PROVIDER NEWSLETTER

Health Choice Utah
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INSIDE THIS EDITION

To return to this page, click on "Provider Newsletter" at the top of any page.

HEALTH | CHOICE
UTAH

MEET OUR NEW CHIEF MEDICAL OFFICER

We are delighted to announce that Mary Pak, MD, MBA, FACP joined University of Utah Health Plans as the Chief Medical Officer in March. She spent the last 20+ years in Wisconsin where she was a practicing academic hospitalist with a faculty appointment as Clinical Professor at University of Wisconsin School of Medicine and Public Health. Dr. Pak also spent more than 15 years as the medical director and then Associate Chief Medical Officer and Vice President, Value Based Outcomes and Network Performance at Quartz Health Solutions, a provider-owned managed care organization based in Wisconsin.

During her tenure at Quartz, Dr. Pak built longstanding relationships with the provider groups in their network, initially through pay for performance programs that then grew into quality incentive contracting with potential to transform into value-based arrangements. Dr. Pak met with each group regularly to provide and receive feedback regarding the arrangement. By partnering to optimize healthcare quality, this program demonstrated improvement in the health of the population as measured through HEDIS, including colorectal cancer screening, breast cancer screening, and immunizations.

As evidenced by her career, Dr. Pak values relationships and partnerships and hopes to establish those connections here in Utah in order to continue advancing excellence in healthcare quality while minimizing disparities.

BALANCING CLAIMS WITH COB

Effective September 2024, the Utah Department of Health and Human Services (DHHS) implemented SNIP EDI Validation Level 3 editing (Balancing Claim Validation). This validation ensures that, for coordination of benefits (COB) claims, the total billed and paid amounts at the claim and service line levels align with the amounts billed and paid by the primary payer.

Beginning May 1, 2025, Health Choice Utah will enforce the same validation for all submitted claims. Providers need to verify that claims are balanced within their software systems, before submission, to avoid front-end rejections or claim denials.

ENHANCING QUALITY OF CARE WITH CPT II CODES FOR HEDIS

As valued members of our health plan network, your commitment to delivering high-quality care is essential to our collective success. One crucial aspect of maintaining and improving care quality is the effective use of CPT® II codes for Healthcare Effectiveness Data and Information Set (HEDIS®) measures.

WHAT ARE CPT II CODES?

CPT II codes are tracking codes used for reporting performance measures. Unlike traditional CPT codes, which describe medical procedures and services, CPT II codes capture clinical components such as results, evaluations, and management services. These codes are integral to HEDIS, a widely used set of performance measures in the healthcare industry.

CPT II codes are billed in the procedure code field, just as are CPT Category I codes. They should be billed with a $0.00 or $0.01 charge amount and are not separately valued or reimbursed.

WHICH GAPS CAN BE CLOSED BY USE OF CPT CATEGORY II CODES?

Measure	CPT II Code	Description
CBP-Controlling Blood Pressure	3074F	Systolic less than 130
	3075F	Systolic 130-139
	3077F	Systolic greater than or equal to 140
	3078F	Diastolic less than 80
	3079F	Diastolic 80-89
	3080F	Diastolic great than or equal to 90
KED- Diabetic Kidney Screening	3060F	Positive microalbuminuria result documented and reviewed
	3061F	Negative microalbuminuria result documented and reviewed
	3062F	Positive macroalbuminuria result documented and reviewed
	3066F	Documentation of treatment for nephropathy
	4010F	ACE or ARB therapy prescribed or currently being taken
PPC-Timeliness of Prenatal Care	0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care). Report also date of visit and, in a separate field, the date of the last menstrual period (LMP).
PPC-Postpartum Care	0503F	Postpartum care visit

WHICH GAPS CAN BE CLOSED BY USE OF CPT CATEGORY II CODES? *(CONTINUED)*

Measure	CPT II Code	Description
GSD- Hemoglobin A1c	3044F	Most recent HbA1c level <7.0%
	3051F	Most recent HbA1c level ≥7.0 - ≤8.0%
	3052F	Most recent HbA1c level ≥8.0 - ≤9.0%
	3046F	Most recent HbA1c level >9.0%
EED – Diabetic Eye Exams	2022F	Dilated retina exam interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
	2023F	Dilated retina exam interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
	2024F-7	Standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
	2025F-7	Standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
	2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos documented and reviewed; with evidence of retinopathy
	2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos documented and reviewed; without evidence of retinopathy
	3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)

WHY USE CPT II CODES?

