DIH Rules Matrix 8-21-25

Rule Summary	Bulletin Publication	Effective
R410-14 Administrative Hearing Procedures; This amendment removes the requirement for the director of the Division of Integrated Healthcare to approve final decisions and includes provisions that allow for an agency review appeal option.	**7-1-25**	**8-7-25**
R414-10-5 Service Coverage Limitations; This amendment clarifies service coverage for family planning through specific restrictions to fertility coverage. It also makes other technical changes.	**8-15-25**	**9-22-25**
R414-60-5 Limitations; This amendment clarifies service coverage for family planning through specific restrictions to fertility coverage. Additionally, it clarifies coverage of drugs for weight loss and makes other technical changes.	**8-15-25**	**9-22-25**

The public may access proposed rules published in the State Bulletin at https://rules.utah.gov/publications/utah-state-bull/

State of Utah
Administrative Rule Analysis
Revised May 2024

NOTICE OF SUBSTANTIVE CHANGE		
TYPE OF FILING: Amendment		
Rule or Section Number:	**R410-14**	**Filing ID: Office Use Only**
Date of Previous Publication (Only for CPRs):	Click or tap to enter a date.	

Agency Information

1. Title catchline:	Health and Human Services, Integrated Healthcare, Administrative Hearings	
Building:	Cannon Health Building	
Street address:	288 N. 1460 W.	
City, state	Salt Lake City, UT	
Mailing address:	PO Box 1433325	
City, state and zip:	Salt Lake City, UT 84114-3325	
Contact persons:		
Name:	**Phone:**	**Email:**
Eric Stott	801-538-4238	emstott@utah.gov
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Please address questions regarding information on this notice to the persons listed above.		

General Information

2. Rule or section catchline:

R410-14. Administrative Hearing Procedures

3. Purpose of the new rule or reason for the change:

Through internal review, the Department of Health and Human Services determined it is necessary to remove the requirement for the director of the Division of Integrated Healthcare to approve final decisions. Additionally, the department determined it is necessary to add an agency review appeal option to this rule.

4. Summary of the new rule or change:

This filing removes rule text requiring the division director to approve final decisions and adds language allowing for an agency review appeal option. Additionally, it makes style and formatting changes for clarity, to align the rule with other rules under the department, and for compliance with the Rulewriting Manual for Utah.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:

A) State budget:

There is no anticipated fiscal impact to the state budget as a result of this filing. While the addition of the agency review appeal option may introduce a new process, the responsibility for the new process will fall within the scope of existing agency management and will not introduce a cost or a savings to the state. Additionally, removing the requirement for the division director to review a final order does not introduce any fiscal impact to the process of issuing a final order.

B) Local governments:

There is no anticipated fiscal impact to local governments as a result of this filing. While the agency review appeal option may apply to a local government if it is a party to an administrative proceeding, there is no cost or savings associated with engaging in the appeal process.

C) Small businesses ("small business" means a business employing 1-49 persons)**:**

There is no anticipated fiscal impact to small businesses as a result of this filing. While the agency review appeal option may apply to a small business if it is a party to an administrative proceeding, there is no cost or savings associated with engaging in the appeal process.

D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**

There is no anticipated fiscal impact to non-small businesses as a result of this filing. While the agency review appeal option may apply to a non-small business if it is a party to an administrative proceeding, there is no cost or savings associated with engaging in the appeal process.

E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**

There is no anticipated fiscal impact to other persons as a result of this filing. While the agency review appeal option may apply to other persons if that other person is a party to an administrative proceeding, there is no cost or savings associated with engaging in the appeal process.

F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**

There are no anticipated compliance costs for affected persons as a result of this filing. While the addition of the agency review appeal option may introduce a new process, the responsibility for the new process will fall within the scope of existing agency management and will not introduce a cost to the department. Additionally, removing the requirement for the division director to review a final order does not introduce any cost to the process of issuing a final order.

G) Regulatory Impact Summary Table (This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts will be included in narratives above.)

Regulatory Impact Table

Fiscal Cost	**FY2025**	**FY2026**	**FY2027**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Cost	**$0**	**$0**	**$0**
Fiscal Benefits	**FY2025**	**FY2026**	**FY2027**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**

H) Department head comments on fiscal impact and approval of regulatory impact analysis:

The Executive Director of the Department of Health and Human Services, Tracy S. Gruber, has reviewed and approved this regulatory impact analysis.

Citation Information

6. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:

Subsection 26B-1-202(1)	Subsection 26B-1-204(1)	42 CFR 431 Subpart E (2025)

42 U.S.C. 1396a(a)(3)		

Incorporations by Reference Information

7. Incorporations by Reference (if this rule incorporates more than two items by reference, please include additional tables):	
A) This rule adds or updates the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*):	
Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

B) This rule adds or updates the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*):	
Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

Public Notice Information

8. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)		
A) Comments will be accepted until:		Click or tap to enter a date.
B) A public hearing (optional) will be held:		
Date (mm/dd/yyyy):	**Time** (hh:mm AM/PM):	**Place** (physical address or URL):
To the agency: If more space is needed for a physical address or URL, refer readers to Box 4 in General Information. If more than two hearings will take place, continue to add rows.		

9. This rule change MAY become effective on:	Click or tap to enter a date.
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	Click or tap to enter a date.

R410. Health and Human Services, Integrated Healthcare, Administrative Hearings.
R410-14. Administrative Hearing Procedures.
R410-14-1. [~~Introduction and~~]Authority and Purpose.

(1) Subsections 26B-1-202(1) and 26B-1-204(1), 42 CFR 431 Subpart E (2025), and 42 U.S.C. 1396a(a)(3) authorize this rule.

(2) This rule sets forth the administrative hearing procedures for actions that the Division of Integrated Healthcare or other agency, as defined below, takes.[

~~(2) Section 26B-1-213, Section 63G-4-102, 42 U.S.C. 1396a(a)(3), and 42 CFR 431 Subpart E authorize this rule.~~]

R410-14-2. Definitions.

(1) Terms in this rule are defined in Rule R414-1 and Section 63G-4-103. Additionally:[~~The definitions in Rule R414-1 and Section 63G-4-103 apply to this rule.~~

~~(2) The following definitions also apply:~~]

([~~a~~]2) "Action" means:

([~~i~~]a) a denial or termination of eligibility for participation in a program or as a provider;

(b) a denial, reduction, or revocation of reimbursement for services for a provider;

(c) a denial, [~~termination~~]reduction, suspension, or [~~reduction~~]termination of medical assistance for a member;

([~~ii) a reduction, denial or revocation of reimbursement for services for a provider;~~

~~(iii) a denial or termination of eligibility for participation in a program, or as a provider;~~

~~(iv~~]d) a determination by a skilled nursing facility[~~ies~~] [~~and~~]or nursing facility[~~ies~~] to transfer or discharge a resident[~~s~~];

([~~v~~]e) an adverse benefit determination, as defined in Subsection R410-14-20(2)(a);

(f) an adverse determination, as defined in Subsection (2)(b); or

([~~vi) an adverse benefit determination as defined in Subsection R410-14-20(2)(a); or~~

~~(vii~~]g) the placement of a Medicaid [~~enrollee~~]member on the restriction program, as described under Section R414-29-3.

([~~b~~]3) "Adverse determination" means a determination, [~~made~~]in accordance with Subsection 1919(b)(3)(F) or Subsection 1919(e)(7)(B) of the Social Security Act, that:

(a) [the]an individual does not require the level of services provided by a nursing facility; or

(b) [~~that the~~]an individual does or does not require specialized services.

([~~e~~]4) "Agency" means:

(a) the Division of Integrated Healthcare (DIH) within the Department of Health and Human Services[~~, (DHHS),~~], except the Office of Substance Use and Mental Health;

(b) the Department of Workforce Services (DWS)[~~,~~]; or

(c) any [~~managed health care organization (~~]MCO[~~)~~] that [~~has~~]conduct[~~ed~~]s or perform[~~ed~~]s an action[~~ as defined in this rule~~].

([~~d~~]5) "Aggrieved person" means any member, enrollee, or provider who is adversely affected by an action[~~ of an agency~~].

([~~e~~]6) "Child Health Evaluation and Care" program or "CHEC" means [~~Child Health Evaluation and Care program, which is~~]Utah's version of the federally mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid child health program.

([~~f~~]7) "De novo" means anew[~~,~~] or considering the question of a case for the first time.

([~~g~~]8) "Decision" or "order" means a ruling by a presiding officer that determines the legal rights, duties, privileges, immunities, or other legal interests of a party.

(9) "Department" means the Department of Health and Human Services[~~ (DHHS)~~].

([~~h) " DWS" means the Department of Workforce Services.~~

~~(i~~]10) "Eligibility agency" means:

(a) the department;

(b) DWS[~~, DHHS,~~]; or

(c) any entity the agency contracts with to determine medical assistance eligibility.

([~~j~~]11) "Ex parte[~~"~~] communication[s]" means direct or indirect communication in connection with an issue of fact or law, between the [~~hearing~~]presiding officer and only one party[~~ only~~].

