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.**

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HEALTH PLANS
UNIVERSITY OF UTAH

UPDATE ON CYBERSECURITY DISRUPTION

In response to the security breach experienced by our business partner, Change Healthcare, University of Utah Health Plans has been implementing new processes and relationships to mitigate impacts on providers and members.

WHAT HAPPENED

As you are likely aware, Change Healthcare was faced with a cyber threat to a key data system, beginning in February. Once they discovered the threat, they immediately disconnected their systems, including those that impact some payment data applications for medical and pharmacy claims at University of Utah Health Plans—as well as many other insurers across the nation. This resulted in a disruption in many providers and pharmacies' ability to bill services and prescriptions or receive some payments and remittance advices.

RECOMMENDED SOLUTIONS

Claims – There are several alternative methods available for providers to submit non-retail-pharmacy claims. The preferred method is to submit claims electronically through another claims clearinghouse, such as SmartData Solutions, Claim.MD, or Availity®, or directly through Utah Health Information Network (UHIN). If that is not an option at this time, you can email claims through a secure email service **as a .pdf file** to uuhp@hsc.utah.edu.

Payments – Paper checks bore the greatest impact from this disruption. We have temporarily contracted with an alternate vendor to process and mail paper checks; however, this is not a long-term solution. We strongly encourage you to sign up for Electronic Funds Transfer (EFT) through your EDI clearinghouse to ensure funds are deposited directly to your bank account.

Remittance Advices – If you have received payment for claims but have not received the remittance advice for the payment, you can contact Customer Service for the member's benefit plan to have your remittance advice emailed or faxed to you.

Line of Business	Phone Number
Healthy U Medicaid	833-981-0212 | 801-213-4104
Utah Individual and Family Plans	833-981-0214 | 801-213-4111
Commercial and Group Plans	833-091-0213 | 801-213-4008

Thank you for your patience as we and other insurers navigate through this challenge. If you experience outstanding issues regarding claims, payments, or remits, please reach out to our Customer Service department.

MAKE YOUR OFFICE MORE EFFICIENT WITH EDI, ERA, AND EFT

Electronic transactions via electronic data interchange (EDI) software offer significant benefits for your office. Electronic claims, remittance advices, and payment can help improve efficiency, productivity, and cash flow through less redundancy, reduced data entry errors, and faster turnaround times.

EDI CLAIMS ADVANTAGES

Of the claims that University of Utah Health Plans (U of U Health Plans) receives electronically, 80% pass through our claims processing system without processor intervention. The average turnaround time for EDI claims (received date to check being received in the provider office) is 15 days.

ACCEPTED TRANSACTIONS

U of U Health Plans and Utah Health Information Network (UHIN), our designated clearinghouse, are HIPAA-compliant in the following transactions:

- **270/271** *0051010x279a1 Eligibility Request/Response* (real-time)
- **276/277** *Claim status inquiry/response* (real-time)
- **277CA** *Claim acknowledgment/error report*
- **835** *005010x221a1 (Remittance advice)*
- **837** *005010x224* (Dental claims)
- **837** *005010x222**a1*** (Professional claims)
- **837** *005010x223**a2*** (Institutional claims)
- **999** *Acknowledgment*
- **COB** *Coordination of Benefits*
- **EFT** *Electronic Funds Transfer* (in conjunction with the 835)

ABOUT UHIN

U of U Health Plans is a member of UHIN, a non-profit coalition of payers and providers in Utah. UHIN members have come together to reduce the administrative costs of healthcare through standardizations of electronic interactions.

- Our trading partner number with UHIN is **HT000179-002**.
- Visit UHIN.org for more information.

BENEFITS OF ERA AND EFT

Why wait for snail mail when Electronic Remittance Advice (ERA) And Electronic Funds Transfer (EFT) can deliver claim information to you and payments to your bank account the same day as they are posted?