Streamlined Reporting – CPT II codes simplify the process of reporting quality performance measures, reducing the need for manual chart abstraction. This efficiency allows providers to focus more on patient care rather than administrative tasks.

Accurate Data Collection – By using CPT II codes, providers can supply more precise medical data, which helps in identifying and closing gaps in care more accurately and quickly. This proactive approach supports better clinical outcomes and enhances overall care quality.

Closing Care Gaps – CPT II codes help in closing patient care gaps through the claims process, ensuring that patients receive timely and appropriate interventions.

Reduced Burden – Billing CPT II codes reduces the burden of chart reviews for selected HEDIS measures. This reduction in administrative workload allows providers to allocate more time to direct patient care.

CONCLUSION

In summary, the use of CPT II codes is essential for healthcare providers striving to enhance the quality of care, reduce administrative burdens, support performance measurement, and ensure compliance. Incorporating CPT II codes into your practice is a win-win situation. It not only enhances the accuracy and efficiency of reporting, but also contributes to better patient outcomes and improved HEDIS scores.

We encourage all providers in our network to utilize these codes to their full potential and continue striving for excellence in patient care.

Thank you for your dedication and hard work. Together, we can achieve remarkable improvements in healthcare quality.

ANSWERING YOUR APPEALS QUESTIONS

In the various workshops, presentations, and surveys we conduct throughout each year, appeals is one topic that always raises questions. Here are some of the most common appeal issues we frequently address, as well as trends we see in submitted appeals.

CORRECTED CLAIM VS APPEAL

The following examples provide clarification on denials that should be addressed with a corrected claim, and denials that should be addressed with an appeal. The below are examples only and not a comprehensive list.

Denials best addressed through the corrected claim process

Whether you receive a denial due to missing or incorrect information on a claim, or realize you made an error after submitting the claim, follow the Corrected Claims instructions in our Provider Manual.

Information that can be corrected on a claim

- Incorrect patient information, such as patient demographics or insurance information
- Incorrectly reported procedure or diagnosis code(s)
- Missing coding information, such as modifiers or units
- Missing medical documentation (e.g., records to demonstrate medical necessity or a sterilization form)
- Missing Coordination of Benefits (COB) information (e.g., Primary insurance EOP or PIP Exhaust letter)

Duplicate claims

- If the claim was denied as a duplicate
  - Ensure that the original claim has completed processing before resubmitting a corrected claim
  - Ensure you are applying the appropriate claim number to your corrected claim; if you need assistance identifying the appropriate claim number, contact customer service for the member's benefit plan

    Note: if you do not include the processed claim number to your corrected claim, the corrected claim will be denied as a duplicate

Denials best addressed through the appeals process

- Medical Necessity Denials – If a claim is denied due to the payer (Health Choice Utah) deeming the service was not medically necessary, you can appeal. Provide additional documentation, such as medical records and physician notes, to support the necessity of the service.
- Authorization Denials – If a claim is denied due to lack of prior authorization, but you have evidence that authorization was obtained, appeal the denial. Include the authorization number and any related correspondence.
- Experimental or Investigational Treatment Denials – If a claim is denied because the treatment is considered experimental, you can appeal with supporting clinical evidence and peer-reviewed studies that justify the treatment.
- Coverage Termination Denials – If a claim is denied because the insurer claims the patient's coverage was terminated, but you have proof of active coverage, appeal the decision.
- Denial Error – If you feel a denial was incorrectly applied by the plan, you can appeal with supporting evidence.