([~~k~~]12)(a) "Grievance" means an expression of dissatisfaction about any matter other than an action as defined in this rule.

(b) [~~G~~]A grievance[s] may include:

(i) the quality of care of services provided; [~~and~~]or

(ii) an aspect[s] of interpersonal relationships, such as rudeness of a provider or employee or the failure to respect the rights of an MCO member[~~enrollee of a managed care organization (MCO)~~].

([~~l~~]13) "Grievance system" means the overall [~~system that includes grievances and appeals handled by an MCO and access to~~]process for an MCO to collect, review, and make a determination on a grievance or appeal and for the individual who files an appeal to access the administrative hearing process set out in this rule.

([~~m~~]14) "[~~Hearing officer~~]Mail" means [~~solely any person designated by the DIH Director ~~]to [~~conduct administrative hearings pursuant to this rule~~]send through mail services, email, fax, or hand-delivery.

([~~n~~]15) "Managed care organization" or "MCO" means an entity that:

(a)(i) is a health maintenance organization[,];

(ii) is a prepaid mental health plan[~~,~~]; or

(iii) is a dental managed care plan; and

(b) [~~ that~~]contracts with DIH to provide health, behavioral health, or oral health services to Medicaid or Children's Health Insurance Program members.

([~~o~~]16) "Medical record" means a record that contains medical data of a medical assistance member[~~ or enrollee~~].

[~~(p)~~] (17) "Office" means the Office of Administrative Hearings within the Department of Health and Human Services.

(18)(a) "Party" includes:

(i) the agency or an individual designated by the agency head to represent the agency in an adjudicative proceeding;

(ii) an aggrieved person; or

(iii) a claimant.

(b) "Party" does not include:

(i) the general public;

(ii) a witness testifying at an adjudicative proceeding; or

(iii) an Artificial Intelligence (AI) bot, computer, or program.

(19) "Presiding officer" means an agency head, or individual designated by the agency head, by rule, or by statute to conduct an adjudicative proceeding and may include:

(a) a division or office director

(b) a hearing officer;

(c) a statutorily created board or committee;

(d) an administrative law judge; and

(e) the superintendent of an agency institution.

(20) "Provider" means any person or entity that is licensed and otherwise authorized to furnish health care to [~~medical assistance~~]members[~~ or medical assistance MCO enrollees~~].

([~~q~~) ~~"Order" means a ruling by a hearing officer that determines the legal rights, duties, privileges, immunities, or other legal interests of one or more specific persons.~~

~~(r~~]21) "Scope of service" means behavioral, medical, or oral[~~, or behavioral~~] health services [~~set out~~]under Title R414, Integrated Healthcare, as a covered benefit.

([~~s~~]22) "State fair hearing" means an administrative hearing conducted pursuant to this rule.

R410-14-3. Administrative Adjudicative Procedures.

(1) Except as provided in this rule or [~~as~~]otherwise designated by rule or statute or converted pursuant to Subsection 63G-4-202(3), [~~all~~]each adjudicative proceeding[~~s~~] conducted pursuant to this rule [~~are~~]shall be designated an informal adjudicative proceeding[s].

(2) An aggrieved person may file a written request for agency action, pursuant to Subsections 63G-4-201(3)(a) and (b)[~~,~~] and in accordance with this rule.

(a) A provider may file a written request for agency action without the consent of the member or MCO enrollee if the request for agency action pertains to the denial of an authorization for service or a denial of payment on a claim.

(b) A provider may not file a request for agency action if the request for agency action pertains to the denial, change, or termination of eligibility of a member [~~or enrollee~~]for a medical assistance program.

(3) If a medical issue is in dispute, each request [~~must~~]shall include supporting medical documentation. [~~DIH~~]The office may schedule a hearing only when it receives sufficient medical records and may dismiss a request for agency action if it does not receive supporting medical documentation in a timely manner.

(4) An agency shall provide a written notice of action to each aggrieved person. [-]These actions include:

(a) denial or limited prior authorization of a requested service including the type or level of service;

(b) eligibility for assistance;

(c) payment of a claim; and

([~~b~~]d) scope of service[~~;~~

~~(c) denial or limited prior authorization of a requested service including the type or level of service; and~~

~~(d) payment of a claim~~].

(5) The notice [~~must~~]shall include:

(a) a statement of the action the agency intends to take;

(b) the date the intended action becomes effective;

(c) the reasons for the intended action;

(d) the specific regulations that support the action, or the change in federal law, state law, or DIH policy which requires the action;

(e) the right to request a hearing;

(f) the right to represent oneself, the right to legal counsel, or the right to use another representative at the hearing; and

(g) if applicable, an explanation of the circumstances under which reimbursement for medical services will continue or may be reinstated pursuant to this rule.

(6) The agency shall mail the notice at least ten calendar days before the date of the intended action except that:

(a) the agency may mail the notice before the date of action in accordance with 42 CFR 431.213 (2025); and

(b) the agency may shorten the period of advance notice to five days before the date of action if [~~it~~]the agency has facts that indicate [~~it~~]the agency shall [~~must~~]take action due to probable fraud by the member or provider and the facts have been verified by affidavit.

R410-14-4. Hearings.

(1) [~~DIH~~]The office shall conduct informal hearings[~~ for issues except those specifically designated as formal hearings pursuant to this rule. The hearing~~]. The presiding officer may convert the proceeding to a formal hearing if an aggrieved person requests a hearing that meets the criteria set forth in Section 63G-4-202.

(2) If a hearing under this rule is converted to a formal hearing pursuant to Section 63G-4-202, the formal hearing [~~must~~]shall be conducted in accordance with these criteria except as otherwise provided in Sections 63G-4-204 through 63G-4-208 or other applicable statute[~~s~~].

(3) [~~DIH~~]The office shall conduct a hearing in connection with an [~~agency~~]action if the aggrieved person requests a hearing and there is a disputed issue of fact. [-]If there is no disputed issue of fact, the [~~hearing~~]presiding officer may deny a request for an evidentiary hearing and issue a [~~recommended~~]decision without a hearing based on the record. [-]In the [~~recommended~~]decision, the [~~hearing~~]presiding officer shall specifically set out [~~all~~]any material and relevant fact[~~s~~] not in dispute.

(4)(a) There is no disputed issue of fact if every material fact the agency relied upon in taking the adverse action or in obtaining the relief sought in the adjudicative proceeding is established by:

(i) the aggrieved person's own acknowledgment or admission;

(ii) an adjudication from a court of competent jurisdiction; or

(iii) a record submitted by either party if the aggrieved person does not challenge the record's accuracy.

(b) When the reasonableness of the agency's action is the primary issue under consideration, rather than whether there is a factual basis for the agency's action, the issue of reasonableness remains in dispute even if there is no dispute as to any underlying material fact that resulted in the agency's action[~~the aggrieved person submits facts that do not conflict with the facts that the agency relies upon in taking action or seeking relief~~].

(5) If the aggrieved person objects to the hearing denial, the person may raise that objection as grounds for relief in a request for [~~reconsideration~~]agency review.

(6) An MCO may not require an aggrieved person to [~~utilize~~]use arbitration or mediation to resolve an action. [-]An aggrieved person may file a request for hearing relating to an action regardless of any contractual provision with an MCO that may require arbitration or mediation.

(7) The [~~hearing~~]presiding officer may not grant a hearing if the issue is a state or federal law requiring an automatic change in eligibility for medical assistance or covered services that affect the aggrieved person.

R410-14-5. Request for Hearing.

(1)(a) An aggrieved person shall request a hearing by:

(i) [~~submitting the request on~~]completing the DIH ["]Form to Request [~~for~~]a State Fair Hearing[~~/Agency Action" form.~~]; and

(ii) [~~The aggrieved person must then submit~~]submitting the form by mail, fax, or other electronic means as directed on the form or the [~~N~~]notice of [~~A~~]agency [~~A~~]action[~~ or Request for Hearing Form~~].

(b) The request [~~must~~]shall explain why the aggrieved person is seeking agency relief.

(2) Except as [~~set forth~~]described in Section R410-14-20, a hearing[~~s~~] [~~must~~]shall be requested within the following deadlines:

(a) a medical assistance provider or member [~~must~~]shall request a hearing within 30 calendar days from the date that DIH sends a written notice of [~~its intended~~]agency action.

(b) a medical assistance member [~~must~~]shall request a hearing with DWS regarding medical assistance eligibility [~~for medical assistance~~]within 90 calendar days from the date the agency sends a written notice of [~~its intended~~]agency action.

(c) a medical assistance member [~~must~~]shall request a hearing with [~~DIH~~]the office regarding a determination of disability for [~~the purposes of~~]medical assistance eligibility within 90 calendar days from the date that DIH sends a written notice of [~~its intended~~]agency action.

(d) a medical assistance member [~~must~~]shall request a hearing regarding approval or denial of a scope of service within 30 calendar days from the date the agency sends written notice of [~~its intended~~]agency action.

