PROVIDER CONNECTION

University of Utah Health Plans
Provider Publication
May 2025

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

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. Feel free to reach out to Provider Relations via email if you would like to connect with Dr. Pak.

GROWING MEMBERSHIP IN HEALTHY PREMIER BENEFIT PLANS

Membership in our Healthy Premier benefit plans is growing! Several additional employer groups in Utah have recently enrolled in a Healthy Premier plan. As we announced in the August 2024 *Provider Connection*, **University of Utah Health Hospitals and Clinics** employees had the option to join our Healthy Premier – U of U Hospitals & Clinics Plan, starting July 1, 2024; several thousand have made that choice. Now, **University of Utah Academics** employees will have the option to join our Healthy Premier U of U Community Plan, **effective July 1, 2025**. All of these plans will be associated with the Healthy Premier provider network that aligns with the named benefit plan.

We are so grateful to all our providers for being an integral part of our network and for the exceptional care you give our members. Your dedication and expertise are vital to our mission of delivering high-quality care to our members.

Visit the Provider Portal for detailed benefit information for any of your patients who are our members. If you have other questions about benefits or eligibility, contact the Customer Service team for your patient's benefit plan.

BENEFIT PLAN	LOCAL PHONE NUMBER	TOLL-FREE PHONE NUMBER
Healthy U Medicaid	801-213-4104	833-981-0212
Healthy U CHIP	801-213-0525	833-404-4300
U of U Health Plans – Commercial	801-213-4008	833-981-0213
U of U Health Plans– Individual	801-213-4111	833-981-0214
Healthy Premier – U of U Hospitals & Clinics Plan	801-213-0274	833-443-3440

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, U of U Health Plans 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
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)
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

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

Measure	CPT II Code	Description
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

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 (U of U Health Plans) 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

U of U Health Plans have 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 for the member's benefit plan:

- Commercial Group and Individual/Family plans
- Healthy U Medicaid products
- Healthy U CHIP

REQUESTS FOR MAGNETIC RESONANCE IMAGING (MRI) SERVICES

U of U Health Plans 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: U of U Health Plans cannot determine medical necessity based on the MRI report alone.

MEDICAID OUTPATIENT HOSPITAL ADJUSTMENT FACTOR

Healthy U 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)

MEDICAID RATE DISPUTES

Participating providers receive an established payment amount for each service they render.

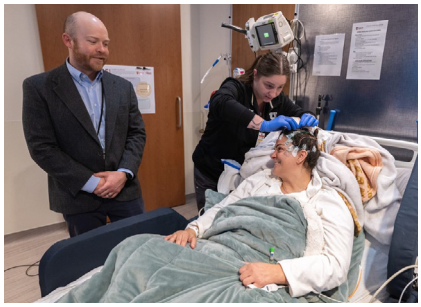
- **For commercial group, Individual/Family plans, and Healthy U Behavioral members** – This amount is determined by U of U Health Plans as is identified in their fee schedule rate exhibit.
- **For Healthy U Medicaid** – Unless otherwise specified in your provider contract, the amount is determined by the state and can be viewed in the fee schedule available on the PRISM Coverage and Reimbursement Lookup tool.
- **For Healthy U CHIP** – Unless otherwise specified in your provider contract, services covered by Medicaid can be viewed in the fee schedule available on the PRISM Coverage and Reimbursement Lookup tool. For services covered by CHIP, request these fees by emailing Provider Relations.

We receive a large number of payment rate disputes regarding Medicaid/CHIP plans with payment expectations based on contracts for commercial group and Individual/Family plans. Remember to consider to which type of plan your patient belongs and view the appropriate fee schedule for that plan prior to lodging a rate dispute.

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.

MEMBER RIGHTS AND RESPONSIBILITIES

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

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:

TYPE OF PLAN	LOCAL PHONE NUMBER	TOLL-FREE PHONE NUMBER
Healthy U Medicaid	801-213-4104	833-981-0212
Healthy U CHIP	801-213-0525	833-404-4300
U of U Health Plans – Commercial	801-213-4008	833-981-0213
U of U Health Plans– Individual	801-213-4111	833-981-0214
Healthy Premier – U of U Hospitals & Clinics Plan	801-213-0274	833-443-3440

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.

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.

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.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.