Appeal Submission

Health Choice Utah has one level of internal appeal, make best use of your appeal, submitting a complete appeal statement and all applicable documentation to support your case for overturn of the denial. Make sure you follow the correct appeal process found in the provider manual.

REQUESTS FOR MAGNETIC RESONANCE IMAGING (MRI) SERVICES

Health Choice Utah requires prior authorization for MRIs. When filing an appeal, supporting clinical documentation and the MRI report must be submitted to establish medical necessity. Documentation must consist of office visit notes and/or progress notes including, but not limited to: physical exam, abnormal findings, duration of symptoms, and previous failed conservative treatments.

Note: Health Choice Utah cannot determine medical necessity based on the MRI report alone.

MEDICAID OUTPATIENT HOSPITAL ADJUSTMENT FACTOR

Health Choice Utah Medicaid, in concert with Utah Medicaid and CMS, recently clarified the outpatient adjustment factor (also referred to as "decoupler") used with any of the following Outpatient Prospective Payment System (OPPS) status indicators:

Guideline	OPPS Status Indicator
Reduction factor/decoupler applies to codes with any of these status indicators	J1, J2, P, R, S, T, U, V
Reduction factor/decoupler does NOT apply to codes with any of these status indicators	K, Q1 to Q4, X, N (no separate payment)

A NEW COMMUNITY EPILEPSY RESOURCE ENHANCING COMPREHENSIVE CARE

In late 2024, the Epilepsy Monitoring Unit (EMU) at University of Utah Health was expanded to significantly enhance the comprehensive Epilepsy Program. This specialized unit has grown from two to 10 beds, greatly increasing capacity to provide advanced care for patients with seizure disorders.

The expanded EMU fosters greater collaboration between community providers and University of Utah Health specialists, ensuring seamless transitions of care. Community providers can now coordinate admissions without needing privileges at University Hospital, streamlining access for patients and enhancing the overall care experience.

Many patients with epilepsy face years of uncertainty before discovering they may be candidates for surgery. The EMU helps shorten this wait by providing timely evaluations. For those not eligible for surgery, the EMU offers critical insights that guide alternative treatments. Patients are often referred to the Long-Term Monitoring Unit to clarify the diagnosis of epilepsy, identify the type and origin of seizures, and ensure they receive the most appropriate treatment.

By the Numbers

- 20% of patients diagnosed with "epilepsy" do not actually have the condition, resulting in unnecessary and potentially harmful treatments. Proper monitoring of patients in a setting like the EMU greatly reduces the risk of misdiagnosis.
- 1/3 of patients with epilepsy have “drug resistant epilepsy” and may be candidates for surgical intervention.
- 75% seizure-freedom rates for patients with drug-resistant epilepsy who elect for surgery, with minimal risks.
- Three-fold reduction in the risk of sudden unexplained death in epilepsy (SUDEP) for surgical candidates.
- 20 years is the mean delay between seizure onset and presurgical evaluation for adults with drug-resistant epilepsy.
- More than 125 epilepsy surgeries were performed last year.
- More than 20 EMU clinical research trials are currently active.

If you have a patient that may benefit from assessment and evaluation, please visit Epilepsy Treatment for Seizure Symptoms for more information about the Epilepsy Monitoring Unit. The EMU will work with you, the referring physician, in care of your patient.

ONE UTAH HEALTH COLLABORATIVE: TRANSFORMING HEALTHCARE FOR ALL UTAHNS

One Utah Health Collaborative, Governor Spencer Cox's groundbreaking initiative, is aimed at revolutionizing healthcare in Utah. Launched in 2022, this community-owned nonprofit organization is dedicated to creating a healthcare system that is affordable, high-quality, and accessible for all residents.

The Collaborative's innovative approach involves aligning the community, identifying opportunities, and accelerating innovation to address the state's unique healthcare needs. By fostering partnerships between government, healthcare leaders, and citizens, the One Utah Health Collaborative is working to implement the Utah Model of Care. This model emphasizes efficiency, person-centered care, prevention, and transparency, ensuring that healthcare services are effective and trusted.