(3) A hearing request that an aggrieved person sends [~~via~~]through the mail is [~~deemed~~]considered filed on the date of the postmark. [-]If the postmark date is illegible, erroneous, or omitted, the request is [~~deemed~~]considered filed on the date the agency receives it, unless the sender can demonstrate the mailing date through [~~competent~~]credible evidence.

(4) Failure to submit a timely request for a hearing constitutes a waiver of an individual's due process rights.

(5) [~~DIH~~]The office may dismiss a request for a hearing if the aggrieved person:

(a) withdraws the hearing request in writing;

(b) verbally withdraws the hearing request at a prehearing conference;

(c) fails to appear or participate in a scheduled proceeding without good cause;

(d) prolongs the hearing process without good cause;

(e) cannot be located or agency mail is returned without a forwarding address;[~~ or~~]

(f) fails to provide medical records that the agency requests; or

(g) does not respond to any correspondence from the [~~hearing officer~~]office.[~~ or fails to provide medical records that the agency requests.~~]

R410-14-6. [~~Reinstatement and~~]Continuation and Reinstatement of Services.

(1) [~~Continuation of Services. ~~]If the agency mails [~~the~~]a notice of agency action in the time required by Section R410-14-3 and the recipient requests a hearing within [~~10~~]ten days of the date the notice was mailed, the agency shall continue services until a decision is rendered after the hearing. The agency may terminate or reduce services if [~~unless~~]it is determined at the hearing that the sole issue is one of federal or state law or policy and the agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

(2)[~~- Reinstatement of Services.~~

~~————~~](a) The agency may reinstate services if a recipient requests a hearing no[~~t~~] more than [~~10~~]ten days after the date of the action. [-]The reinstated services [~~must~~]shall continue until a hearing decision is rendered unless, at the hearing, it is determined that the sole issue is one of federal or state law or policy.

(b) The agency shall reinstate and continue services until a decision is rendered after a hearing if:

(i) the agency takes action without giving a ten[~~10~~]-day notice as required by Section R410-14-3[~~,~~];

(ii) the recipient requests a hearing no[~~t~~] more than [~~10~~]ten days after the date the notice of agency action is mailed; and

(iii) the action is not the result of the application of federal or state law or policy.

R410-14-7. Notice of Hearing.

[~~(1) ~~]The [~~agency~~]office shall notify [~~the aggrieved person ~~]each party or [~~representative~~]a party representative in writing of the date, time, and place of the hearing[~~,~~] and shall mail the notice at least ten calendar days before the date of the hearing unless [~~all parties~~]each party agrees to an alternative [~~time frame~~]timeframe. [~~- All aggrieved persons must~~]Each party shall inform the agency of a current email address, mailing address, and telephone number.

[~~(2) If DIH must provide notice of a hearing, the notice becomes effective on the date of first class mailing to the party's address of record.~~

]

R410-14-8. Prehearing Procedures.

(1) [~~DIH~~]The office shall schedule a [~~preliminary~~]prehearing conference[~~, or begin negotiations~~] in [~~writing, within 30 calendar days from the date~~]a timely manner after [~~it~~]the office receives the request for a hearing[~~- or agency action~~].

(2) The [~~hearing officer may elect to conduct a preliminary~~]purpose of the prehearing conference is to:

(a) arrange for the exchange of proposed exhibits or prepared expert testimony;

(b) formulate or simplify the issues;

([~~b~~]c) obtain admissions of fact and documents that will avoid unnecessary proof;[

~~(c) arrange for the exchange of proposed exhibits or prepared expert testimony;~~]

(d) outline procedures for the hearing; or

(e) [~~to ~~]agree to other matters that may expedite the orderly conduct of the hearing or settlement.

(3) The [~~hearing~~]presiding officer may request a review of the medical record by a DIH CHEC Utilization Review committee to evaluate the medical necessity of benefits or services under dispute.

(a) The committee's recommendation is not binding[~~,~~] but may be admitted as evidence and included in the hearing record.

(b) If a party to the proceeding objects to the committee's determination, a representative of the committee [~~must~~]shall be available at the hearing for examination by the [~~hearing~~]presiding officer and [~~the parties~~]each party.

(4) The [~~hearing~~]presiding officer may require [~~the parties~~]any party to submit a prehearing position statement setting forth [~~the parties'~~]that party's positions.

(5) [~~The parties~~]A party may enter into a written stipulation during the preliminary conference or at any time during the process.

(6) Ex parte communication[~~s~~] with the [~~hearing~~]presiding officer [~~are~~]is prohibited.

(a) If a party attempts ex parte communication, the [~~hearing~~]presiding officer shall inform the offeror that any communication the [~~hearing~~]presiding officer receives off the record[~~,~~] will become part of the record and furnished to [~~all parties~~]every party.

(b) Ex parte communication[~~s~~] does not apply to communication[~~s~~] on the status of the hearing and uncontested procedural matters.

(7) The agency shall allow the aggrieved person or a representative to examine [~~all~~]each DIH document[~~s~~] and record[~~s~~] upon written request to DIH at least three days before the hearing.

(8) A party may request access to protected health information in accordance with Rule R380-250, which implements the privacy rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(a)(i) The agency may request copies of pertinent records in the possession of a party and the member's health care providers.

(ii) In the event the member or provider fails to produce the records within a reasonable time, DIH may review [~~all~~]each pertinent record[~~s~~] in the custody of the member or provider during regular working hours [~~after~~]at least three days [~~of~~]after issuing written notice.

(b) The member shall submit necessary medical records with the hearing request when possible[~~. Necessary medical records include~~], including:

(i) the provision of each service and activity addressed in the hearing request;

(ii) the first and last name of the party;

(iii) the reason for performing the service or activity that includes the party's complaint or symptom[~~s~~];
(iv) the member's medical history;
(v) examination findings;
(vi) diagnostic test results;
(vii) the goal or need the plan of care identifies; and
(viii) the observer's assessment, clinical impression, or diagnosis that includes the date of observation and identity of the observer.
(c) The necessary medical records [~~must~~]shall demonstrate that the service is:
(i) medically necessary;
(ii) consistent with the diagnosis of the member's condition; and
(iii) consistent with professionally recognized standards of care.
(9) The [~~hearing~~]presiding officer may require each party to file a signed prehearing disclosure form at least ten calendar days before the scheduled hearing that identifies:
(a) fact witnesses;
(b) expert witnesses; and
(c) any exhibits and reports [~~the parties~~]each party intends to offer into evidence at the hearing.
(10) Each party shall supplement the disclosure form with information that becomes available after filing the original form.

R410-14-9. Form and Service of Papers.
(1) Any document that a party files with [~~DIH~~]the office in a proceeding [~~must~~]shall:
(a) be signed and dated by the party or the party's authorized representative;
(b) be typed or legibly written;
([~~b~~]c) bear a caption that clearly shows the title of the hearing;
([~~c~~]d) bear the docket number, if any; and
[~~(d) be dated and signed by the party or the party's authorized representative; and~~
]](e) contain the address and telephone number of the party or the party's authorized representative.
(2) The party that files a document with [~~DIH~~]the office shall also serve a copy of the document to [~~all parties~~]each party to the proceeding or [~~their~~]the party's representative[s] and file a proof of service with [~~DIH~~]the office [~~that~~]consisting[s] of a certificate of service.
(3) A document may be served by mail, fax, or email address to the party's address or phone number on record with the agency.
(4) In addition to the methods [~~set forth~~]described in this rule, a party may be served as permitted by the Utah Rules of Civil Procedure.

R410-14-10. Conduct of Hearing.
(1) The [~~agency~~]office shall conduct hearings in accordance with Section 63G-4-203 on a de novo basis.
(2)(a) [~~DIH~~]The department shall appoint an impartial [~~hearing~~]presiding officer to conduct hearings.
(b) An officer involved in the initial determination of the action may not be appointed as the presiding officer.[~~Previous involvement in the initial determination of the action precludes an officer from appointment.~~]
(3) [~~T~~]Any telephonic hearing[s] [~~will~~]shall be held at the discretion of the [~~hearing~~]presiding officer.
(4) The [~~D~~]department is not responsible for any travel costs incurred by the member in attending an in-person hearing.
(5) The [~~hearing~~]presiding officer shall take testimony under oath or affirmation.
(6) Each party has the right to:
(a) present evidence, argue, respond, conduct cross-examination, and submit rebuttal evidence;
(b) introduce exhibits;
(c) impeach any witness regardless of which party first called the witness to testify; and
(d) rebut the evidence against the party.
(7)(a) Each party may admit any relevant evidence and use hearsay evidence to supplement or explain other evidence as may be required for full disclosure of all facts relevant to the disposition of the hearing.
(b) Hearsay[~~, however,~~] is not sufficient by itself to support a finding unless admissible over objection in a civil action[~~s~~].
(c) The [~~hearing~~]presiding officer shall give effect to the rules of privilege recognized by law and may exclude irrelevant, immaterial, and repetitious evidence.
(8) The [~~hearing~~]presiding officer may question any party or witness.
(9) The [~~hearing~~]presiding officer shall control the evidence to obtain full disclosure of the relevant facts and to safeguard the rights of [~~the parties~~]each party. [-]The [~~hearing~~]presiding officer may determine the order in which the officer receives the evidence.
(10)(a) The [~~hearing~~]presiding officer shall maintain order and may recess the hearing to regain order if a person engages in disrespectful, disorderly, or disruptive conduct.
(b) The [~~hearing~~]presiding officer may remove any person, including a participant from the hearing, to maintain order.

