PROVIDER CONNECTION

University of Utah Health Plans
Provider Publication
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PROVIDER CONNECTION: YOUR NEED-TO-KNOW SOURCE

Provider Connection delivers timely updates regarding University of Utah Health Plans provider networks and products each quarter: February, May, August, and November. Within this newsletter, you'll find announcements, updates to medical policies, helpful tips, and more.

Accessing the newsletter online makes it easier to share with everyone in your office. To ensure you receive the latest newsletter as soon as it's available, subscribe to our email list. We promise we won't spam you, and we'll never share your information. **Subscribe today to stay in the know.**

INSIDE THIS EDITION

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HEALTH PLANS
UNIVERSITY OF UTAH

"STAY UP TO DATE" COMMUNITY VACCINATION COLLABORATION

U of U Health Plans, Health Choice Utah®, Molina Healthcare®, and Select Health® are collaborating to promote vaccinations for children's safety. With Utah's pediatric vaccination rates falling below the national average, the risk of preventable diseases—like measles and polio—increases. The campaign encourages community involvement in raising awareness about the importance of vaccines. For more information, visit Stay up to Date, connect with us on social media, and find us in your local communities to help protect Utah's children and communities.

BEST-PRACTICES: BILLING HOME HEALTH

Home Health services ensure our members receive the care they need when confined to home or when ongoing care does not require hospital or skilled nursing facility level of care. The goal of home health care is to help the patient recover from an illness or injury, become more self-sufficient, be able to perform Activities of Daily Living, or slow the patient's decline. **Home Health services must always be prior authorized.**

When home health is needed, the following items are required for prior authorization:

- Services must be **medically necessary** to treat the covered person's illness, injury, or medical condition.
- Services must be **clinically appropriate**, meaning the right treatment, frequency, extent, and place of service.
- Services must **not be for the convenience** of the covered person, their family, or healthcare providers.
- **Billed services must be on the member's Plan of Care** that is signed by the healthcare Provider and have an approved authorization on file.

SUBMITTING A PRIOR AUTHORIZATION REQUEST

There are two ways to submit a prior authorization request:

» Online embedded form – visit our Prior Authorization web page.
- Scroll down to and click on "**Submit a Prior Authorization Request**."
- Complete all requested information, attach documentation, and click "**Submit**."

» Online Provider Portal – Log in or register.
- In the "Authorizations" section on the home page, view "Prior Authorization Guidelines" and "Codes Requiring Prior Authorization."
- The "Prior Authorization Form" is also available in the "Authorizations" section, or under the "Office Management" tab at the top of the page.
- Complete all information, attach documentation, and click "**Submit**."

COMMON CLAIM ERRORS

Referring Providers – No referring provider listed, or referring provider is not registered with Medicaid.

Prior Authorizations – No prior authorization on file, or not enough units requested in prior authorization.

Timely Filing –

Healthy U Medicaid	Commercial or Individual/Family
(Medicaid primary) 365 days from DOS	(Primary) 365 days from DOS
(Medicare primary) within the later of 365 days from DOS or 180 days from Medicare EOB date	(Secondary) 180 days from primary's EOB adjudication date
(Corrections) 365 days from DOS	(Corrections) 365 days from DOS

Medicaid Note

Medicaid requires that every member be reassessed every 60 days to recertify the need for continuing home health care.

QUESTIONS?

Customer Service for Member's Benefit Plan:	
Healthy U Medicaid	833-981-0212 | 801-213-4104
Healthy U CHIP	833-404-4300 | 801-213-0525
U of U Health Plans – Commercial	833-981-0213 | 801-213-4008
U of U Health Plans – Individual/Family	833-981-0214 | 801-213-4111
Healthy Premier U of U Hospitals & Clinics Plan	833-443-3440 | 801-213-0274

GENETIC TESTING COVERAGE AND REQUIREMENTS

U of U Health Plans has identified growing utilization of genetic testing services and, subsequently, denials for these services are increasing year over year due to utilization of out-of-network labs, failure to confirm plan benefits, and follow plan process. Noncovered genetic testing services can result in high-dollar surprise bills to the member. To protect the patient, providers can explain the potential for noncoverage to the member so they can make an informed decision on whether to continue with the prescribed testing. If the member wants to proceed, the provider can request prior authorization, as required.

University of Utah Health Plans covers some genetic testing when the prior authorization requirements are followed, the plan policy criteria are met, and an in-network lab is used.

