate modifiers
  - Mileage for the loaded ambulance only
  - Waiting time (when necessary)
- The ambulance base rate includes medical supplies, interventions, and oxygen, which should not be billed separately.
- Ambulance response and treatment, no transport—HCPCS code A0998 may be used in situations when member transport is not necessary.

Modifiers

Modifier 50

Medicaid policy and PRISM programming have been updated to allow Modifier 50 to be appended to a claim for bilateral procedures when appropriate.

Section I: General Information Provider Manual, Chapter 8-3.1 Payment on Claims for Restricted Members, is updated to include Modifier 50 in the allowed modifiers eligible for reimbursement.

Also, **Chapter 12-7.3 Modifier used in a Claim**, of the same manual is updated to state the following:

- Modifier 50: (bilateral procedures) Bilateral surgeries are procedures performed on both sides of the body during the same operative session. Do not append to procedures when the code description specifically states it is a unilateral or bilateral procedure.

Telehealth

Telehealth services policy updates

- Medicaid policy for telehealth was updated on May 1, 2025. This update includes information about what services may be delivered via audio-visual or audio-only telehealth.
- **Section I: General Information Provider Manual**, Chapter 8-4.2, is updated to include detailed information regarding coverages and limitations.
- A list of Medicaid-approved telehealth codes is published under the **All Providers General Attachments** on the Medicaid website. This list does not include codes that specify “telehealth” in the code description.

Telehealth services policy updates

Telepsychiatric consultation

- Per 26B-3-123, Utah Code Annotated, interprofessional consultations are covered when a board-certified psychiatrist consults with a physician or physician assistant to provide expert treatment advice.
- The consulting psychiatrist reports the appropriate interprofessional consultation CPT code to receive payment for their consulting services, and the treating physician or PA reports the appropriate E&M code.
- The requesting physician or PA must be identified on the claim. If the requesting entity is not identified on the claim, the consultation service will be denied.
- Consultation codes may not be reported if the consulting provider saw the member within 14 days before the interprofessional consultation or if the consultation leads to a transfer of the member's care within 14 days.

Integrated healthcare services

New provider manual

In November 2024, a new policy manual titled **Integrated Healthcare Services** was published

The purpose of this manual is to help direct providers towards the reporting of services such as:

- Chronic Care Management (CCM)
- Principle Care Management (PCM)
- Behavioral Health Integration (BHI)
- The Psychiatric Collaborative Care Model (CoCM)
- Health Behavior Assessments and Interventions (HBAI)
- Transitional Care Management
- Advanced Care Planning (ACP)

The policies in this manual are not new, rather they serve as a repository of information specific to integrated healthcare.

Women’s health updates

Salpingectomy coverage

- Effective May 1, 2025, Utah Medicaid has covered salpingectomy procedure for the purpose of female sterilization.
- Prior authorization will not be required for this procedure; however, in order for claims to process correctly the Sterilization Consent Form must be completed and uploaded into the PRISM document management portal when submitting claims for these services.
- This form must be completed at least 30 days, but not more than 180 days, prior to the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery.
- This service will be reported using the following CPT codes:
    - **58661- Laparoscopy, surgical**; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
    - **58700 - Salpingectomy**, complete or partial, unilateral or bilateral (separate procedure)

Contact us

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