(c) If a person shows persistent disregard for order and procedure, the [~~hearing~~]presiding officer may:

([~~a~~]i) restrict the person's participation in the hearing;

([~~b~~]ii) strike pleadings or evidence; or

([~~c~~]iii) issue an order of default.

(11) [~~If a party desires t~~]To employ a court reporter to make a record of the hearing, [~~it~~]a party must file an original transcript of the hearing with the [~~hearing~~]presiding officer at no cost to the agency.

(12) The party who initiates the hearing process through a request for agency action has the burden of proof as the moving party.

(13) When a party possesses[~~,~~] but fails to introduce certain evidence, the [~~hearing~~]presiding officer may infer that the evidence does not support the party's position.

(14) An AI bot, computer, or program may not appear, dictate, listen to, record, or summarize any adjudicative proceeding or hearing under this rule.

(15) If a party sends an AI bot, computer, or program to appear at a hearing instead of the party, the presiding officer:

(a) shall consider this a failure to appear on the part of the party; and

(b) may issue an order of default against the party under the relevant default provisions of Title 63G, Chapter 4, Administrative Procedures Act.

(16) A party shall mail a copy of any motion or pleading that the party files with the office to each of the other parties named in the action.

(a) The non-moving party shall:

(i) unless the office dictates otherwise, file any response to a motion or pleading filed with the office within ten calendar days; and

(ii) mail a copy of that response to each of the other parties named in the action.

(b) Any motion or pleading received by the office after the regular business hours of Monday through Friday, 8 a.m. to 5 p.m., excluding state holidays, is considered received the following business day.

R410-14-11. Witnesses and Subpoenas.

(1) A party shall arrange for a witness to be present at a hearing.

(2) At the request of a party or at the [~~hearing~~]presiding officer's discretion, the presiding officer may [~~on his own or at the request of a party,~~] order a witness excluded so that [~~they~~]the witness cannot hear another witness's testimony.

(3) Discovery is prohibited, but the office may issue a subpoena or other order to compel the production of necessary evidence.

(4)(a) An attorney may issue a subpoena for necessary evidence.

(b) A party who is not represented by an attorney may request a subpoena from the office.

(c) When the presiding officer issues a subpoena to a party, the party shall serve that subpoena on the witness.

(5)(a) A party shall request a subpoena as soon as possible after a hearing date is set.

(b) The office may not issue a subpoena fewer than 16 calendar days before the hearing.[~~The hearing officer may issue a subpoena to compel the attendance of a witness or the production of evidence upon written request by a party that demonstrates a sufficient need.~~]

([4]6) The [~~hearing~~]presiding officer may issue a subpoena on [~~his~~]the presiding officer's own motion.

([~~5~~]7) A party may file an affidavit that requests the [~~hearing~~]presiding officer to subpoena a witness to produce books, papers, correspondence, memoranda, or other records. [-]The affidavit [~~must~~]shall include:

(a) the name and address of the person or entity [~~upon whom~~]being served the subpoena[~~ is to be served~~];

(b) a description of [~~the~~]any account, book, document[~~s~~], letter, object, paper[~~s~~], [~~books, accounts, letters,~~]photograph[~~s, objects~~], or other tangible item[s] that the applicant seeks;

(c) material that is relevant to the issue of the hearing; and

(d) a statement by the applicant that, to the best of [~~his~~]the applicant's knowledge, the witness possesses or controls the requested material.

([~~6~~]8) A party shall arrange to serve any subpoena that the [~~hearing~~]presiding officer issues on [~~its~~]the party's behalf[~~,~~] and shall serve a copy of the affidavit that [~~it~~]the party presents to the [~~hearing~~]presiding officer.

([~~7~~]9) Except for an employee[s] of an agency, a witness that the [~~hearing~~]presiding officer subpoenas to attend a hearing is entitled to appropriate fees and mileage. [-]The witness shall file a written demand for fees with the [~~hearing~~]presiding officer within ten calendar days from the date that [~~he~~]the witness appears at the hearing.

([~~8~~]10) The [~~hearing~~]presiding officer may issue an order of default against any party that fails to appear, participate, or obey an order entered by the [~~hearing~~]presiding officer.

R410-14-12. Record.

(1)(a) The [~~hearing~~]presiding officer shall make a complete hearing record[~~ of hearings~~].

(b) A hearing record is the sole property of [~~DIH~~]the office, and [~~DIH~~]the office shall maintain the complete hearing record electronically in a secure area.

(2) Proceedings other than hearings may be recorded at the discretion of the [~~hearing~~]presiding officer.

(3) If a party requests a copy of [~~the~~]a hearing's recording[~~ of a hearing~~], that party may transcribe the recording at the party's sole cost.

(4) [~~DIH~~]The office or [~~its~~]a designated agent shall [~~retain~~]keep recordings of [~~all~~]each hearing[s] for [~~a period of~~]one year.

(5) [~~DIH~~]The office shall [~~retain~~]keep written records of [~~all~~]each hearing[~~s~~] for [~~a period of 10~~]ten years pending further litigation.

R410-14-13. Continuances or Further Hearings.

(1) The [~~hearing~~]presiding officer, on the officer's own motion or at the request of a party showing good cause, may:

(a) continue the hearing to another time or place; or

(b) order a further hearing.

(2) If the [~~hearing~~]presiding officer determines that additional evidence is necessary for the proper determination of the case, the officer may:

(a) continue the hearing to a later date and order [~~the parties~~]any party to produce additional evidence; or

(b) close the hearing and hold the record open to receive additional documentary evidence.

(3)(a) The [~~hearing~~]presiding officer shall provide to [~~all parties~~]each party any evidence that [~~they~~]the officer receives.

(b) [~~and e~~]Each party [~~has~~]shall have the opportunity to rebut that evidence.

(4) The [~~hearing~~]presiding officer shall provide written notice of the time and place of a continued or further hearing, except when the officer orders a continuance during a hearing and [~~all parties~~]each party receives oral notice.

R410-14-14. [~~Proposed Decision and Final Agency Review~~]Orders.

(1) [~~At~~]Within a reasonable time after the [~~conclusion~~]close of [~~the~~]a hearing, or after[~~the~~] a party's failure to request a hearing within a reasonable time prescribed by agency rules, the presiding officer shall [~~take the matter under advisement and submit a recommended decision to the DIH Director or the director's designee. The recommended decision is based on the testimony and evidence entered at the hearing, Medicaid policy and procedure, and legal precedent.~~]issue a signed order that conforms to Subsection 63G-4-203(1)(i).

(2) [~~The recommended decision must contain findings of fact and conclusions of law.~~

~~(3) The DIH Director or the director's designee may:~~

~~(a) adopt the recommended decision or any portion of the decision;~~

~~(b) reject the recommended decision or any portion of the decision, and make an independent determination based upon the record; or~~

~~(c) remand the matter to the hearing officer to take additional evidence, and the hearing officer thereafter shall submit to the DIH Director or the director's designee a new recommended decision.~~

~~(4) The director or designee's decision constitutes final administrative action and is subject to judicial review.~~

~~(5) DIH shall send~~]The office shall mail a copy of the [~~final administrative action~~]order to each party or representative, [~~and~~]notifying the[~~m~~] party of [~~their~~]any right to agency review and judicial review.

([~~6~~]3) [~~The parties~~]Each party shall comply with [~~a final decision~~]the order from the [~~director~~]presiding officer reversing the agency's decision within ten calendar days.

([~~7~~]4)(a) The [~~DHHS Executive Director~~]department's executive director shall review [~~all recommended decisions~~]each order to determine approval of medical assistance for an organ transplant.

(b) The executive director's decision constitutes final administrative action and is subject to judicial review.

R410-14-15. Amending Administrative Orders.

(1) [~~DIH~~]The presiding officer may amend an order if the [~~hearing~~] officer determines the order contains a clerical error.

(2) [~~DIH~~]The office shall [~~notify the parties of its intent to amend the order by serving a notice of agency action signed by the hearing officer.~~

~~(3) The DIH Director shall review the amended order and the director or designee shall issue a final agency amended order.~~

~~(4) DIH shall provide~~]mail a copy of the final amended order to [~~the respondent and the petitioner~~]each party.

R410-14-16. Availability of Agency Review.

A party [~~to the proceeding~~]may [~~move for reconsideration~~]obtain agency review of [~~DIH's~~]a final [~~administrative action in accordance with Sections 63G-4-301 through 63G-4-302. A person may seek review of a DWS hearing decision concerning eligibility for medical assistance~~]order by filing a [~~written~~]request [~~for agency review~~]with [~~DWS in accordance with~~]the department's executive director, pursuant to Section 63G-4-301.