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.

Access and Availability Standards

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.

Access Standard:	Primary Care Provider	Specialty Care Provider	Behavioral Health Provider
	Within 2 days	Within 2 days	Within 48 hours (2 days)

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 and Medicaid and CHIP** – Includes school physicals
- **Medicaid and CHIP only** – Includes symptoms generally less intrusive and less serious than those requiring urgent care

Access Standard:	Primary Care Provider	Specialty Care Provider	Behavioral Health Provider
	Within 30 days	Within 30 days	» Initial visit for routine care within 10 business days » Follow-up routine care within 30 days

After-Hours Care (**Commercial and Individual/Family plans only**)

Offer after-hours care or provide directions on where to receive after-hours care

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

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**

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.

USE OUR PROVIDER DIRECTORY TO IDENTIFY YOUR NETWORK

In a recent U of U Health Plans survey, some of the respondents were unsure whether they were contracted with University of Utah Health Plans, or in which networks they participated. Easily Identify your U of U Health Plans networks by consulting our online provider directory (or click on "Find a Provider" at the top of every page on uhealthplan.utah.edu or uhealthplan.utah.edu/providers).

To begin, select a network from the drop-down arrow. If you don't know your network(s), our most common networks are Healthy Premier and Healthy U Medicaid. Next, enter your zip code and provider type, then click "Search Providers." On the resultant screen, you can refine your search by a variety of criteria.

Click on the correct provider's name to see their demographic details. In the "Additional Information" column, all of their contracted networks are displayed under "Network."

Now is a great time to look up the providers in your office to ensure all of their information is correct. Need to change anything? Complete and submit a Provider Information Update Form online or through your Provider Portal Local Administrator account. Be sure to complete all appropriate fields—like languages spoken or handicap accessible—to make your information as complete as possible with one update.

While you're updating your information, did you know you can also have a link to your practice's website displayed in our directory? Your patients (and our auditors) will appreciate having helpful, accurate information at their fingertips.

EXPANDING ACCESS TO MATERNAL SUPPORT: ADDING DOULAS TO HEALTH PLANS NETWORKS

As part of our ongoing efforts to improve maternal and infant health outcomes, we are excited to announce the addition of certified doulas to our commercial provider networks. Doulas are trained professionals who offer nonmedical advice, information, emotional support, and physical comfort to individuals during their pregnancy, labor, and postpartum periods.

WHY DOULAS?

Numerous studies have shown that doula-assisted births lead to improved maternal and infant health outcomes, including:

- Lower rates of preterm birth and low birth weight
- Reduced need for medical interventions, such as cesarean sections
- Higher satisfaction with the birthing experience
- Improved postpartum mental health and breastfeeding success rates

WHAT THIS MEANS FOR OUR MEMBERS

With the inclusion of doulas in our networks, members enrolled in our commercial benefit plans have access to these valuable services as part of their maternity care benefits.

HOW TO ACCESS DOULA SERVICES

Members can visit our Provider Directory to find a participating certified doula in their area. Additionally, our care coordination team is available to assist in connecting members with doulas who meet their needs and preferences.

LOOKING AHEAD

We believe every birthing individual deserves the highest level of support. To that end, this initiative represents a significant milestone in enhancing maternal healthcare services.

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.

HEALTHY U MEDICAID

DIABETES PREVENTION PROGRAM ENROLLMENT PILOT FOR MEDICAID

In conjunction with the One Utah Health Collaborative, U of U Health Plans 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

University of Utah Health Plans is pleased to join in the 2025 vaccination social media campaign, StayUpToDate, a joint initiative including Health Choice Utah, 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.

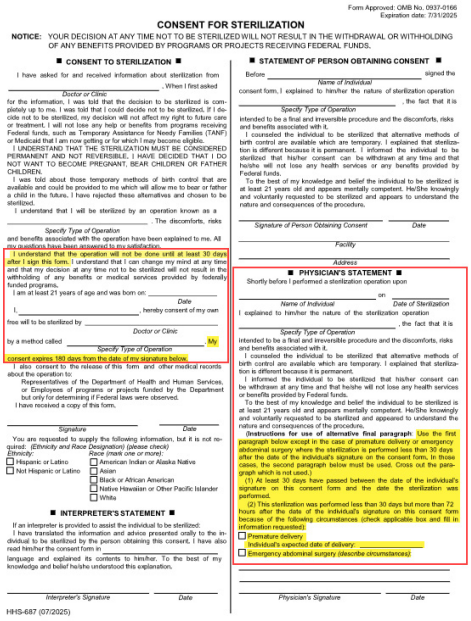
You can be a part of this effort by sharing content on social media. Visit StayUpToDate today.