Through continuous innovation and collaboration, the One Utah Health Collaborative is paving the way for a healthier future for all Utahns.

SUCCESS STORIES

Screen Utah Initiative – One of the Collaborative's notable achievements is the Screen Utah initiative, which aims to reverse the state's declining colorectal cancer screening rates. More than 25 healthcare organizations have joined forces to ensure every eligible Utahn has access to the right test at the right time. This unified effort has led to significant improvements in screening rates, ultimately saving lives through early detection[1]. The recent Early Action Report highlights what University of Utah Health Plans and Health Choice Utah are doing to support this important initiative.

Digital Health Interoperability Pilot – In partnership with Governor Cox and Leavitt Partners, the Collaborative is leading Utah's Digital Health Interoperability Pilot. This project focuses on creating a seamless exchange of health information across different systems, improving care coordination and patient outcomes[2].

For more information, visit the One Utah Health Collaborative website.

REFERENCES

1. One Utah Health Collaborative. Screen Utah: Early Action Report. Utah Business, 6 Mar. 2025. Web. 12 Mar. 2025.

2. One Utah Health Collaborative. Explore the Utah Model of Care. OUHC. 2025. Web. 12 Mar. 2025.

DIABETES PREVENTION PROGRAM ENROLLMENT PILOT FOR MEDICAID

In conjunction with the One Utah Health Collaborative, Health Choice Utah is participating in the Diabetes Prevention Program enrollment pilot for Medicaid recipients. This pilot aims to reduce the incidence of type 2 diabetes among Medicaid beneficiaries by providing access to lifestyle change programs.

Early results have shown promising outcomes, with participants achieving significant weight loss and improved health metrics, demonstrating the program's potential to enhance long-term health and reduce healthcare costs.

JOINT ACO SOCIAL MEDIA CAMPAIGN: INCREASING VACCINATION AWARENESS IN UTAH

A COLLABORATIVE INITIATIVE FROM UTAH'S ACOs TO PROMOTE IMMUNIZATIONS AMONG UTAHNS

Health Choice Utah is pleased to join in the 2025 vaccination social media campaign, StayUpToDate, a joint initiative including University of Utah Health Plans, Molina, and Select Health aimed at improving immunization rates among Medicaid members. This campaign, which will be piloted in Utah County, focuses on engaging women ages 18 to 50, reinforcing the importance of staying up to date on immunizations to protect individual and community health.

CAMPAIGN OVERVIEW

Objective: Increase vaccination rates among Medicaid members in Utah County by promoting awareness and action.

Primary Audience: Women ages 18 to 50, including mothers, caregivers, and working professionals.

Messaging Approach: Emphasizing personal and family health through social media engagement, storytelling, and healthcare provider partnerships.

Call-to-Action: Encourage individuals to visit Utah's immunization page for trusted information.

Focusing on flu, Tdap, HPV, and childhood immunizations, we and our partners will post three or four short videos per quarter across social media platforms. These videos will feature healthcare professionals and caregivers to drive awareness.

PROVIDER AND CAREGIVER PARTNERSHIPS

Here's where you, our network providers, come in. We will collaborate with a diverse array of healthcare providers to enhance credibility. While health plans will be posting content across their social media accounts, we want you to join us in cross-promoting by sharing content to your clinic's social media pages and local healthcare networks.

THEMED MONTHLY CONTENT

January: New Year, New You – Flu vaccine awareness

March: Spring into Wellness – Women's preventive care

May: Mother's Day – Protecting family moments

August: Back-to-School – Immunizations for children and parents

November: Holiday Gatherings – Staying protected during the season

GOALS

Increase immunization adherence and vaccine appointments and dispel some of the myths surrounding vaccines.