R410-14-17. Judicial Review.

A party to the proceeding may obtain judicial review in accordance with Section 63G-4-102 and [~~Sections 63G-4-401 through 63G-4-405~~]Title 63G, Chapter 4, Part 4, Judicial Review.

R410-14-18. Declaratory Orders.

(1) DIH may issue a declaratory order[~~s~~] in accordance with Rule R380-1.

(2) If DIH does not issue a declaratory order within 60 days after receipt of the request, the petition [~~is~~]shall be denied.

(3) DIH shall retain the request for a declaratory ruling in [~~its~~]DIH's records.

(4) DIH may not issue a declaratory order if an adjudicative proceeding that involves the same parties and issue is pending before the [~~agency~~]office, state court, or federal court[~~, or state court~~].

R410-14-19. Interpreters.

(1) If a party notifies [~~DIH~~]the office that [~~it~~]the party needs an interpreter, [~~DIH~~]the office shall arrange for an interpreter at no cost to the party.

(2) The party may arrange for an interpreter to be present at the hearing only if the [~~hearing~~]presiding officer can verify the interpreter is at least 18 years of age[~~,~~] and fluent in English and the language of the person testifying[~~, who testifies~~].

(3) The [~~hearing~~]presiding officer shall instruct the interpreter to interpret word for word[~~,~~] and not to summarize, add, change, or delete any of the testimony or questions.

(4) The interpreter [~~must~~]shall swear under oath to truthfully and accurately translate [~~all~~]each statement[~~s~~], question[~~s~~], and answer[~~s~~].

R410-14-20. MCO Grievance and Appeal System.

(1) The procedures in [~~Section R410-14-20~~]this section apply only to an appeal[~~s~~] or request[~~s~~] for agency action arising from an action[~~s~~] taken by an MCO.

(2) Terms [~~For~~]in this section[~~, the following definitions apply~~] are defined as follows:

(a) "Adverse benefit determination" means one of the following actions by an MCO:

(i) the denial or limited authorization of a requested service, including the type and level of service[~~s~~], any requirement[~~s~~] for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(ii) the reduction, suspension, or termination of a previously authorized service;

(iii) the denial, in whole or in part, of payment for a service;

(iv) the failure to provide a service[~~s~~] in a timely manner;

(v) the failure to act within the time frames provided in 42 CFR 438.408(b) (2025);

(vi) the denial of a request by a Medicaid [~~enrollee~~]member who is a resident of a rural area with only one MCO to exercise the [~~enrollee~~]member's right under 42 CFR 438.52(b)(2)(ii) to obtain services outside of the network;

(vii) the denial of a[~~n enrollee~~] member's request to dispute a financial liability, including cost sharing[~~,~~] or any copayment[~~s~~], premium[~~s~~], deductible[~~s~~], coinsurance, and other [~~enrollee~~]member financial liability[~~ies~~]; or

(viii) the restriction of a Medicaid member [~~enrollee that utilize~~]who uses services at a frequency or amount that [~~are~~]is not medically necessary, in accordance with state utilization guidelines.

(b) "Appeal" means a review by an MCO of an action as defined in [~~Section R410-14-20~~]this section or a request for [~~DIH~~]the office to review a final decision made by an MCO as a result of the MCO's appeal process.

(c) "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination, including:[~~.~~]

(i) [~~Grievances may include~~]the quality of care or services provided[~~,~~] and aspects of interpersonal relationships, such as rudeness of a provider or employee[~~,~~] or failure to respect the [~~enrollee~~]member's rights, regardless of whether remedial action is requested[~~.~~]; and

(ii) [~~Grievance includes an enrollee~~]a member's right to dispute an extension of time proposed by the MCO to make an authorization decision.

(d) "Grievance and appeal system" means the processes the MCO implements to handle an appeal[~~s~~] of an action and grievance[~~s~~].

(e) "Party" means the agency, or other person commencing an adjudicative proceeding, any respondent[~~s~~], and any MCO who is or may be obligated to pay a claim or provide a benefit or service to a member.

(3) An MCO shall establish a grievance and appeal system in accordance with this rule, 42 CFR 431.200 et seq. and 42 CFR 438.400 et seq. and the MCO's contractual obligations entered into with DIH.

(4) The MCO grievance and appeal system shall include a written internal grievance and appeal procedure for an aggrieved person to challenge an action by the MCO.

(5) The MCO shall provide to its [~~enrollee~~]members and providers written information that explains the grievance and appeal procedure, including a right to request a state fair hearing in accordance with this rule.

(6) The MCO's notice of action shall comply with the requirements set forth in Section R410-14-3, 42 CFR 438.402, and 42 CFR 438.404.

(7) The MCO's written notice of final decision shall comply with the requirements set forth in 42 CFR 438.408 and include an explanation of the aggrieved person's right to a state fair hearing [~~pursuant to~~]in accordance with this rule.

(8)(a)(i) Unless otherwise stated in this section, an aggrieved party may appeal an MCO final written disposition on an action by requesting a state fair hearing in accordance with this rule.

(ii) The hearing request [~~must~~]shall include a copy of the final written notice of the MCO disposition.

(b)(i) An aggrieved person must exhaust the MCO grievance and appeal procedure before requesting a state fair hearing for an action other than the restriction of a Medicaid [~~enrollee~~]member. [-]In the case of an MCO that fails to adhere to the notice and timing requirements in 42 CFR 438.400 et seq., the [~~enrollee~~]member is considered to have exhausted the MCO's appeals process.

(ii) The hearing request [~~must~~]shall include a copy of the final written notice of the MCO decision.

(c) The aggrieved party [~~must~~]shall request a hearing within 120 days from the date of the MCO final written notice of the decision.

(d)(i) If an appeal is based on a dispute regarding the payment liability between two or more MCOs, the aggrieved person is not required to exhaust the MCO grievance procedure for each MCO before requesting a state fair hearing under this rule.

(ii) If DIH identifies an MCO that may be liable to pay the claim and did not participate in the underlying grievance procedure, [~~it~~]DIH shall send notice to that MCO that [~~it~~]the MCO may be subject to liability and [~~its~~]of the MCO's right to participate in the state fair hearing.

(iii) If more than one MCO is party to the state fair hearing, DIH shall provide a notice to [~~all parties~~]each party that shall include:

(A) the identity of [~~all parties~~]each party[~~,~~];

(B) the reason for the dispute[~~,~~];

(C) a copy of the hearing request[~~,~~];

(D) [~~and~~] a statement specifying that [~~the~~]any MCO that did not participate in the underlying MCO grievance and appeal procedure may be subject to payment liability, described in Subsection (8)(d)(ii); and

(E) a statement of [~~its~~]the right to participate in the state fair hearing.

(e) DIH may[~~, but is not required to,~~] file an answer or other response or position statement in the hearing proceeding at any time so long as it gives notice to other parties no [~~less~~]fewer than five days before the hearing. [-]If DIH chooses not to file a response or position statement, [~~it~~]DIH does not waive [~~its~~]the right to participate in the hearing.

(9)(a) If the MCO or state fair hearing presiding officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO [~~must~~]shall authorize or provide the disputed services promptly and as expeditiously as the [~~enrollee~~]member's health condition requires[~~,~~] but before 72 hours from the date [~~it~~]the MCO receives notice reversing the determination.

(b) If the MCO or state fair hearing presiding officer reverses a decision to deny authorization of services and the [~~enrollee~~]member received the disputed services while the appeal was pending, the MCO or [~~the state~~]DIH [~~must~~]shall pay for those services in accordance with state policy and rule[~~s~~].

R410-14-21. Preadmission Screening Resident Review (PASRR) Hearings.

Pursuant to 42 U.S.C. 1396r, any resident [~~and~~]or potential resident of a nursing facility, whether Medicaid eligible or not, who disagrees with the preadmission screening and appropriateness of a placement decision that DIH or [~~its~~]a designated agent makes, has the right to an informal hearing upon request in accordance with this rule and the requirements set out in 42 CFR 483.200, Subpart [~~D~~]E.

R410-14-22. Nurse Aide Registry Hearings.

(1) Pursuant to 42 U.S.C. 1395i-3, each nurse aide is subject to investigation of any allegation[~~s~~] of resident abuse, neglect, or misappropriation of resident property.

(2) Before a substantiated claim can be entered into the registry:

(a) DIH or [~~its~~]a designated agent shall investigate each complaint; and

(b) the nurse aide [~~is~~]shall be entitled to a hearing that [~~DIH or its designated agent~~]the office conducts[~~ before a substantiated claim can be entered into the registry~~].

R410-14-23. Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), and Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) Hearings.

Pursuant to 42 CFR 431, Subpart D, DIH shall provide an appeals hearing procedure for SNFs, ICFs or ICF/IDs. [~~DIH~~]The office shall conduct the informal hearing pursuant to this rule and the requirements of 42 CFR 431.153 and 42 CFR 431.154.