Greater Efficiency

With ERA (transaction 835), you can review claims as soon as processing is complete, with no lag time waiting for the mail. Additionally, most EDI software can be configured to automatically post claim information directly to the patient's account without having to manually reenter the data. Using ERA decreases time spent reconciling accounts and reduces data entry errors.

Greater Security

With EFT, payments are deposited directly to your bank account as soon as the payment is processed. EFT eliminates concerns of your check being delivered to the wrong address, stolen from the mail, or signed and cashed by an unauthorized person. EFT also eliminates the need for a staff member to spend time carrying the check to the bank. And, as with ERA, most EDI software can be configured to automatically post payments directly to the patient's account.

ENROLL IN EDI, ERA, AND EFT

EDI transactions are standardized throughout the industry. This means your office can enjoy the efficiencies gained through EDI when doing business with most payers.

Visit Electronic Data Interchange (EDI) for more information about:

- » Enrolling for EDI
- » Submitting claims
- » Receiving assistance
- » Accepted transactions

Don't wait—make your office more efficient by signing up for EDI, ERA, and EFT today.

U OF U HEALTH PLANS TO OFFER "CHIP" BENEFITS

We are so pleased to announce that U of U Health Plans is working towards offering services for the Children's Health Insurance Program (CHIP). CHIP is a health insurance plan specifically for children under age 19 who do not qualify for Medicaid or have other insurance. **Coverage for CHIP members will begin July 1, 2024**.

Covered benefits include:

- » Doctor visits
- » Prescriptions
- » Immunizations
- » Well-child exams
- » Mental health services
- » Hearing and eye exams
- » Hospital and emergency care

The preventive services listed (well-child visits and immunizations) do not require a copay or other out-of-pocket expenses.

For more information, call Customer Service at **833-404-4300**. After June 1, 2024, you can also visit Healthy U CHIP.

U OF U HEALTH PLANS AT THE 2024 CONNECT THE DOTS SUMMIT

More than 350 attendees from community organizations throughout Utah met with Provider Relations consultants from U of U Health Plans and representatives from other payers and sponsors at the Connect the Dots Summit.

The summit, held on March 27, 2024 at the Utah Cultural Celebration Center in West Valley City and sponsored by Health Choice Utah, brings together organizations that promote community wellness. Education on a variety of topics is presented at the summit with the goal of building a strong network of partnerships and resources to benefit our communities.

ADVANTAGE U (MEDICARE ADVANTAGE) RUN OUT

As we informed you in the August and November 2023 editions of Provider Connection, as well as via emails and postal letters, **effective January 1, 2024, U of U Health Plans no longer offers Advantage U (Medicare Advantage) member plans**. While we will no longer offer Advantage U in 2024, we will continue processing claims and appeals for **dates of service prior to January 1, 2024**, in accordance with standard CMS timely filing guidelines. Please make all staff in your office aware of this change, and remind them to **submit all Advantage U claims as soon as possible**.

We sincerely appreciate the care you provided our Advantage U members, and look forward to continuing our relationship in support of our other products and networks.

LEARN MORE

Advantage U website

Click on the “For Providers” tab for a menu of resources available for providers.

QUESTIONS?

- Claims and benefits – Advantage U Customer Service I **855-275-0374**
- Contracting and general questions – Provider Relations I **801-587-2838**
- Part D Prescription Medications – contracted with CVS Caremark® I **888-970-0851**

MEMBER RIGHTS AND RESPONSIBILITIES

Note: This information is shared with every member at time of enrollment.

WHAT ARE MEMBER RIGHTS?