Collaboration & Execution

By uniting efforts and leveraging social media for health education, the StayUpToDate campaign aims to drive higher immunization rates and build vaccine confidence among Utah's Medicaid population.

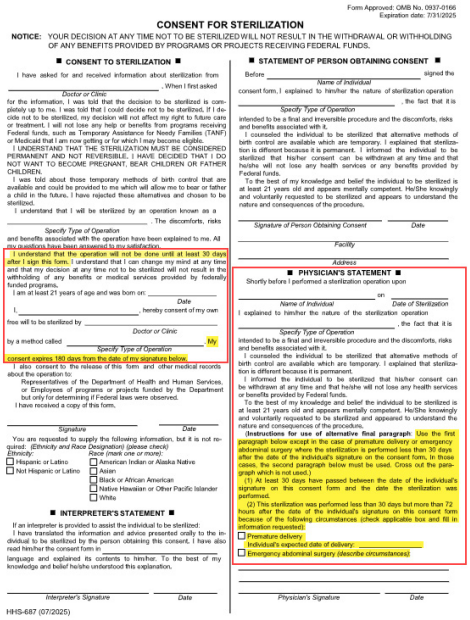
Each ACO partner will rotate monthly responsibility for managing advertising budgets and content distribution.

You can be a part of this effort by sharing content on social media. Visit StayUpToDate today.

DON'T SKIP THE FINAL STEP– UPDATED STERILIZATION OR ABORTION FORMS

We appreciate your efforts to ensure sterilization services for Medicaid members are properly prior authorized and documented. As the state has recently updated their consent/acknowledgement forms for sterilization services, please remind your staff members of requirements for the following forms. Be sure you are using the most recent form.

FORMS



Form Approved: OMB No. 0937-0166
Expiration date: 7/31/2025

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (Doctor or Clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ (Specify Type of Operation). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____ (Date).

I, _____, hereby consent of my own free will to be sterilized by _____ (Doctor or Clinic) by a method called _____ (My Specify Type of Operation) consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (Signature) _____ (Date)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (mark one or more):
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ (Interpreter's Signature) _____ (Date)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (Name of Individual) signed the consent form, I explained to him/her the nature of sterilization operation _____ (Specify Type of Operation) - the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ (Signature of Person Obtaining Consent) _____ (Date)

_____ (Facility)

_____ (Address)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (Name of Individual) on _____ (Date of Sterilization) I explained to him/her the nature of the sterilization operation _____ (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery:
Individual's expected date of delivery: _____
☐ Emergency abdominal surgery (describe circumstances):

_____ (Physician's Signature) _____ (Date)

HHS-687 (07/2025)

Consent to Sterilization section

Be aware that the patient should receive this form and understand the language therein. **Time constraints**: The sterilization procedure must not be performed until at least 30 days after the patient signs the form. The consent expires 180 days from the date of the patient's signature.

Physician's Statement section

We've noticed that an important area of the form is often being overlooked when it is submitted. At the end of the form, in the section marked "**Instructions for use of alternative final paragraph**," remember to **circle** the statement that applies—marked (1) or (2)—and **cross out** the statement which does not apply to this patient's consent form.

CONSENT FOR STERILIZATION form – This must be the official OMB form, not an internal one. The OMB form is currently dated July 2025.

HYSTERECTOMY ACKNOWLEDGEMENT FORM – Updated August 2024. There are no time constraints listed.

ABORTION ACKNOWLEDGEMENT AND CERTIFICATION FORM – Recently updated. There are no time constraints listed.

DENIALS

The following denials apply in these circumstances:

CO251/N228 DENY *INCOMPLETE OR INVALID CONSENT FORM RECEIVED*

- Claim that requires a form but for which we don't have one on file
- The wrong form was submitted (e.g., sterilization form submitted when a hysterectomy is performed)

CO252/N28 DENY *MISSING REQUIRED FORM*

- The form was not submitted with the claim

Submit the correct and completed form via our MDOC process.