COVERAGE

Medicaid Plans – Refer to the Utah Medicaid Physician Services Manual Section 8-12, Laboratory Services, which outlines Medicaid coverage criteria for genetic testing services. **Laboratory services include:**

- 8-12.9 Genetic Testing
- 8-12.10 Genetic Testing for EPSDT
- 8-12.10.4 Next Generation Sequencing (NGS)
- 8-12.10.5 Noncovered Testing

Commercial/Individual Marketplace/CHIP Plans – U of U Health Plans Coverage Policies outline coverage for the following types of genetic testing (see specific links below). Coverage policies are reviewed annually. New policies may be added throughout the year, as they become available.

- MP-057 Genetic Testing for Melanoma
- REIMB-009 Preventive Care Screening
- MP-045 General Policy on Genetic Testing
- REIMB-007 Next Generation Sequencing (NGS)
- MP-046 Carrier Screening for Genetic Diseases
- MP-018 Cell-Free DNA (cfDNA) Testing for Fetal Aneuploidy
- MP-030 Pharmacogenomic Testing for Behavioral Health Disorders
- MP-033 Genetic Testing for Breast and/or Ovarian Cancer Susceptibility
- MP-020 Methylenetetrahydrofolate Reductase (MTHFR) Mutation Testing
- MP-038 Circulating Tumor DNA and Circulating Tumor Cells for Cancer Management (Liquid Biopsy)
- MP-003 Chromosomal Microarray (CMA)/Comparative Genomic Hybridization (CGH) Testing for Developmental Delay and Fetal Demise

PRIOR AUTHORIZATION

Typically, genetic testing requires prior authorization. Search Codes Requiring Prior Authorization for specific code requirements.

IN-NETWORK LABS

To confirm a genetic testing laboratory's participating network status, visit the U of U Health Plans Provider Directory.

1. Leave the location information blank.
2. Select "**Other Providers**" and then click "**Search Providers**."
3. On the resulting screen, narrow your search by selecting "**Laboratory/Pathology**" in the "Specialty" drop-down menu, then click "**Search**" to refresh the results.

WHEN AND HOW TO REQUEST A PEER-TO-PEER REVIEW

The primary role and purpose of a Peer-to-Peer (P2P) review is to provide additional information to discuss a denied decision. A P2P is an opportunity for conversation and to provide clinical context that may not have been provided with the initial prior authorization request. Granting a P2P does not indicate that a decision will be overturned or reversed.

Visit our Prior Authorization web page and scroll down to "Peer-to-Peer Information and Form" for an overview of the P2P process and Frequently Asked Questions.

Please bear in mind the following guidelines:

- **Submission of a Request Does Not Guarantee a Peer-to-Peer**
  A completed Peer-to-Peer Request Form (Medical, Pharmacy) is required, but approval for a P2P is not assured. If the case does not meet the outlined criteria, it may be directed to the appeal process.
- **Timeliness of Request**
  Requests must be submitted within 7 calendar days of the denial letter's date. Requests submitted outside this timeframe will be referred to the appeals process.
- **Scheduling Requirements**
  Providers must offer at least two different time slots for the P2P, with at least two hours separating the requested times.

  The proposed times should be at least two business days from the date of submission, to allow for documentation review and scheduling.

  While U of U Health Plans strives to accommodate provider availability, advanced planning is essential given the fast-paced nature of the health plan's operations.
- **Call Availability**
  During the scheduled 30-minute window, U of U Health Plans will attempt to contact the provider twice.

  If unsuccessful, one additional opportunity will be granted to reschedule before referring the matter to the appeals process.

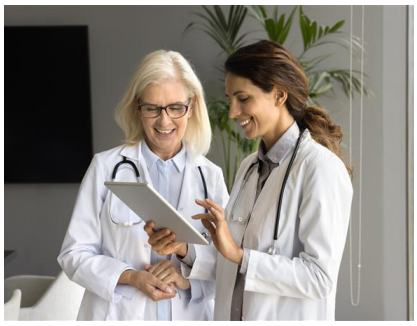
The P2P process is not specialty matched and **does not replace the appeal process**.

Providers are encouraged to ensure complete and accurate submissions to facilitate effective scheduling and discussions.

Again, a Peer-to-Peer review provides an opportunity to discuss additional information and/or clinical context to aid in reviewing a denied decision that may not have been available during initial prior authorization review. A P2P does not replace an initial prior authorization review, nor does it guarantee that a decision will be overturned or reversed.