University of Utah Health Plans wants to give our members the best care and service. U of U Health Plans members have the right to:

- Make recommendations about these rights.
- Get health care within appropriate time frames.
- Be treated with respect, dignity, and a right to privacy.
- Use their rights at any time without being treated badly.
- Have their medical visits, conditions, and records kept private.
- Voice a complaint or appeal about the organization or the care it provides.
- Ask for and receive a copy of their medical record, and ask to have it corrected if needed.
- Make decisions about their health care with their healthcare provider, including refusing treatment.
- Be free from restraint or seclusion if it is used to coerce (force), discipline, retaliate, or for convenience.
- Get information about their health and medical care, such as how a treatment will affect the member and their treatment options.
- Talk to U of U Health Plans about appropriate or medically necessary treatment options, regardless of cost or benefit coverage.
- Get information about the organization, benefit plans, its services, its practitioners and providers, and member rights and responsibilities.
- Receive the following information upon request:
  - Member rights and responsibilities
  - The services U of U Health Plans offers
  - How to get help and emergency care when their doctor's office is closed
  - Involvement in medical research
  - Grievances and Appeals
  - How U of U Health Plans operates, such as our policy for selecting providers, what we require of them, any practice guidelines (rules) providers use to care for members, and our confidentiality policy.

If members need help understanding any of this information, they can call the Customer Service phone number for their benefit plan:

Plan Name	Wasatch Front	Toll-free
Healthy U Medicaid	801-213-4104	833-981-0212
Commercial groups	801-213-4008	833-981-0213
Individual and Family plans	801-213-4111	833-981-0214

WHAT ARE MEMBER RESPONSIBILITIES?

To keep members and their family healthy and help us care for them, members should remember to:

- Respect the staff and property at their provider's office.
- Stay fit and well by taking care of themselves and their family.
- Supply information needed to Health Plans and to treating providers in order to provide care.
- Keep appointments or let the provider's office know as soon as possible if member can't make it.
- Let the group administrator know if member moves, changes phone number, gets married or divorced, has a baby, or someone in the family dies.
- Understand member's health problems, work with member's provider to develop agreed upon treatment goals, and do all members can to meet goals.
- Read the Member Guide. If members need help understanding it, they can call the appropriate U of U Health Plans Customer Service number listed above.
- Always talk to their doctor about any health information in any newsletter or on any website to make sure it is best for them. Never use this information instead of what their doctor says is best.
- Follow provider recommendations, plans, and instructions for care that members and providers have agreed upon. If members don't agree, or have questions about treatment plan or goals, talk to their provider.

DOCUMENTING BLOOD PRESSURE READINGS TO SUPPORT HEDIS PERFORMANCE

The Healthcare Effectiveness Data and Information Set (HEDIS) tool is used to measure many aspects of clinical care, with the end goal of ensuring members receive the highest quality of care and achieve their best health. This article details some of the key documentation features for the HEDIS measure, Controlling High Blood Pressure (CBP).

MEASURE DEFINITION

The CBP measure evaluates the percentage of members 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was controlled (<140/90 mm Hg). Systolic BP must be below 140 mm Hg and diastolic BP must be below 90 mm Hg to be considered controlled.

This measure applies to all of our health product plans for Commercial groups, Individual and Family plans, and Healthy U Medicaid plans.

TIPS FOR DOCUMENTING BLOOD PRESSURE READINGS

- Record all blood pressure readings. If a patient with hypertension has a BP reading above 140/90 mm HG on any given visit, take the blood pressure again, before the patient leaves the office, to see if the pressure decreases. Record both readings.
- Document patient home blood pressure readings in the medical record. Patient-reported blood-pressure readings from any digital device are acceptable, as long as the BP reading is documented in the patient's medical record.

- For this measure, the patient is "non-compliant" if there is no BP reading documented during the year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).
- A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. Ranges and thresholds do not meet compliance criteria for this measure.

Examples:

Compliant Documentation	Non-Compliant Documentation	Non-Compliant Reason
Systolic 124 Diastolic 82	Systolic 120s Diastolic 80s	The BP reading is not recorded as a distinct numeric result.
The patient recorded a blood pressure reading today at home that was 125/80.	The patient reports usual blood pressures at home of 120s/80s.	The BP reading is not recorded as a distinct numeric result.
Average BP: 139/70	BP readings average between 110-120 mm HG systolic and 70-80 mm HG diastolic.	The BP reading is documented as a range, not as distinct numeric results.