STANDING REMINDER – CHECK MEMBER ELIGIBILITY AND BENEFITS

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

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

SEE A DISCREPANCY BETWEEN PRISM AND PROVIDER PORTAL OR EPIC?

Send us a heads-up at providers@healthchoiceutah.com to help us keep our files aligned with PRISM.

PHARMACY

Our medication and pharmacy information is updated as changes occur. Please visit our Pharmacy website at least quarterly to view the most recent information.

RECENT AND UPCOMING FORMULARY CHANGES

Health Choice Utah may add or remove drugs from the formulary during the year. If a drug that you are currently prescribing is scheduled to be removed from the formulary, we will notify you and the affected member at least 60 days before the change becomes effective. In cases where the U.S. Food and Drug Administration (FDA) deems a drug unsafe, or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from the formulary and notify you and the member afterward.

View Current Drug Lists (formularies) for each benefit plan, as well as the most current Formulary Change Notice.

PHARMACY NETWORK CHANGES – CVS RETAIL PHARMACIES

Effective May 1, 2025, **CVS Retail Pharmacies** are no longer part of the RealRx Retail Pharmacy Network. RealRx manages the pharmacy benefits on behalf of Health Choice Utah. This change does not impact CVS Specialty Pharmacy.

- CVS recently mandated a price increase to RealRx that would increase out-of-pocket costs for our members.
- In addition, many CVS retail pharmacies stopped processing claims for many of our members. We needed to transition members to new pharmacies to avoid interruption of care.
- After evaluating our options, we decided to remove CVS retail pharmacies from the network.

If your patient needs assistance finding an in-network pharmacy, visit the RealRx Home Dashboard and scroll down to "Pharmacy Locator" or contact Pharmacy Customer Service.

The RealRx Pharmacy Customer Service team is available 24 hours a day, 365 days a year by calling **855-864-1404**.

QUESTIONS ABOUT PHARMACY BENEFITS?

- For Medical Pharmacy Medications, call **877-358-8797**.
- For Retail Pharmacy Medications, call **855-864-1404**.

PHARMACY RESOURCES

- View our Pharmacy Formularies for notices regarding upcoming changes to the formulary.
- View our Preferred Drug List (PDL)/Formulary for updates regarding retail and specialty pharmacy medications. This list also includes prescribing limits such as quantity limits, step therapy, and/or prior authorization requirements. Multiple formularies are available, depending on the member's benefit plan.
- Pharmacy Prior Authorization forms are available online with specific requirements for use and limitations listed in the form. Visit our Coverage Policies site to ensure you are submitting the correct form for the requested medication. Bookmark these links in your internet favorites for quick access to submit pharmacy prior authorization requests.
- The Retail Pharmacy Online Prior Authorization (PA) Submission tool has been updated to allow prior authorization as well as formulary exceptions to be submitted through the same web page. If submitting a formulary exception, it is important to indicate this on your request. To submit a request online, visit the RealRx Home Dashboard and click on the "Get Started" button under "Request Prior Authorization or Formulary Exception."

CODING CORNER

CODES REQUIRING PRIOR AUTHORIZATION

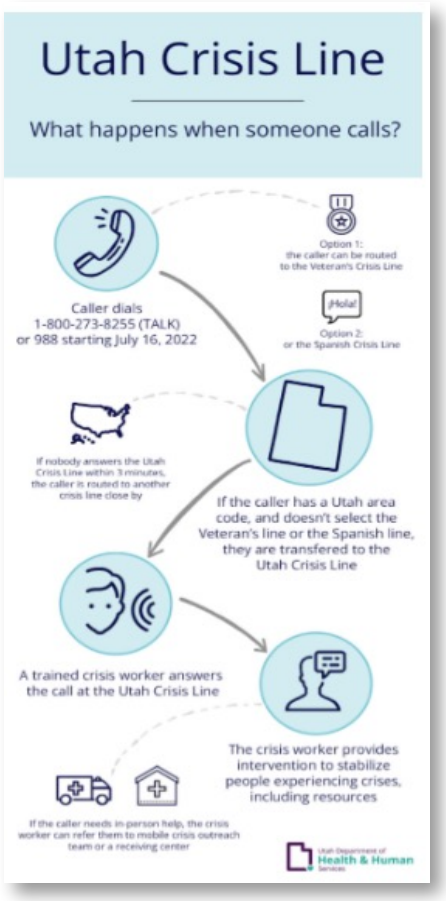
We regularly review our list of Codes Requiring Prior Authorization and update it as changes occur, including removing codes no longer requiring authorization. Please search this list prior to scheduling procedures or prescribing durable medical equipment to determine if prior authorization is required. Also take a moment to view Upcoming Changes to Codes Requiring Prior Authorization to ensure your authorizations for future procedures are also compliant.

