PROVIDER CONNECTION

University of Utah Health Plans
Provider Publication
August 2024

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

U OF U HEALTH PLANS INTRODUCES BENEFIT PLAN FOR UNIVERSITY OF UTAH HOSPITAL & CLINICS EMPLOYEES

Effective July 1, 2024, U of U Hospitals & Clinics employees can select the Healthy Premier University of Utah Hospitals & Clinics Plan (Healthy Premier UUHC) for their insurance coverage. Employees can access the statewide Healthy Premier provider network for physical (medical) health care and the Huntsman Mental Health Institute (HMHI) Behavioral Health Network (HMHI BHN) for behavioral health care.

Q: Will U of U employees be required to only use University Hospital and University of Utah Medical Group providers?

No. Employees receive in-network benefits when they obtain physical health care from any provider contracted with the Healthy Premier network. If the member prefers, services can be rendered by out-of-network providers at the noncontracted benefit rate.

Q: Can U of U employees see an in-network Healthy Premier behavioral health provider?

Behavioral health (including mental health and substance use) services are managed through the HMHI Employee Assistance Program (EAP). In-network services are accessed through the HMHI Behavioral Health Network.

Q: If I have a prior authorization on file for a U of U employee (as my patient) with Regence Blue Cross Blue Shield of Utah (BCBSU), do I need to get a new authorization?

No. If the U of U employee changed their insurance coverage from Regence BCBSU to U of U Health Plans, we will honor all prior authorizations completed by Regence. We will receive a file of approved authorizations for U of U employees who have switched insurance coverage.

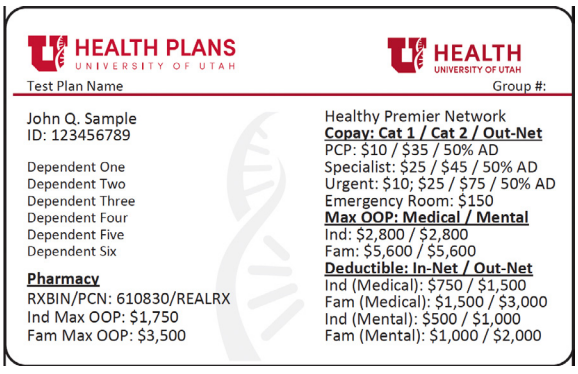
Q: How will U of U employees know who is in-network?

The Healthy Premier provider network is available via our online Provider Directory. A separate network called "Healthy Premier – U of U Hospitals & Clinics Employees" is available in the "Search by Provider Network" dropdown list. U of U Health employees should select this option as it includes physical health providers only.

For behavioral health providers, U of U Health employees can use the HMHI Provider Directory or contact the HMHI team at **801-587-9319** or **800-926-9619** to find an appropriate in-network provider.

Q: Will the ID Card indicate Healthy Premier University of Utah Hospitals & Clinics Plan?

Yes, through application of the U Health logo in the upper right corner on the front of the ID card.



U OF U HEALTH PLANS NOW CREDENTIALING HMHI BHN PROVIDERS

For many years, U of U Health Plans has administered claims for the Huntsman Mental Health Institute's (HMHI) Behavioral Health Network (BHN). We're very pleased to have recently been chosen as the credentialing agent for the Behavioral Health Network of mental/behavioral health professionals, effective June 1, 2024.

If you are a provider with HMHI BHN, your credentialing materials—when they come due—will come from U of U Health Plans rather than HMHI's BHN office. If you are a new provider with HMHI BHN, you will be contacted by U of U Health Plans if information is needed to complete your credentialing.

We rely on your CAQH® profile to gather much of the information necessary to complete your credentialing. To expedite credentialing/recredentialing activities, review (or establish) your CAQH profile today to ensure all information is current.

QUESTIONS?

- Review our Credentialing Process
- Email provider.credentialing@hsc.utah.edu
- Email HMHIBHN@hsc.utah.edu

DIRECTORY ACCURACY REQUIREMENT

Have you ever driven to a favorite restaurant only to find out it had moved? Or maybe arrived at that restaurant to find it no longer served your favorite dish? Similarly, it's frustrating for our members when they use the provider directory to find a participating provider, call for an appointment, and then learn the provider is no longer accepting new patients—even though the directory said they were. Or finding out when they arrive for their appointment that the office location has changed. The purpose of provider directories is to help members find the most appropriate in-network provider, at the right place. To do this, we rely on providers to keep their practice information up to date.