R410-14-24. Home and Community-Based Waiver Hearings.

(1) Pursuant to 42 CFR 431 Subpart E, DIH shall provide an appeals hearing procedure for home and community-based waiver hearings. [~~DIH~~]The office shall conduct the informal hearing pursuant to this rule and the requirements of 42 CFR 431.200 through 431.250.

(2)(a) For home and community-based waivers in which the Division of Services for People with Disabilities (DSPD) is the designated operating agency and the grievance is based on whether the person meets the eligibility criteria for state matching funds through [~~DHHS~~]the department in accordance with [~~Title 26B, Chapter 1, Coordinating Council for Persons with Disabilities~~]Section 26B-1-430, the eligibility determination of the operating agency is final.

(b) If DSPD determines that an individual does not meet the eligibility criteria for state matching funds through [DHHS]the department, [~~it~~]DSPD shall inform the individual in writing and provide the individual an opportunity to appeal the decision through the [~~DIH~~]administrative hearing process in accordance with Section R539-3-8.

(c) The DSPD decision is dispositive for the purposes of this subsection. [~~DIH~~]The office shall sustain the determination, and there is no right to further agency review.

R410-14-25. Restriction Program Hearings.

(1) Pursuant to 42 CFR 431.54(e), the [~~D~~]department may restrict a Medicaid member[~~s~~] who [utilize]uses services at a frequency or amount that [~~are~~]is not medically necessary, in accordance with state utilization guidelines.

(2) DIH shall give the member notice and opportunity for an informal hearing pursuant to this [~~section~~]rule before imposing restrictions.

R410-14-26. Eligibility Hearings.

DWS conducts eligibility hearings in accordance with Section R414-301-7.

KEY: Medicaid
Date of Last Change: [~~November 5, 2023~~]2025
Notice of Continuation: August 12, 2022
Authorizing, and Implemented or Interpreted Law: 26B-[~~3-108~~]1-204; 26B-1-213; 63G-~~4~~-102

State of Utah
Administrative Rule Analysis
Revised May 2025

NOTICE OF SUBSTANTIVE CHANGE		
TYPE OF FILING: Amendment		
Rule or section number:	**R414-10-5**	**Filing ID: OFFICE USE ONLY**
Date of previous publication (only for CPRs):	Click or tap to enter a date.	

Agency Information

1. Title catchline:	Health and Human Services, Integrated Healthcare	
Building:	Cannon Health Building	
Street address:	288 N. 1460 W.	
City, state:	Salt Lake City, UT	
Mailing address:	PO Box 143102	
City, state and zip:	Salt Lake City, UT 84114-3102	
Contact persons:		
Name:	**Phone:**	**Email:**
Craig Devashrayee	801-538-6641	cdevashrayee@utah.gov
Mariah Noble	385-214-1150	mariahnoble@utah.gov
Please address questions regarding information on this notice to the persons listed above.		

General Information

2. Rule or section catchline:	
R414-60-5. Service Coverage and Limitations	
3. Are any changes in this filing because of state legislative action?	Changes are not because of legislative action.
If yes, any bill number and session:	HB 1 (2025 General Session), SB 25 (2024 3rd Special Session)
4. Purpose of the new rule or reason for the change:	
As a result of internal review, the Department of Health and Human Services determined it was necessary to update this section to clarify service coverage for family planning under the Medicaid program.	
5. Summary of the new rule or change:	
This amendment removes specific restrictions to fertility coverage under the Medicaid program and makes nonsubstantive style and formatting changes in accordance with the Rulewriting Manual for Utah and other rules under the Department of Health and Human Services.	

Fiscal Information

6. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:
A. State budget:
Based on agency data and research, the department estimates a cost of about $1,781,500 to the state budget to cover a segment of the population who receive medical treatments that include surgery, radiation, chemotherapy, or other medical interventions that pose the risk of sterility or lead to iatrogenic infertility. This amount is based on the estimated number of new and current members who qualify for and receive in vitro fertilization (IVF) services. The number of people estimated to qualify for and receive IVF services is 7% of the state's population. According to census data, there were approximately 3.5 million people living in the state as of 2024, and 7% of that estimated population is about 245,000 people who would qualify.
B. Local governments:
Local governments are not anticipated to see any fiscal impact as they neither fund nor provide fertility services under the Medicaid program.
C. Small businesses ("small business" means a business employing 1-49 persons)**:**
There is no anticipated fiscal impact to small businesses as a result of this filing, as there are no IVF clinics that qualify as small businesses at the time of this filing.

D. Non-small businesses ("non-small business" means a business employing 50 or more persons):

There is potential revenue for the 13 non-small business IVF clinics throughout the state at the time of this filing. There is, however, no data to estimate an amount, as there is no method to indicate how many individuals will seek fertility treatment, nor how many will opt to receive services from these particular clinics.

E. Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***):

Other persons or entities may see potential revenue or out-of-pocket savings. There is, however, no data to estimate these amounts as there is no method to indicate how many individuals will seek fertility treatment, nor how many will opt to receive services from clinics in the state.

F. Compliance costs for affected persons:

The compliance cost for the state budget is estimated to be approximately $7.27 for each of the estimated 245,000 members who qualify for and receives IVF services.

There are no compliance costs for any other affected persons, as this change creates an inestimable amount of out-of-pocket savings for individuals who qualify for fertility service coverage and potential revenue for a single business or provider.

G. Regulatory Impact Summary Table (This table includes only fiscal impacts the agency was able to measure. If the agency could not estimate an impact, it is excluded from this table but described in boxes A through F.)

Regulatory Impact Summary Table

Fiscal Cost	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**
State Budget	$1,781,500	$1,781,500	$1,781,500	$1,781,500	$1,781,500
Local Governments	$0	$0	$0	$0	$0
Small Businesses	$0	$0	$0	$0	$0
Non-Small Businesses	$0	$0	$0	$0	$0
Other Persons	$0	$0	$0	$0	$0
Total Fiscal Cost	**$1,781,500**	**$1,781,500**	**$1,781,500**	**$1,781,500**	**$1,781,500**
Fiscal Benefits	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**
State Budget	$0	$0	$0	$0	$0
Local Governments	$0	$0	$0	$0	$0
Small Businesses	$0	$0	$0	$0	$0
Non-Small Businesses	$0	$0	$0	$0	$0
Other Persons	$0	$0	$0	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**	**$0**	**$0**
Net Fiscal Benefits	**($1,781,500)**	**($1,781,500)**	**($1,781,500)**	**($1,781,500)**	**($1,781,500)**

H. Department head comments on fiscal impact and approval of regulatory impact analysis:

The Executive Director of the Department of Health and Human Services, Tracy S. Gruber, has reviewed and approved this regulatory impact analysis.

Citation Information

7. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:

Section 26B-1-213	Section 26B-3-108	Section 26B-3-215
Section 26B-3-216		

Incorporation by Reference Information

8. Incorporation by Reference (if this rule incorporates more than two items by reference, please include additional tables):

A. This rule adds or updates the following title of material incorporated by reference (a copy of the material incorporated by reference must be submitted to the Office of Administrative Rules. *If none, leave blank*):

Official Title of Materials Incorporated (from title page)	

Publisher	
Issue Date	
Issue or Version	

B. This rule adds or updates the following title of material incorporated by reference (a copy of the material incorporated by reference must be submitted to the Office of Administrative Rules. *If none, leave blank*)**:**	
Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

Public Notice Information

9. The public may submit written or oral comments to the agency identified in box 1.		
A. Comments will be accepted until:		Click or tap to enter a date.
B. A public hearing (optional) will be held (The public may request a hearing by submitting a written request to the agency, as outlined in Section 63G-3-302 and Rule R15-1.)**:**		
Date:	**Time** (hh:mm AM/PM)**:**	**Place** (physical address or URL)**:**
Click or tap to enter a date.		
To the agency: If more than one hearing is planned to take place, continue to add rows.		

10. This rule change MAY become effective on:	Click or tap to enter a date.
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. The office may return incomplete forms to the agency, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	Click or tap to enter a date.

R414. Health and Human Services, Integrated Healthcare.
R414-10. Physician Services.
R414-10-5. Service Coverage and Limitations.

(1) This section contains general information on coverage and limitations for physician services.

(a) Physician services may be provided only within the parameters of accepted medical practice and are subject to limitations and exclusions established by the [~~D~~]department based on[~~the basis of~~] appropriateness, medical necessity,[~~appropriateness,~~] and utilization control considerations.

(b) Medicaid covers cosmetic or reconstructive procedures pursuant to Section R414-1-29.

(c) Medicaid covers experimental or medically unproven physician services pursuant to Rule R414-1A.