QUALITY IMPROVEMENT & PATIENT CARE

MAY IS MENTAL HEALTH AWARENESS MONTH

RESOURCES

- NAMI
  National Alliance on Mental Illness.
- Love Your Mind
  Sponsored by Huntsman Mental Health Institute.
- Huntsman Mental Health Institute
  Care for all ages and all levels of care.
- 988 Lifeline
  Help available 24/7/365 through phone call, text, or chat.



DID YOU KNOW HEALTH CHOICE UTAH WORKS WITH MEMBERS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH? (SDOH)

SDOH stands for Social Determinants of Health. It refers to the non-medical factors that influence a person's health and well-being. These factors include:

- **Income and social status:** Poverty, income inequality, and access to social services
- **Education:** Level of education, access to quality education
- **Employment:** Job security, working conditions
- **Housing:** Quality and affordability of housing
- **Food security:** Access to nutritious food
- **Transportation:** Access to reliable transportation
- **Neighborhood safety and environment:** Quality of air and water, crime rates
- **Healthcare access:** Availability and affordability of healthcare services
- **Social and cultural factors:** Discrimination, social support, cultural norms

Health Choice Utah staff work to screen members with health risk assessments and connect eligible members with Care Management Services and Community Health Workers to help address social determinants of health and access to needed referrals and resources.

LET'S REVIEW THE BEHAVIORAL HEALTH QUALITY MEASURES

Measure evaluates percentage of discharges for members 6 years of age and older who were hospitalized for treatment OR had an emergency department visit for mental illness or intentional self-harm diagnoses AND who had a follow-up visit with a mental health practitioner.

Two rates are reported:

- Discharges for which the member received follow-up **within 7 days after discharge**
- Discharges for which the members received follow-up **within 30 days after discharge**

For both indicators, any of the following meet criteria for a follow-up service:

- Behavioral health outpatient visit with a mental health provider
- Intensive outpatient or partial hospitalization
- Outpatient visit with a mental health provider and with appropriate place of service code
- Intensive outpatient visit or partial hospitalization
- Community mental health center visit with appropriate place of service code
- Transitional care management services
- Electroconvulsive therapy with appropriate place of service code
- Telehealth or telephone visit with a mental health provider
- Behavioral health care setting visit
- Psychiatric collaborative care management

	Description	Provider Type	Follow-up Needed
FUM	Follow-up AFTER **Emergency Room** visit for Mental Health	Primary Care **OR** Behavioral Health Practitioner	Outpatient visit **within 7 days preferred** but seen at least within 30 days of discharge
FUA	Follow-up AFTER **Emergency Room** visit for Substance Use Disorder	**Behavioral Health Provider** (LCSW, Psychiatry, LMFT Psychologist, PMHNP-APRN	Outpatient visit **within 7 days preferred** but seen at least within 30 days of discharge
FUH	Follow-up AFTER Hospitalization for Mental Health	**Behavioral Health Provider** (LCSW, Psychiatry, LMFT Psychologist, PMHNP-APRN)	Outpatient visit **within 7 days preferred** but seen at least within 30 days of discharge

COLORECTAL CANCER SCREENING & PROSTATE CANCER

COLORECTAL CANCER SCREENING – (COL-E)

Members 50-74 years of age who had an appropriate screening for colorectal cancer.