In addition, to help patients navigate health care, the Centers for Medicare & Medicaid Services (CMS) and, more recently the No Surprises Act, require that you keep your practice information up to date with every payer with which you contract. Please carefully read and share the information needed for your office to be compliant—as well as increase your patient satisfaction.

In 2016, CMS launched a multi-year study of provider directory accuracy[1]. The findings suggest that as many as 87.43% of practice locations across the U.S. displayed "egregious" errors that could impact health plan members' ability to receive in-network care. At that time, CMS implemented directory accuracy requirements that were codified in the federal No Surprises Act, effective January 1, 2022.

As inaccuracies in provider directories can create barriers to care for patients, provider directory accuracy is an important aspect of the No Surprises Act. The Act requires all healthcare providers and facilities to "maintain business processes to submit provider directory information at specified times to support plans and issuers in maintaining accurate, up to date provider directories."[2]

Providers and facilities must submit provider directory information to the health plan in any of the following circumstances:

- When there are material changes to the content of provider directory information
- When the provider or facility enters into a network agreement with the health plan
- When the provider or facility terminates a network agreement with the health plan
- At any other time (including upon the request of the health plan) determined appropriate by the provider, facility, or the Secretary of Health and Human Services (HHS)

University of Utah Health Plans is implementing a good-faith process to maintain accurate and up-to-date information in online and published provider directories. Our goal is to provide the most accurate data available in the timeliest manner.

HOW TO REVIEW AND UPDATE YOUR INFORMATION

Via our Provider Portal

- To review your Provider Directory listing(s), hover over or click on the "Office Management" tab, then click on the "Provider Directory" link in the drop-down menu.
- To make updates to the information listed in the directory, hover over or click on the "Administration" tab, then click on the "Provider Updates" link in the drop-down.

Via our Provider Website

- Review your practice's listing(s) in our Provider Directory. From the Network drop-down menu, choose one of the networks with which you are contracted.
- If any information is not current, submit corrections via our Provider Update Form.

Coming Soon: We're developing a Provider Directory Attestation tool to prompt providers to review their directory listings on a regular basis. More to come in the near future about an automated notification process.

Remember: Keep your clinic information up to date on CAQH to give payers access to your clinic's most current information. This helps us keep directories updated and streamline the verification process.

QUESTIONS?

Contact your Provider Consultant, or call our Provider Relations department at **833-970-1848** or **801-587-2838** or email provider.relations@hsc.utah.edu.

REFERENCES:

[1]Study of provider directory accuracy: Online Provider Directory Review Report. CMS. JAN 31 2018. Web. Accessed SEP 8 2022

[2]Maintain business processes to submit provider directory information . . . : The No Surprises Act's Continuity of Care, Provider Directory, and Public Disclosure Requirements. CMS. JULY 13 2022. Web. Accessed SEP 8 2022.

WHICH IS WHICH – PROVIDER WEBSITE VERSUS PROVIDER PORTAL

One of the most common comments we receive in our annual Provider Satisfaction Surveys is, "I never know whether I should look in the Provider Website or the Provider Portal for the information I need." It's a great question; and the answer will be pretty standard for most insurance payers with which you do business.

The easiest starting point is to determine if the information contains PHI.
Yes? Go to the Provider Portal.
No? Go to the Provider Website.

Here's an overview of what you'll find in each site.

Topic	Provider Website (No Login Needed)	Provider Portal (Login Required)
Contact information for questions about the Provider Portal		✓
Contact and general information for Provider Relations, Contracting, and Credentialing	✓	
Contact information for all U of U Health Plans Departments	✓	
Member eligibility, detailed benefits, year-to-date accumulators		✓
Services/Codes that require prior authorization	✓	✓
Prior authorization guidelines	✓	✓
Prior Authorization Request form	✓	✓
Responses to prior authorization requests		✓
Overview of Electronic Data Interchange (EDI) transactions	✓	
Review claims and payments (claims must be submitted via EDI or paper)		✓
Complete Compliance tasks		✓
Upload medical documentation		✓
View rosters of members whom you treat		✓
Correspond with Care Managers or Customer Service		✓
Update clinic or provider demographic information	✓	✓
Provider Directory search	✓	✓
Healthwise Knowledgebase and Code Lookup tools		✓
Educational resources, such as Clinical Practice Guidelines, Medical and Pharmacy Policies, Provider Manual, Provider Connection newsletter, and all forms that do not include PHI	✓	
Pharmacy information and formularies	✓	