If you feel a Peer-to-Peer is warranted, visit Policies, Guidelines & Forms, scroll down to “Peer to Peer Information and Form,” then select, complete, and fax the appropriate (medical or pharmacy) Peer to Peer Review Request Form. Contact information is provided on each form if you have any questions.

We appreciate the care and services you provide our members.



EXPERT SUPPORT FOR PCPS – JUST A "CALL-UP" AWAY

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

CALL-UP provides the following benefits:

- Addresses the needs of patients ages 24 years and younger
- No cost to providers or patients throughout Utah
- Optimizes PCPs' ability and confidence to diagnose and treat mild to moderate mental health issues
- Improves quality of care and health outcomes for patients by enhancing early interventions
- Improves the continuum of care by encouraging behavioral health and physical health integration
- Ensures appropriate referrals for individuals with serious health concerns

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

HEALTHY U MEDICAID

BEHAVIORAL HEALTH PROVIDERS MUST REPORT CRITICAL INCIDENTS

As part of the requirements of the Medicaid 1115 waiver that allows us to pay for mental health and substance use residential treatment, the state of Utah is required to report any critical incidents involving any behavioral health provider to the Centers for Medicare and Medicaid (CMS).

Critical incidents should be reported for all Medicaid members with Serious Mental Illness (SMI).

If you become aware of any critical incident involving your facility, practice or patient you must report these to our Compliance department within 30 days of the incident.

We appreciate your help with this requirement to ensure Utah Medicaid can continue to cover residential treatment for Medicaid members.

TYPES OF CRITICAL INCIDENTS THAT MUST BE REPORTED:

- A serious injury of a member that occurred on the Behavioral Health facility premises and required an overnight admission to a hospital medical unit
- A serious physical assault of a member that occurred on the Behavioral Health facility premises and required medical intervention at a medical facility/medical unit/ER
- A serious physical assault by a member that occurred on the Behavioral Health facility premises and required medical intervention at a medical facility/medical unit/ER for the assailant and/or the victim
- An unexpected death of a member that occurred on Behavioral Health facility premises
- A sexual assault of or by a member that occurred on Behavioral Health facility premises
- An abduction of a member that occurred on Behavioral Health facility premises
- An instance of care ordered or provided to a member by someone impersonating a healthcare professional, that occurred on the Behavioral Health facility premises
- Behavioral Health provider medication errors resulting in an impact on the member's well-being, medical status or functioning
- A serious suicide attempt by a member that required an overnight admission to a hospital medical unit
- A completed suicide by a member
- A homicide that is attributed to a member

REPORTING REQUIREMENTS AND TIMEFRAMES

» Email Healthy U Compliance at healthplanscompliance@utah.edu with all of the following information:
  - Member's name and Medicaid ID
  - Provider/Facility Name
  - Date of the incident
  - Type of incident

» Only report critical incidents that involve Medicaid members with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).

» Report critical incidents within 30 days of the incident, even if the member has not been formally discharged from behavioral health services (not just for those actively in treatment).

DEFINITIONS

Critical incident means an event or occurrence that causes harm to a Medicaid Member or serves as an indicator of risk to a Medicaid Member's health or welfare, or the Medicaid Member causes harm to another individual.

Serious mental illness (SMI) means a mental, behavioral or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. SMI applies to individuals who are 18 years of age or older.

Serious emotional disturbance is a diagnosable mental health condition in a child or adolescent, 0 to18 years of age, that significantly impacts their ability to function in family, school, or community settings.

Behavioral health facility premises includes all levels of care (inpatient, outpatient, residential and day treatment). It also includes the occurrence of a critical incident while a service was being provided via telehealth or in home.

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 uuhpenrollment@hsc.utah.edu 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.

HUMIRA BIOSIMILAR UPDATE – COMMERCIAL AND INDIVIDUAL/FAMILY PLANS

As a reminder, Humira became non-formulary, effective January 1, 2025.

Simlandi® (adalimumab-ryvk) was added to the formulary on January 1, 2025, as a preferred agent with prior authorization required. Simlandi joins Hadlima (adalimumab-bwwd) as the two adalimumab medications on our Preferred formulary.

Simlandi is available in all the same dosage forms and strengths as Humira, including latex free and citrate free formulations, and it is the only biosimilar that is currently interchangeable. It may be requested for any indication allowed for Humira coverage.