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

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



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 _____ (Specify Type of Operation). My 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

HHS-687 (07/2025)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the _____ (Name of Individual) 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

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.

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 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.

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.

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 University of Utah Health Plans. 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.

RealRx 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 – Individual/Family plans – **855-869-4769**
- U of U Health Plans – Commercial groups – **855-859-4892**
- Healthy Premier - U of U Hospitals & Clinics Plan – **855-856-5690**

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**
- Healthy U CHIP – **833-404-4300**
- U of U Health Plans – Individual/Family plans – **833-981-0214**
- U of U Health Plans – Commercial group plans – **833-981-0213**
- Healthy Premier - U of U Hospitals & Clinics Plan – **833-443-3440**

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 – Individual/Family plans – **855-869-4769**
- U of U Health Plans – Commercial group plans – **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

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.

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

NEW POLICIES		
Policy Number	***Policy Name***	***Effective Date***
MP-045 (New)	Ketamine-Assisted Psychotherapy (KAP)	**04/16/2025**
Commercial Plan: U of U Health Plans may cover ketamine-assisted psychotherapy if certain criteria are met. Please see the policy for further details. U of U Health Plans does not cover the administration of ketamine in any form (IV, IM, nasal, oral, or sublingual) for the purpose of Ketamine-Assisted Psychotherapy (KAP), as it is considered investigational for psychiatric conditions at this time.		
MP-070 (New)	Sleep Studies	**03/22/2025**
Commercial Plan: U of U Health Plans covers certain sleep studies when specific criteria are met. Please see the policy for a list of coverage criteria.		
ADMIN-004 (New)	Experimental/Investigational Services	**03/22/2025**
Commercial Plan: U of U Health Plans does NOT cover Experimental/Investigational services that are not FDA approved, available scientific evidence does not support the intervention's beneficial impact on health outcomes, the intervention is not proven to be as safe or effective in achieving an outcome equal to or exceeding the outcome of alternative therapies, or the intervention is not proven to be applicable outside the research setting. Please see the complete policy for further specifications.		

REVISED POLICIES		
Policy Number	*Policy Name*	*Effective Date*
MP-001 (Revised)	Transcranial Magnetic Stimulation-Repetitive (rTMS)	02/04/2025
Commercial Plan: Health Plans changed the criteria of documented failure of "4 psychopharmacologic agent trials of adequate dose and duration (>4 weeks)" to "2 antidepressants trials of therapeutic dose and duration (>6 weeks).		
MP-004 (Revised)	Hypoglossal Nerve Stimulation and Other Devices for Sleep Apnea	02/19/2025
Commercial Plan: Health Plans made a couple of changes to the criteria for the hypoglossal nerve stimulators in adults with moderate-to-severe OSA. First the BMI was moved from ≤ 32 to ≤ 35 kg/m2 and secondly the age was lowered from ≥ 22 years to ≥ 18 years.		
MP-016 (Revised)	Infertility Testing and Treatment	01/22/2025
Commercial Plan: The addition of prolactin level labs for both males and females, along with the cryopreservation of gametes for members undergoing cancer treatment were added to the criteria.		
MP-046 (Revised)	Carrier Screening for Genetic Diseases	01/22/2025
Commercial Plan: U of U Health Plans added the condition "Hemoglobinopathies (sickle cell disease, thalassemias, and others)" as a covered criteria for carrier testing in pregnant individuals or those considering to become pregnant.		
MP-069 (Revised)	Serologic Testing for Liver Fibrosis	02/19/2025
Commercial Plan: The nomenclature was updated from "nonalcoholic fatty liver disease (NAFLD)" to "metabolic dysfunction-associated steatotic liver disease (MASLD)"		

REIMBURSEMENT POLICY UPDATES

NEW POLICIES
No new reimbursement policies at this time.
REVISED POLICIES
Not Applicable