(d) Program limitations and non-covered services are maintained in the Coverage and Reimbursement Code Lookup and updated by notification through the Medicaid Information Bulletin. [-]Medicaid [~~does~~]may not cover any[~~the following types of services~~]:

(i) medically unnecessary or unreasonable service;
(ii) paternity test;
(iii) service claimed fraudulently;
(iv) service, elective in nature, based on patient request or individual preference rather than medical necessity;
(v) service provided during a period in which an individual is ineligible for Medicaid;
(vi) service provided without required prior authorization;
(vii) service rejected or disallowed by Medicare when the rejection is based on any reason listed in this section;
(viii) service that fails to meet existing standards of professional practice;
(ix) service that represents abuse or overuse[~~services rendered during a period in which an individual is ineligible for Medicaid;~~

~~(ii) medically unnecessary or unreasonable services;~~
~~(iii) services that fails to meet existing standards of professional practice;~~
~~(iv) services rendered without required prior authorization;~~

~~(v) services, elective in nature, based on patient request or individual preference rather than medical necessity;~~
~~(vi) services claimed fraudulently;~~
~~(vii) services that represents abuse or overuse;~~
~~(viii) services rejected or disallowed by Medicare when the rejection is based on any of the reasons listed in this section;~~
~~(ix) services for which third party payers are primarily responsible for coverage, such as Medicare, private health insurance, and liability insurance pursuant to Rule R527-936. Medicaid may make a partial payment up to the Medicaid maximum if a third party does not reach the payment limit~~];

(x) related service[s], supply[~~ies~~], or institutional cost[s] during a post-operative recovery period, if the service or procedure is not covered for any [~~of the~~]reason[s] specified in this section[~~,~~] or due to policy exclusion; and

(xi)(A) service for which third party payers are primarily responsible for coverage, such as Medicare, private health insurance, and liability insurance, pursuant to Rule R527-936.

(B) Medicaid may make a partial payment up to the Medicaid maximum if a third party does not reach the payment limit[~~paternity tests~~].

(e) Medicaid covers treatment for alcoholism or drug dependency in an inpatient setting pursuant to Subsection R414-2A-7(1).

(2) Medicaid [~~does~~]may not cover the following family planning services:

(a) any surgical procedure[s] for the reversal of previous elective sterilization on both males and females; or

[~~(b) infertility studies;~~
~~(c) in vitro fertilization;~~
~~(d) artificial insemination;~~
~~(e)~~](b) surrogate motherhood, including any service[s], test[s], and related charge[s].

(3) Medicaid may only cover anesthesia services performed by a licensed, qualified provider.

(4) Medicaid [~~does~~]may not cover any anesthesia standby service[s].

(5) Medicaid may cover[s] the following surgical global services and procedures:

(a) preoperative examination, initiation of the hospital record, and development of a treatment program either in the physician's office on the day before admission, in the hospital, or in the physician's office on the same day as hospital admission;

(b) the operation;

(c) any topical, local, or regional anesthesia; and

(d) the normal, uncomplicated follow-up care covering the period of hospitalization and office follow-up for progress checks or any service directly related to the surgical procedure.

(6) The following criteria apply to global services.

(a) A physician may not bill for an office visit the day before surgery, for preadmission or admission workup, or for subsequent hospital care while the patient is being prepared, hospitalized, or under care for a global surgical service.

(b)(i) Only the consulting physician may bill for consultation services when consultation and no other service is provided.

(ii) When a consulting physician admits and follows a patient, independently or concurrently with the primary physician, the consulting physician may only use admission codes and subsequent care codes.

(c)(i) Office visits after hospitalization that relate to the same diagnosis are part of the global service.

(ii) The only exception to either inpatient or office service is for a service related to a complication[s], exacerbation[s], or recurrence of another disease[s] or problem[s] requiring an additional or separate service.

(d) [~~C~~]Any complication[s], exacerbation[s], recurrence, or the presence of another disease[s] or injury[~~ies~~], which requires a service[~~s~~] concurrent with the initial surgical procedure during the listed period of normal follow-up care, may warrant additional charges only when the record shows extensive documentation and justification of the additional service[s].

(e) When an additional surgical procedure is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods continue concurrently to [~~their~~]the follow-up periods' normal terminations.

(f) Preoperative examination and planning are covered as separate services only under the following circumstances[~~.~~]:

(i) [~~W~~]when the preoperative visit is the initial visit for the physician and prolonged detention or evaluation is required to establish a diagnosis to determine the need for a specific surgical procedure[~~,~~] or to prepare the patient[~~.~~];

(ii) [~~W~~]when the preoperative visit is a consultation and the consulting physician does not assume care of the patient[~~.~~]; or

(iii) [~~W~~]when diagnostic procedures are not part of the basic surgical procedure.

(7) Medicaid [~~does~~]may not cover early elective delivery, whether vaginal or caesarean, before 39 weeks.

[~~(8) The following references apply to abortion, sterilization, and hysterectomy.~~]

([~~a~~]8) [~~For information on abortion policy, see~~]Limited abortion services shall meet the requirements of Rule R414-1B.

([~~b~~]9) Sterilization and hysterectomy procedures [~~must~~]shall meet the requirements of 42 CFR 441 Subpart F (2024).

([~~9~~]10) Organ transplant services [~~must~~]shall meet the requirements of Rule R414-10A.

([~~10~~]11) Medicaid may cover the following psychiatric services as a medical benefit:

(a) a mental health service that targets the diagnosis or treatment of developmental disability or organic disorder;

(b) a physician-ordered psychiatric service[s] for a patient hospitalized in a non-psychiatric unit of a hospital;[

~~(b) mental health services that target the diagnosis or treatment of developmental disability or organic disorder; and~~] or

(c) a psychosocial evaluation[s] requested before organ transplant[~~ations~~], a psychiatric evaluation[s] before another medical service[s] or surgical procedure[s], and an evaluation[s] for an individual[s] with a condition[s] that requires chronic pain management services.

([~~11~~]12) Medicaid may cover[s] the following pain management services:

(a) pain management for delivery and acute post-operative pain; and
(b) treatment for chronic pain.
([~~12~~]13) Medicaid may cover a prescription medication[~~s~~] subject to the requirements of Rule R414-60.

KEY: Medicaid
Date of Last Change: March 1, 2022
Notice of Continuation: [~~October 19, 2021~~]2025
Authorizing, and Implemented or Interpreted Law: 26-1-213; 26B-3-108; 26B-3-215; 26B-3-216

State of Utah
Administrative Rule Analysis
Revised May 2025

NOTICE OF SUBSTANTIVE CHANGE		
TYPE OF FILING: Amendment		
Rule or section number:	**R414-60-5**	**Filing ID: OFFICE USE ONLY**
Date of previous publication (only for CPRs):	Click or tap to enter a date.	

Agency Information

1. Title catchline:	Health and Human Services, Integrated Healthcare	
Building:	Cannon Health Building	
Street address:	288 N. 1460 W.	
City, state:	Salt Lake City, UT	
Mailing address:	PO Box 143102	
City, state and zip:	Salt Lake City, UT 84114-3102	
Contact persons:		
Name:	**Phone:**	**Email:**
Craig Devashrayee	801-538-6641	cdevashrayee@utah.gov
Mariah Noble	385-214-1150	mariahnoble@utah.gov
Please address questions regarding information on this notice to the persons listed above.		

General Information

2. Rule or section catchline:	
R414-60-5. Limitations	
3. Are any changes in this filing because of state legislative action?	Changes are because of legislative action.
If yes, any bill number and session:	SB 39 (2023 General Session)
4. Purpose of the new rule or reason for the change:	
Upon determining it was necessary to file an amendment to Section R414-10-5, the Department of Health and Human Services (department) also determined it was necessary to update this section to reflect those changes and clarify service coverage for family planning under the Medicaid program.	
5. Summary of the new rule or change:	
This amendment removes restrictions on fertility coverage under the Medicaid program. It also clarifies coverage of drugs for weight loss. Additionally, this filing makes style and formatting changes to comply with the Rulewriting Manual for Utah and to align with other rules under the department. It also updates a statutory citation that has been renumbered from Section 26-18-2.4 to Section 26B-3-105.	

Fiscal Information

6. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:
A. State budget:
This filing is not anticipated to have a direct fiscal impact to the state budget, as it updates limitations based on an amendment to Section R414-10-5. The anticipated cost for Medicaid covering in vitro fertility services is captured in the fiscal information section for the amendment to Section R414-10-5.
B. Local governments:
Local governments are not anticipated to see any fiscal impact as they neither fund nor provide fertility services under the Medicaid program.
C. Small businesses ("small business" means a business employing 1-49 persons):
This filing is not anticipated to have a direct fiscal impact to small businesses, as it updates limitations based on an amendment to Section R414-10-5. Additionally, there are no IVF clinics that qualify as small businesses at the time of this filing.

D. Non-small businesses ("non-small business" means a business employing 50 or more persons):

This filing is not anticipated to have a direct fiscal impact to non-small businesses, as it updates limitations based on an amendment to Section R414-10-5. The anticipated fiscal impact to non-small businesses is captured in the fiscal information section for the amendment to Section R414-10-5.

E. Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***):

This filing is not anticipated to have a direct fiscal impact to other persons, as it updates limitations based on an amendment to Section R414-10-5. The anticipated fiscal impact to other persons is captured in the fiscal information section for the amendment to Section R414-10-5.