BEST PRACTICES FOR IMPROVING HEDIS SCORES

- Measure blood pressure at every visit
- Outreach to members to schedule appointments
- Counsel the member about healthy lifestyle changes like improved diet and increased exercise
- Correctly and consistently document BP readings in medical records, irrespective of type of visit—telehealth, telephone, virtual, or office
- Stress to members the importance of medication adherence and the benefits of controlled blood pressure; simplify medication regimens whenever possible

CODING BLOOD PRESSURE AND HYPERTENSION

Description	Codes
Hypertensive Diseases — Controlled and Uncontrolled*	ICD-10: I10 to I15
Outpatient Visit Codes	CPT: 99202 to 99205, 99211 to 99215, 99241 to 99245, 99347 to 99350, 99381, to 99387, 99391 to 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483, 99341 to 99345 HCPCS: T1015**

* "ICD-10-CM Official Guidelines for Coding and Reporting FY 2023 — UPDATED April 1, 2023 (October 1, 2022 – September 30, 2023). Centers for Medicare & Medicaid Services. March 20, 2023." https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines-updated-01/11/2023.pdf.

** In the Outpatient Visit Codes row, HCPCS T1015 applies only to Healthy U (Medicaid) claims.

We are committed to work with you to improve the quality of care our members receive. Please share with us what you've found effective in your practice to meet the CBP HEDIS measures

APPOINTMENT ACCESS STANDARDS

We are dedicated to ensuring our members have timely access to the services they need. Providers participating in one or more of our networks are expected to also ensure members have access to timely care by complying with the Access Standards below. These standards are established by the Centers for Medicare & Medicaid Services (CMS), the State of Utah, and per the Federal Register Qualified Health Plan requirements.

The following Appointment Access Standards are established in our Provider Manual. Please review these standards with the appropriate staff and incorporate any changes to your business practices as may be warranted. We recently conducted an appointment access standards survey. If your practice is not meeting the standards, your Provider Relations consultant will contact your office.

APPOINTMENT WAIT TIMES

Note: A PCP is defined as a generalist in any of the following areas: Family Practice, General Practice, General Internal Medicine, Obstetrics/Gynecology (by physician), and Pediatrics.

<table>
<tr><th colspan="4">Access and Availability Standards</th></tr>
<tr><td colspan="4">Urgent Care
» Commercial, Individual/Family plans – Not life-threatening
» Medicaid and CHIP – Symptomatic, not life-threatening, treated in a provider's office. Does not indicate dangerousness, but patient's functioning is seriously impaired and symptoms are moderate to severe.</td></tr>
<tr><td>Access Standard:</td><td>Primary Care Provider
Within 2 days</td><td>Specialty Care Provider
Within 2 days</td><td>Behavioral Health Provider
Within 48 hours (2 days)</td></tr>
<tr><td colspan="4">Routine, Non-Urgent Care
» Does not apply to appointments for regularly scheduled visits to monitor a chronic condition, if the schedule calls for visits less frequently than once every month
» Commercial, Individual/Family plans, Medicaid, and CHIP – Includes school physicals
» Medicaid and CHIP only – Includes symptoms generally less intrusive and less serious than those requiring urgent care</td></tr>
<tr><td>Access Standard:</td><td>Primary Care Provider
Within 30 days</td><td>Specialty Care Provider
Within 30 days</td><td>Behavioral Health Provider
» Initial visit for routine care within 10 business days
» Follow-up routine care within 30 days</td></tr>
<tr><td colspan="4">After-Hours Care (Commercial and Individual/Family plans only)
Offer after-hours care or provide directions on where to receive after-hours care</td></tr>
<tr><td colspan="4">Non-Life-Threatening Emergency (Commercial and Individual/Family plans only)
Within 6 hours, or direct patients to the Emergency Room or behavioral health crisis services</td></tr>
<tr><td colspan="4">Initial Contact Requiring Emergency Services (Healthy U Behavioral [Medicaid] only)
Initial contact includes by telephone or a walk-in basis
Screening within 30 minutes of initial contact
» Face-to-face appointment offered within one-hour of initial contact screening if determined to be an emergency
» Face-to-face appointment offered within 5 business days of initial contact screening if determined to be urgent
» Face-to-face appointment offered within 15 business days of initial contact screening if determined to be non-urgent</td></tr>
</table>