Two important items that you will not find on either site:

- Medicaid eligibility – The state controls Medicaid eligibility files, therefore you must use the Medicaid Lookup Tool to view a member's eligibility. Remember, Medicaid enrollment can change from month to month, so it's important to check eligibility prior to every appointment.
- Huntsman Mental Health Institute's Behavioral Health Network – although U of U Health Plans processes claims for HMHI BHN, they are a separate entity; therefore, their membership files reside in a database not available via the Provider Portal. To check eligibility, benefits, or claims for HMHI's Behavioral Health Network, you must call their Customer Service team at **801-213-4008** option 3.

We're here to help you find the information you need. Feel free to reach out to us.

- Email Provider Relations: provider.relations@hsc.utah.edu
- Email Provider Portal: UofUHPProviderPortal@umail.utah.edu

PROVIDER SATISFACTION SURVEY WRAP-UP

We extend a hearty THANK YOU to the nearly 650 of you who responded to our 2024 Provider Satisfaction Survey. We're pleased to see the progress we've made year-over-year to address suggestions gathered from past surveys. We're in the process of reviewing results of this year's survey to develop new plans and goals based on your suggestions.

As expressed by Jen Muhlestein, Senior Director of Provider Network Development, "We very much appreciate the feedback, take your suggestions seriously, and are always looking for ways to improve so providers can focus on taking care of patients."

Watch for invitations next spring to take our 2025 Provider Satisfaction Survey and encourage others in your office to complete the survey, as well. Your voice helps us improve in those areas most important to you.

COORDINATE WITH OUR CARE MANAGEMENT TEAMS

Have you utilized our Care Management programs? The programs are designed to assist you in managing our members with multiple chronic conditions and comorbidities. We also offer programs that provide condition-specific interventions for those with chronic conditions including asthma, diabetes, and/or congestive heart failure.

Our Care Management programs offer members individual attention and online resources to help meet their healthcare goals. Services include education, advocacy, and coordination of members' needed services. Our care managers work with our members and their treating providers to help our members reach optimal health.

Our care managers are registered nurses and licensed clinical social workers. Reach out at any time to request assistance with managing your patient's overall healthcare services. The programs are available with no out-of-pocket cost for members interested in our care management services. To refer a patient, contact us at **801-213-4008**, option 2.

Learn more about available Care Management services.

COMPLETE AND ATTEST TO ADA ASSESSMENT TODAY

We are dedicated to ensuring our members have access to network providers. The Americans with Disabilities Act (ADA) standards are readily available to all providers. These requirements include appropriate physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. We include this information in our provider directories for each network provider listed. If you have not already submitted the Assessment and Attestation Tool for ADA Compliance this year, please complete this short survey as soon as possible.

HELPING MEMBERS WITH DIABETES SEE BETTER OUTCOMES

Everyone wants the best health outcomes for members with diabetes. Whether they have Type 1 or Type 2 diabetes, they are susceptible to microvascular complications such as diabetic retinopathy, which is often asymptomatic until the condition has progressed sufficient to exhibit damage. To monitor this risk and facilitate early intervention, a periodic dilated eye exam is recommended by state and federal organizations. The National Committee on Quality Assurance (NCQA) assesses health plans and providers annually to ensure important quality measures, including periodic diabetic eye exams, are being promoted, rendered, and tracked.

Quality scores in 2023, the most recent results available, show great opportunities to improve the rate of diabetic eye exams. Our measures across the various lines of business show the following compliance rates for eligible members:

Eligible Members Completing Dilated Eye Exam	2021	2022	2023
Healthy U Medicaid	50.12%	52.31%	56.45%
Healthy U Integrated	44.04%	47.45%	48.18%
U of U Health Plans Individual and Family plans	49.88%	56.51%	52.02%
U of U Health Plans Commercial Group plans	47.68%	49.79%	50.48%

For some of our benefit plans, less than half of eligible members with diabetes are receiving recommended diabetic eye exams. Our members, and all of your patients with diabetes, need your help to achieve the best outcomes.