ANNUAL NOTICE OF PHARMACY RESOURCES FOR PRESCRIBERS

For the 2025 year, a list of medical pharmacy medications that require authorization or are excluded, and the Preferred Drug List (PDL)/Formulary for retail/specialty pharmacy medications are available online. "Bookmark" the sites in following section to your internet favorites for convenient reference.

MEDICAL PHARMACY MEDICATIONS

View the current list of medical pharmacy services and products requiring prior authorization or that are excluded by visiting Search Codes Requiring Authorization.

For injections, infusions, and other medications administered in a clinical setting, complete the appropriate Prior Authorization Form:

- Online Submission Form
- Fax Form

Remember to attach supporting documentation as indicated. Failure to submit clinical documentation to support this request will result in a dismissal of the request.

RETAIL PHARMACY MEDICATIONS

For retail and specialty pharmacy medications, view the Preferred Drug List (PDL)/Formulary for covered medications, drug tiers, prescribing limits, generic substitution, therapeutic interchange, step therapy, or prior authorization requirements. Pick the formulary that matches your member's benefit plan.

Retail Pharmacy Prior Authorization (PA) Process

Retail pharmacy PA requests may be submitted online or by fax. For online PA requests, visit our Pharmacy Benefit Manager (PBM), RealRx Home Dashboard. Go to "Request Prior Authorization" and click "Get Started".

If you prefer to print and fax the request, complete the appropriate Pharmacy Prior Authorization Form for the specific medication or category for your request and the form specific to the member's benefit plan. If there is not a specific form for the requested medication, use the General Pharmacy Prior Authorization Form for the member's benefit plan. Fax the completed form, along with all supporting documentation, to **385-425-4052**.

If you are requesting a drug that is not on the health plan formulary, complete the Pharmacy Formulary Exception Request Form that corresponds to the member's benefit plan:

- Commercial group or Individual/Family – Pharmacy Formulary Exception Request Form
- Healthy U Medicaid or Healthy U CHIP – Pharmacy Formulary Exception Request Form

Include supporting clinical documentation showing a medical reason that a formulary alternative would not be effective for the member.

For upcoming changes to the formulary coverage and edits, notices are placed on the website for review. View the most current "Formulary Change Notices" on the Pharmacy Formularies web page, just below the Searchable Directories.

Questions regarding a prior authorization or need assistance completing the form?
Call 385-425-5094.

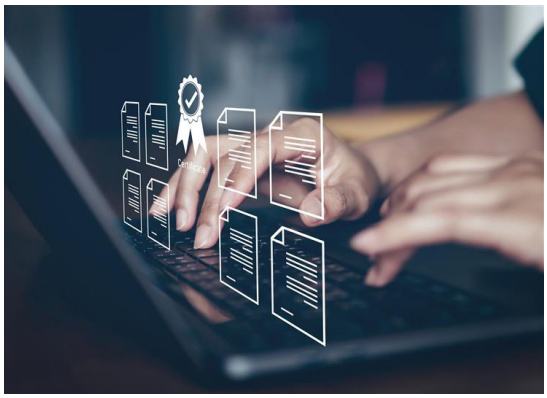
RECENT AND UPCOMING FORMULARY CHANGES

U of U Health Plans 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.

REDUCING THE PHARMACY PRIOR AUTHORIZATION BURDEN

Did you know? Our Pharmacy team proactively reviews medication prior authorizations (PA) that are due to expire in the following month or two. If there is sufficient information to renew the PA (e.g., member adherence, efficacy of treatment for the member, whether the member has seen their provider in the plan year), we are extending the PA for you! This eases your PA burden and also prevents access-to-care issues for your patients. We will notify you any time an authorization has been extended.



Note: Certain medications always require provider submission of the PA request, so always check the formulary.

We are studying more ways to make the PA process easier for you. We'll post updates in future editions of Provider Connection. If you haven't yet, subscribe today so you don't miss a quarterly edition.

QUESTIONS ABOUT PHARMACY BENEFITS?

For **Medical Pharmacy Medications**, call the Customer Service team serving the member's benefit plan:

Healthy U Medicaid	833-981-0212 | 801-213-4104
Healthy U CHIP	833-404-4300 | 801-213-0525
U of U Health Plans – Commercial	833-981-0213 | 801-213-4008
U of U Health Plans – Individual/Family	833-981-0214 | 801-213-4111
Healthy Premier U of U Hospitals & Clinics Plan	833-443-3440 | 801-213-0274

For **Retail Pharmacy Medications**, call the Pharmacy Customer Service team serving the member's benefit plan; available 24 hours a day, 365 days a year:

Healthy U Medicaid	855-856-5694
Healthy U CHIP	855-203-3633
U of U Health Plans – Commercial	855-869-4769
U of U Health Plans – Individual/Family	855-859-4892
Healthy Premier U of U Hospitals & Clinics Plan	855-856-5690

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

Our list of Codes Requiring Prior Authorization is updated as changes occur. 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.