Note: Medicaid and CHIP members must be offered appointments during the same hours of operation offered to commercial members or Medicaid fee-for-service members.

APPOINTMENT SCHEDULING

Providers are required to have an appropriate scheduling system that reserves adequate time allotments for various types of appointments, as well as adequate time reserved for urgent/acute care.

The provider's telephone system must be sufficient to manage the volume of calls coming in to the office.

View the Appointment Access Standards Policy in its entirety in our Provider Manual.

OBTAINING UTILIZATION MANAGEMENT CRITERIA

U of U Health Plans makes every effort to ensure that services being provided to our members meet nationally recognized guidelines, are provided at the appropriate setting (inpatient or outpatient), and that the length of stay can be supported for medical indications. We reference InterQual® and Hayes criteria, nationally recognized guidelines, to help determine medical necessity.

Our Coverage Policies provide guidelines for determining coverage criteria for specific medical, behavioral health, and pharmaceutical technologies, including procedures, equipment, and services.

We would be happy to provide you with a copy of the criteria we used to make a specific utilization management decision. Please call the Utilization Management team at **833-981-0213** option 2 for additional information or email your request to UUHP_UM@hsc.utah.edu.

HEALTHY U MEDICAID

TRAINING REQUIREMENTS TO TREAT GENDER DYSPHORIA IN MINORS

Utah law now requires providers of transgender care for minors to be certified. This information was published in the January 2024 Medicaid Information Bulletin (MIB), **article 24-19: *Hormone Therapy for Gender Dysphoria Prior Authorization***.

The article states, "Healthcare providers and mental health professionals who treat gender dysphoria in minors are required to complete at least 40 hours of education related to transgender healthcare for minors from an approved organization and receive the Transgender Treatment Certification issued by the Utah Division of Professional Licensing (DOPL)."

Reference:

"24-19 Hormone Therapy for Gender Dysphoria Prior Authorization." Medicaid Information Bulletin: January 2024. Utah Department of Health & Human Services, Integrated Health. https://medicaid.utah.gov/utah-medicaid-official-publications/. Jan 2024. Accessed on 21 Mar 2024.

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

EFFECTIVE DATE	LABEL NAME	DESCRIPTION OF CHANGE	PREFERRED ALTERNATIVE(S)	LINE OF BUSINESS
4/1/2024	STRENSIQ®	Excluded from Formulary	Requests reviewed for medical necessity	Commercial
4/1/2024	ARCALYST® 220 MG RECON SOLN	Excluded from Formulary	Requests reviewed for medical necessity	Medicaid
4/1/2024	CRESEMBA®	Excluded from Formulary	Requests reviewed for medical necessity	Commercial
4/1/2024	NURTEC®	Changed from **Non-Preferred** Drug with a Prior Authorization Requirement to **Preferred** Drug with a Prior Authorization Requirement	Generic triptans, Ubrelvy®	Medicaid
5/1/2024	COLCHICINE CAPSULE 0.6 MG	Excluded from Formulary	COLCHICINE TABLET 0.6 MG	Commercial and Individual/Family
5/1/2024	FLOVENT® DISKUS®, FLOVENT HFA, FLUTICASONE PROPIONATE DISKUS, FLUTICASONE PROPIONATE HFA	Excluded from Formulary	Qvar® or Arnuity Ellipta®	Commercial and Individual/Family
5/1/2024	PULMICORT FLEXHALER®	Excluded from Formulary	Qvar or Arnuity Ellipta	Commercial and Individual/Family
5/1/2024	DULERA®	Excluded from Formulary	fluticasone-salmeterol (and Wixela®), Symbicort®, or Breo Ellipta®	Commercial and Individual/Family

PHARMACY RESOURCES

We recommend bookmarking the following links in your Internet favorites for quick access to pharmacy updates, requirements, and forms.