Members may go to ophthalmologists, optometrists, or opticians for their eye exams. Oftentimes, however, the visit is not reported to their PCP or the claim doesn't adequately record the underlying condition or extent of service necessary to count toward the dilated eye exam quality measure.

WHAT IS U OF U HEALTH PLANS DOING?

Members on our commercial and Individual/Family plans have one eye exam covered annually as a preventive exam, regardless of the member's underlying diagnosis. This will hopefully encourage more members to seek annual eye care and, in the process, help us report more diabetic eye exams. To qualify, the exam must be a dilated eye exam and must be performed by an ophthalmologist or optometrist.

We are contacting our members with diabetes who are overdue for a retinal eye examination to encourage them to schedule an appointment for this important exam. A form is included for the member to bring to the appointment to help eye doctors report results back to the member's PCP.

HOW CAN PROVIDERS HELP MEMBERS AND, CONSEQUENTLY, IMPROVE THE DIABETES OUTCOMES MEASURE?

Primary Care Providers: Have a process in place that ensures your patients with diabetes have a diabetic eye exam each year, or every other year if the exam in the prior year was negative for retinal disease. Also, please remind your patients to inform their eye doctors of who is their PCP and to confirm that the eye doctor will send results of the exam to the PCP.

Ophthalmologists and Optometrists: Have a solid process in place to send diabetic eye exam results back to the patient's primary care provider. If a diabetic eye exam isn't in the primary care provider's medical record, even though the exam occurred, the eye exam cannot be counted in the quality measurement report.

Eye health has long-lasting impacts on quality of life. We appreciate your efforts to support our members' total health.

U OF U HEALTH PLANS NOW OFFERS "CHIP" BENEFITS

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

COVERED CHIP BENEFITS INCLUDE	
Well-child exams	Immunizations
Doctor visits	Hospital and emergency care
Prescriptions	Hearing and eye exams
Mental health services	

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

For more information, call **877-KIDS-NOW** (877-543-7669) or visit the CHIP website.

HEALTHY U MEDICAID

UTAH MEDICAID
STATEWIDE PROVIDER TRAINING 2024

Did you see these training opportunities from Utah Medicaid? It's not too late to sign up!

"Utah Medicaid will be offering the 2024 statewide provider trainings in an online live-webinar format. This year we are hosting a variety of trainings covering specific topics. Providers can sign up to attend multiple trainings. For each training, except UOIG, we will have a ten-minute presentation then will open it up for questions. As applicable based on the training, staff will present in the PRISM training environment to show steps and processes.

To register for the 2024 training, please complete the Google Form.

Previous statewide provider trainings are available on the Medicaid website. The 2024 trainings will be posted after the trainings conclude.

The following dates and times are scheduled for the 2024 Medicaid Statewide Provider Training. The duration of the training may be longer or shorter than indicated based on the number of questions asked during the training."

TRAINING DATES

Date	Time (MST)	Training
Tuesday, August 13	10:00 to 12:00	Claims and Billing
Wednesday, August 14	10:00 to 12:00	Provider Enrollment
Thursday, August 15	12:00 to 1:00	Pharmacy Program
Tuesday, August 20	10:00 to 11:30	Healthcare Policy for Hospitals, Outpatient, and Physicians
Wednesday, August 21	10:00 to 11:30	Healthcare Policy for Behavioral Health Providers
Thursday, August 22	10:00 to 11:30	Healthcare Policy for DME, Home Health, Private Duty Nursing, and Personal Care Service Providers
Tuesday, August 27	10:00 to 11:00	Managed Care
Wednesday, August 28	10:00 to 11:00	Dental Providers (Fee-for-service and Managed Care)
Thursday, August 29	10:00 to 11:00	Prior Authorization
Tuesday, September 3	10:00 to 11:30	Utah Office of Inspector General

Reprinted from:

Medicaid Information Bulletin: May 2024. 24-29.
https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Information%20Bulletins/Traditional%20Medicaid%20Program/2024/May2024-MIB.pdf

BALANCE BILLING MEDICAID MEMBERS PROHIBITED

Utah Medicaid is reporting an increase in balance billing referral cases to the Utah Office of Inspector General (OIG). Balance billing Healthy U Medicaid, or any other MCO member is in direct violation of your MCO or Medicaid contract.