COVERAGE POLICY UPDATES

University of Utah Health Plans uses coverage policies as guidelines for coverage determinations in accordance with the member's benefits. All new and updated policies, including policies for services requiring prior authorization, are posted on our Coverage Policies website for 60 days prior to their effective date.

Quarterly notice of recently approved and revised coverage and reimbursement policies is provided in Provider Connection for your convenience. The information listed are summaries of the policies. Click on the hyperlinked policy number to view the coverage or reimbursement policy in its entirety.

The Medical and Reimbursement Policy Updates section of this newsletter does not guarantee coverage is provided for the procedures listed. Coverage policies are used to inform coverage determinations but do not guarantee the service is a covered service. For more information on our coverage policies, visit our Coverage Policies website or contact your Provider Relations consultant.

We also encourage you to visit our Prior Authorization site frequently to view all medical services that require prior authorization, links to our coverage policies, and information on submitting an authorization request. Services that do not yet have a policy are reviewed using Interqual® criteria.

MEDICAL POLICY UPDATES

University of Utah Health Plans uses medical policies as guidelines for coverage determinations in accordance with the member's benefits. Quarterly notice of recently approved and revised medical policies is provided in Provider Connection for your convenience. The Medical Policy Updates section of this newsletter does not indicate that coverage is provided for the procedures listed.

NEW POLICIES		
Policy Number	***Policy Name***	***Effective Date***
MP-013 (New)	Allergy Testing	**11/25/2024**
Commercial Plan: U of U Health Plans may cover allergy testing with eligible testing modalities when certain criteria are met. Please see the policy for further details.		
MP-043 (New)	Fecal Elastase (FE-1) Testing	**11/25/2024**
Commercial Plan: U of U Health Plans covers fecal elastase testing in the assessment of malabsorption in members suspected of possible exocrine pancreatic insufficiency. U of U Health Plans does not cover fecal elastase testing for any other indication as it considered investigational.		
ADMIN-009 (New)	Behavioral Health Intensive Outpatient and Partial Hospitalization Programs	**12/23/2024**
Commercial Plan: U of U Health Plans covers services provided in a behavioral health partial hospitalization or intensive outpatient treatment when the member and facility meet minimum standards. Please see the policy for specific coverage details.		
MP-007 (Revised)	Ambulatory Insulin Pumps and Closed Loop Insulin Delivery System	**10/16/2024**
Commercial Plan: After the policy's annual review, we changed the documentation needed from a diabetes specialist during the 6 months prior to initiation of an insulin pump criterion from 2 visits to 1 visit in an effort to help support rural members.		
MP-014 (Revised)	Treatment of Congenital Hemangiomas (Port Wine Stains)	10/16/2024

NEW POLICIES (*Continued*)		
Policy Number	***Policy Name***	***Effective Date***
Commercial Plan: U of U Health Plans added ulceration of any port wine stain as an additional condition that may warrant laser treatment.		
MP-019 (Revised)	Aqueous Shunts and Stents for Glaucoma	**01/20/2025**
Commercial Plan: Aqueous shunt revision indications were added for the Express, Xen, traditional trabeculectomy, and valve surgeries (such as Baerveldt and other valve devices), that are considered medically necessary.		
MP-071 (Revised)	Therapeutic Nerve Blocks for Post-Operative Pain Management	**01/20/2025**
Commercial Plan: U of U Health Plans added the following criterion for further clarification: "More than three anatomic sites (e.g., specific nerve, plexus or branch as defined by the CPT code description) injected at any one session will be denied"		

REIMBURSEMENT POLICY UPDATES

NEW POLICIES		
Policy Number	***Policy Name***	***Effective Date***
REIMB-040 (New)	Unlisted/Miscellaneous Codes	**11/25/2024**
Commercial Plan: U of U Health Plans requires documentation for all unlisted/miscellaneous codes submitted in order to make sure there is not a more appropriate code, and that the unlisted/miscellaneous code is the only one that reflects the services/procedures being done or supplies being used based on the circumstances. Please see policy for details.		
REVISED POLICIES		
Not Applicable		