Documentation needs to include what test was performed, the date, and the results. "History of" documentation is allowed.

Any of the following meet criteria:

- Fecal occult blood test (FOBT): must be during the MY
- Stool DNA (sDNA) with FIT test: during the MY or 2 years prior to the MY
- Flexible sigmoidoscopy: during the MY or 4 years prior to the MY
- CT colonography: during the MY or 4 years prior to the MY
- Colonoscopy: during the MY or 9 years prior to the MY

THE PSA (PROSTATE SPECIFIC ANTIGEN) TEST IS A BLOOD TEST USED PRIMARILY TO SCREEN FOR PROSTATE CANCER.

This test measures the amount of prostate-specific antigen (PSA) in your blood. PSA is a protein produced by both cancerous and noncancerous tissue in the prostate, a small gland that sits below the bladder in males.

Prostate cancer is common, and it is a frequent cause of cancer death. Early detection may be an important tool in getting appropriate and timely treatment.

WHAT INCREASES THE RISK OF PROSTATE CANCER?

Some people have a greater risk of developing prostate cancer. Knowing the risk factors for prostate cancer can help you determine if or when you want to begin prostate cancer screening. The main risk factors include:

- Older age. After the age of 50, the chance of having prostate cancer goes up.
- Race. For reasons that aren't well understood, Black people have a higher risk of developing and dying of prostate cancer.
- Family history. Risk is higher among people with a parent, sibling, or other close family members with prostate cancer.
- Inherited DNA changes. Certain DNA changes are associated with prostate cancer. Your healthcare team might recommend genetic testing if you have a strong family history of cancer or if a blood relative has been diagnosed with certain DNA changes.

PROSTATE CANCER PREVENTION: WAYS TO REDUCE YOUR RISK

Choose low-fat foods: Foods that have fats include meats, nuts, oils, and dairy products, such as milk and cheese. In some studies, those who ate the highest amount of fat each day had an increased risk of prostate cancer. This does not prove that eating excess fat causes prostate cancer. Other studies have not found this link.

Eat more fruits and vegetables each day: Fruits and vegetables are full of vitamins and nutrients that aid to cut the risk of prostate cancer. Eating more fruits and vegetables also tends to be more filling, so you have less room for other foods that are not as healthy.

Cut down on dairy: In some studies, those who ate higher amounts of milk, cheese, yogurt, and other dairy products each day had the highest risk of prostate cancer. But study results have been mixed. The risk linked to dairy products is thought to be small.

Attain a healthy weight: People who are obese may have a higher risk of prostate cancer. Obesity means a body mass index of 30 or higher. If you carry excess weight, work on losing it. Cut the number of calories you eat each day and exercise more.

Exercise most days of the week: Most studies of exercise and prostate cancer risk have shown that those who exercise may have a lower risk of prostate cancer than those who don't.

Exercise helps your health in many ways. It may lower your risk of heart disease and other cancers. Exercise can help you stay at a healthy weight or lose weight if you need to.

If you don't already exercise, make an appointment with your healthcare professional to make sure it's OK for you to get started. When you begin exercising, go slowly. Find ways to add physical activity to your day. For example, park your car farther away from where you're going. Take stairs instead of elevators.

Aim for 150 to 300 minutes of moderate-intensity physical activity a week or 75 to 150 minutes of vigorous-intensity physical activity or a mix of the two.

Don't smoke: Not all studies have found a link between smoking and prostate cancer. But some studies show that people with prostate cancer who smoke have a higher risk of the cancer coming back. They also have a higher risk of the cancer spreading beyond the prostate.

If you smoke, talk with your healthcare professional about ways to quit.

REFERENCES

1. ncqa.org/behavioral-health/
2. healthchoiceutah.com/health-wellness/overview
3. odphp.health.gov/healthypeople/priority-areas/social-determinants-health
4. mayoclinic.org/