The following statement is available in the Healthy U section of the U of U Health Plans Provider Manual: "Aside from state mandated patient responsibilities, such as copayments, coinsurance, and noncovered services, healthcare providers who agree to treat Medicaid patients, such as Healthy U members, are prohibited by Federal law from billing Medicaid patients directly for covered services. Additionally, providers should not bill Healthy U members for any amount in excess of the contractually agreed upon allowed amount paid by U of U Health Plans for covered services, and the provider must accept Healthy U's payment as payment in full. Failure to abide by state billing rules and regulations, and/or Healthy U Policies and Procedures, may result in the claim(s) being denied for payment. In such cases, the provider is prohibited from billing the member. Refer to the Utah Medicaid Provider Manual for additional rules and regulations."

We appreciate the services you provide our Healthy U members. If you have questions about this clause in your Healthy U or Utah Medicaid agreement, contact your Provider Relations consultant or a Medicaid representative.

REFERENCE:

Medicaid Information Bulletin: May 2024. 24-30.
https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Information%20Bulletins/Traditional%20Medicaid%20Program/2024/May2024-MIB.pdf

CHECKING 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 even 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, Colorado, New Mexico, Arizona, and Nevada – **800-662-9651**
  - From other states – **801-538-6155**

PRISM ENROLLMENT REQUIREMENTS

As we notified you in a special Medicaid edition of Provider Connection in February 2023, providers must be enrolled with Utah Medicaid prior to rendering service to ANY Medicaid member, **including Healthy U Medicaid, Healthy U Behavioral, Healthy U Integrated**, or other ACO-plan members. This requirement also applies to Healthy U CHIP members. Enforcing this rule ensures claims are processed appropriately. The PRISM-enrollment requirement includes ordering, referring, and prescribing (ORP) providers.

CLAIMS IMPACT

Claims for contracted providers who are not enrolled with PRISM **will be denied** by Healthy U Medicaid.

PROVIDER DIRECTORY IMPACT

Contracted providers who are not enrolled with PRISM **will not appear** in our Provider Directory.

QUESTIONS?

Utah Medicaid Provider Enrollment – Call **801-538-6155**, **800-662-9651** (option 3 then 4) or email providerenroll@utah.gov.

Healthy U Medicaid Provider Relations – Call **833-970-1848**, **801-587-2838**, or email provider.relations@hsc.utah.edu.

HEALTHY OUTCOMES MEDICAL EXCELLENCE (HOME)

University of Utah Health oversees a unique program for eligible Medicaid enrollees. The Healthy Outcomes Medical Excellence (HOME) program is designed to coordinate medical and mental health care for people with neurodevelopmental disabilities. Individuals enrolled in this program receive comprehensive, coordinated care services—focused on psychiatry, counseling, and primary care—in the HOME clinic.

The HOME clinic is an outpatient program in an outpatient clinic. This medical-home style of care offers neurodevelopmentally challenged Medicaid enrollees a welcoming, cohesive environment that eliminates many perceived barriers to care. The centralized-care clinic helps patients feel grounded in a familiar space without the complexities of navigating multiple locations and unfamiliar faces.

Take a look at how HOME can benefit your patients who may thrive in this unique program.

- View the Neurobehavior HOME Program Member Handbook
- Talk to a HOME Member Service representative at **801-585-1960**

REPORTING MULTIPLE SAME-DAY MENTAL HEALTH ENCOUNTERS

Following a recent Prepaid Mental Health Plan (PMHP) PRISM technical meeting, we received clarification on how to bill multiple mental health encounters on the same day for the same patient. The statements below are quoted directly from the communication received from the state. Please implement these guidelines into your billing processes.

Per-Encounter Procedure Codes				
90832	90834	90837	90839	90840
90833	90836	90838	96372	99211

"When a service is provided by the same provider more than once on the same day and the service is reported using a code with a per encounter unit of service, put all units on one line of the claim.