F. Compliance costs for affected persons:

There are no compliance costs for affected persons as a result of this filing, as this filing updates limitations based on an amendment to Section R414-10-5. The anticipated compliance cost for Medicaid covering in vitro fertility services is captured in the fiscal information section for the amendment to Section R414-10-5.

G. Regulatory Impact Summary Table (This table includes only fiscal impacts the agency was able to measure. If the agency could not estimate an impact, it is excluded from this table but described in boxes A through F.)

Regulatory Impact Summary Table

Fiscal Cost	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**
State Budget	$0	$0	$0	$0	$0
Local Governments	$0	$0	$0	$0	$0
Small Businesses	$0	$0	$0	$0	$0
Non-Small Businesses	$0	$0	$0	$0	$0
Other Persons	$0	$0	$0	$0	$0
Total Fiscal Cost	**$0**	**$0**	**$0**	**$0**	**$0**
Fiscal Benefits	**FY2026**	**FY2027**	**FY2028**	**FY2029**	**FY2030**
State Budget	$0	$0	$0	$0	$0
Local Governments	$0	$0	$0	$0	$0
Small Businesses	$0	$0	$0	$0	$0
Non-Small Businesses	$0	$0	$0	$0	$0
Other Persons	$0	$0	$0	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**	**$0**	**$0**

H. Department head comments on fiscal impact and approval of regulatory impact analysis:

The Executive Director of the Department of Health and Human Services, Tracy S. Gruber, has reviewed and approved this regulatory impact analysis.

Citation Information

7. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:

Section 26B-1-213	Section 26B-3-108	Section 26B-3-215
Section 26B-3-216		

Incorporation by Reference Information

8. Incorporation by Reference (if this rule incorporates more than two items by reference, please include additional tables):

A. This rule adds or updates the following title of material incorporated by reference (a copy of the material incorporated by reference must be submitted to the Office of Administrative Rules. *If none, leave blank*):

Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	

Issue or Version	

B. This rule adds or updates the following title of material incorporated by reference (a copy of the material incorporated by reference must be submitted to the Office of Administrative Rules. *If none, leave blank*)**:**	
Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

Public Notice Information

9. The public may submit written or oral comments to the agency identified in box 1.		
A. Comments will be accepted until:		Click or tap to enter a date.
B. A public hearing (optional) will be held (The public may request a hearing by submitting a written request to the agency, as outlined in Section 63G-3-302 and Rule R15-1.)**:**		
Date:	**Time** (hh:mm AM/PM)**:**	**Place** (physical address or URL)**:**
Click or tap to enter a date.		
To the agency: If more than one hearing is planned to take place, continue to add rows.		

10. This rule change MAY become effective on:	Click or tap to enter a date.
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. The office may return incomplete forms to the agency, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	Click or tap to enter a date.

R414. Health and Human Services, Integrated Healthcare.
R414-60. Medicaid Policy for Pharmacy Program.
R414-60-5. Limitations.

(1) Medicaid may place limitations on drugs in accordance with 42 U.S.C. 1396r-8 or in consultation with the Drug Utilization Review [~~(DUR)~~]Board. [-]Medicaid includes these limitations in the Pharmacy Services Provider Manual and [~~its~~]attachments. [-]These limitations are incorporated by reference in Section R414-1-5 and may include[~~ the following~~]:

(a) quantity limits or cumulative limits for a drug or drug class for a specified period;

(b) therapeutic duplication limits, which may be placed on drugs within the same or similar therapeutic categories;

(c) step therapy, including documentation of therapeutic failure with one drug before another drug may be used; or

(d) prior authorization.

(2) A pharmacy may dispense a covered outpatient drug that requires prior authorization for up to a 72-hour supply without obtaining prior authorization during a medical emergency.

(3) [~~D~~]A drug[s] listed as non-preferred on the Preferred Drug List (PDL) may require prior authorization as authorized by Section [~~26-18-2.4~~]26B-3-105.

(4) [~~D~~]A drug[s] may be restricted and [~~are~~]is reimbursable only if dispensed by an individual pharmacy or pharmacies.

(5) Medicaid does not cover any drug[s] not eligible for federal medical assistance percentages funds.

(6) Medicaid does not cover any outpatient drug[s] included in the Medicare Prescription Drug Benefit-Part D for any full-benefit dual eligible member[~~s~~].

(7) Medicaid does not cover any drug[s] provided to a member during an inpatient hospital stay, neither as an outpatient pharmacy benefit nor separately payable from the Medicaid payment for the inpatient hospital services.

(8) Medicaid covers prescription cough and cold preparations meeting the definition of a covered outpatient drug.

(9) Medicaid pays for no more than a one-month supply of a covered outpatient drug for each dispensing, except [~~for the following~~]that:

(a) Medicaid may cover a medication[s] on the Utah Medicaid Three-Month Supply Medication List, attachment to the Pharmacy Services Provider Manual, for up to a three-month supply for each[per] dispensing;

(b) Medicaid may cover prenatal vitamins for a pregnant woman, multiple vitamins with or without fluoride for a child who is zero through five years of age, and fluoride supplements for up to a three-month supply for each[per] dispensing;

(c) Medicaid may cover contraceptives for up to a three-month supply for each[per] dispensing; and

(d) Medicaid may cover a long-acting injectable antipsychotic drug[s] in accordance with Section R414-60-12 for up to a three-month supply for each[per] dispensing.

(10) Medicaid pays for a prescription refill only if 80% of the previous prescription has been exhausted, [~~with the~~]except[~~ion~~] [~~of~~]for a controlled substance[s]. [-]Medicaid pays for a prescription refill for a controlled substance[s] after 85% of the previous prescription has been exhausted.

(11) Medicaid covers treatments for fertility preservation and in vitro fertilization, only as described in the Utah Medicaid Provider Manual, for individuals who receive medical treatment that includes surgery, radiation, chemotherapy, or another medical intervention that poses the risk of sterility or leads to iatrogenic infertility.

(1[~~I~~]2) Medicaid does not cover[~~ the following drugs~~]:

(a) a drug[s] for weight loss, except for specific indications;

[~~(b) drugs to promote fertility~~

] ([~~e~~]b) a drug[s] for the treatment of sexual dysfunction;

([~~d~~]c) a drug[s] for cosmetic purposes;

([~~e~~]d) vitamins; except for prenatal vitamins for a pregnant woman, vitamin drops for a child who is zero through five years of age, and fluoride supplements;

([~~f~~]e) an over-the-counter drug[s] (OTC) not included on the Utah Medicaid PDL and Resources attachment to the Pharmacy Services Provider Manual;

([g]f) a drug[s] for which the manufacturer requires, as a condition of sale, that associated tests and monitoring services are purchased exclusively from the manufacturer or its designee;

([~~h~~]g) a drug[s] given by a hospital to a patient at discharge;

([~~i~~]h) breast milk, breast milk substitutes, baby food, or medical foods. [-]Prescription metabolic products for congenital errors of metabolism are covered through the Durable Medical Equipment benefit; and

([j]i) a drug[s] available only through a single-source distribution program[s], unless the distributor is enrolled with Medicaid as a pharmacy provider.

(1[~~2~~]3) [~~C~~]A claim[s] for opioids used for the treatment of non-cancer pain [~~are~~]is subject to the following limitations or restrictions set forth by the Division of Integrated Healthcare (DIH):

(a) initial fill limits;

(b) monthly limits;

(c) quantity limits;

(d) additional limits for a child or pregnant woman;

(e) morphine milligram equivalents (MME) and cumulative morphine equivalents daily (MED) limits;

(f) concurrent use of opioids with high-risk drugs as defined by [~~DMHF~~]DIH; or

(g) concurrent use of opioid medications in members who also receive medication-assisted treatment (MAT) for opioid use disorder.

(1[~~3~~]4) An antipsychotic medication[s] prescribed to a Medicaid member who is 19 years of age or younger [~~are~~]is limited as follows:

(a) no use of multiple antipsychotic drugs;

(b) no off-label use;

(c) no use outside established age guidelines; and

(d) no doses higher than FDA recommendations.

(1[~~4~~]5) [~~E~~]An exception[s] may be granted as appropriate through the prior authorization process.

(1[~~5~~]6) An attention-deficit/hyperactivity disorder (ADHD) stimulant medication[s] [~~are~~]is subject to the following limitations or restrictions set forth by [~~DMHF~~]DIH for Medicaid members:

(a) age limits;

(b) monthly limits;

(c) quantity limits;

(d) cross-class limitations for concurrent use of an amphetamine class with methylphenidate class in children less than 18 years of age; or

(e) the use of no more than two ADHD stimulants by a member of any age.

(1[~~6~~]7) Medicaid evaluates exceptions to ADHD stimulant policy for medical necessity on a case-by-case basis.

KEY: Medicaid
Date of Last Change: [~~July 19, 2024~~]2025
Notice of Continuation: March 11, 2022
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108