» **Notice of formulary changes** are available on our Pharmacy Formularies page. Scroll down to the bottom of the table and click on "**Formulary Change Notice**."

» **Requirements for retail and specialty pharmacy medications** are available on the Pharmacy Formularies page. Multiple formularies are available, depending on the member's benefit plan. Begin by selecting the member's benefit plan; then either type the needed medication in the Drug Name Search or scroll through the Therapeutic Class and subclass to view the drug's benefit tier, prescribing edits (e.g., limits, step therapy, and/or prior authorization requirements), as well as alternative drugs.

REQUESTING PRIOR AUTHORIZATION

Pharmacy prior authorization requests can be submitted online or by fax. Formulary exception requests can only by submitted by fax.

» Visit Coverage Policies – PHARMACY to view the *Pharmacy Prior Authorization Request Form* or the *Pharmacy Formulary Exception Request Form* specific to the member's benefit plan.

» The RealRx Dashboard is useful to submit **prior authorization requests** online; alternatively, PDFs are available if you prefer to fax your prior authorization or formulary exception request. Click on "**Get Started**" to submit the prior authorization request online; or click "***RealRx - Prior Authorization Request Form***" or "***RealRx - Formulary Exception Request Form***" to complete and fax the appropriate form for your request.

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 sections of this newsletter do 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 begin on next page*)

MEDICAL POLICY UPDATES

NEW POLICIES		
Policy Number	***Policy Name***	***Effective Date***
MP-025 **(New)**	**Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases (e.g., Avise® CTD)**	**04/28/2024**
Commercial Plan: U of U Health Plans does NOT cover serum biomarker panel testing with proprietary algorithms and/or index scores for the diagnosis of systemic lupus erythematosus and other connective tissue diseases as current published evidence is insufficient to determine efficacy of this testing. Therefore, they are considered investigational.		
REVISED POLICIES		
Policy Number	***Policy Name***	***Effective Date***
MP-016 **(Revised)**	**Infertility Testing and Treatment**	**03/17/2024**
Commercial Plan: After the fertility specialist annually reviewed this policy, they recommended removing endometrial biopsy as a covered test as it is no longer recommended as part of infertility evaluations.		
MP-048 **(Revised)**	***Phototherapy, Photochemotherapy or PUVA, and Excimer Laser Therapy for Dermatologic Conditions***	***01/17/2024***
Commercial Plan: Clarification added as to when phototherapy should be used for atopic dermatitis and psoriasis (e.g., if there is failure, intolerance or contraindication to conventional medical management).		

REIMBURSEMENT POLICY UPDATES

NEW POLICIES		
Policy Number	***Policy Name***	***Effective Date***
Reimb-005 **(New)**	**Add-on Codes**	**05/08/2024**
Commercial Plan: This policy was created to provide clarification of how we process add-on codes by following the AMA®/CPT® Guidelines. Please see policy for details.		

(*Revised Reimbursement Policies continued*)

REVISED POLICIES		
Reimb-009 **(New)**	**Preventative Care Screening**	**04/28/2024**
Commercial Plan: New USPSTF guidelines related to anxiety disorder screenings in adults, children and adolescents added along with the new FDA approved Natural Cycles® fertility app that is considered a contraceptive device, when certain criteria are met. Please see policy for further details.		
Reimb-030 **(New)**	**Durable Medical Equipment (DME)**	**04/28/2024**
Commercial Plan: In order to help remove the burden of prior authorization (PA) for providers, we removed HCPCS **A7002** (tubing for suction pumps) from the PA List and added it to this policy with limits.		

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