"The clinical documentation requirement is a progress note for each service. For audit purposes an auditor would see the separate progress notes in the medical record and that the total units reported are supported by the number of separate progress notes."

15-Minute Unit Codes					
90846	90847	90791	90792	90849	90853
H0006	H0031	H0038	H0046	H2014	H2017
H2019	H2027	H2032	S5150	T1017	

"When a service is provided by the same provider more than once on the same day and the service is reported using a code with a 15-minute unit of service, total up the units for each service and put the total number of units on one line of the claim.

"The clinical documentation requirement is a progress note for each service, including start and stop time and number of units. For audit purposes an auditor would see the separate progress notes in the medical record and that the total units reported are supported by the actual time and number of units reported with each progress note."

ADDITIONAL INFORMATION

Utah Medicaid Provider Manuals

- » Rehabilitative Mental Health and Substance Use Disorder (SUD) Services
- » Targeted Case Management for Individuals with Serious Mental Illness

Utah Medicaid Coding Tool

- » Utah Medicaid Lookup Tool

ADVANTAGE U (MEDICARE)

ADVANTAGE U CLAIMS 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**. Although we no longer offer Advantage U benefit plans, 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 **855-275-0374**
- Contracting and general questions – Provider Relations **801-587-2838**
- Part D Prescription Medications – contracted with CVS Caremark® . . . **888-970-0851**

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
06/01/2024	PYRIDOSTIGMINE BROMIDE ER 180 MG TAB ER	Uptiered from Preferred Generic to a Non-Preferred Generic	PYRIDOSTIGMINE BROMIDE 60 MG TAB	Commercial
06/01/2024	SUCRALFATE 1 GM/ 10ML SUSPENSION	Uptiered from Preferred Generic to a Non-Preferred Generic. Age Limit of 12 years of age added.	SUCRALFATE 1 GM TAB	All

CHECK CONTROLLED SUBSTANCE DATABASE PRIOR TO PRESCRIBING

DID YOU KNOW?

The Utah Controlled Substance Database program (CSD) is a prescription monitoring program that is a resource for you to identify potential cases of drug abuse and over-prescribing. However, many prescribers are not accessing this valuable resource.

REMINDER

According to Utah law, prescribers are required to check the database for information about a patient **before the first time** the prescriber gives a prescription to a patient for a Schedule II opioid or a Schedule III opioid.

If a prescriber is repeatedly prescribing a Schedule II opioid or Schedule III opioid to a patient, the prescriber must periodically review information about the patient in:

- The Controlled Substance Database
- Another similar record of controlled substances filled for the patient

For more information, view the Controlled Substance Database Act.

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."

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

NEW POLICIES		
Policy Number	***Policy Name***	***Effective Date***
MP-047 **(New)**	**Flicker Fusion**	**06/24/2024**
Commercial Plan: The policy outlines that U of U Health Plans considers critical flicker fusion (CFF) experimental/investigational for ALL indications as the effectiveness of this approach to assessing individuals has not been established in the clinical literature.		

Medical Policy Updates (continued)

REVISED POLICIES		
Policy Number	***Policy Name***	***Effective Date***
ADMIN-008 **(Revised)**	**Custodial/Respite Care**	**07/01/2024**
Commercial Plan: University of Utah Health Employee Plan members may have respite coverage available. Please refer to the U of U Health Employee Plan Summary of Plan Description (SPD) for further details.		
MP-005 **(Revised)**	**Balloon Dilation of the Eustachian Tubes**	**05/20/2024**
Commercial Plan: New coverage criteria added to the policy » A minimum trial of medical management needs to consist of at least 6 weeks; and » Temporomandibular joint (TMJ) disorders and chronic tympanic membrane perforation are contraindications for the procedure.		
MP-012 **(Revised)**	**Formulas and Other Enteral Nutrition**	**07/01/2024**
Commercial and Medicaid Plans: Clarification was made to the policy, outlining that enteral pumps and supplies are allowed when the patient/member is receiving feedings or hydration therapy via a jejunostomy tube, as j-tubes do not tolerate bolus fluid infusion.		
MP-029 **(Revised)**	**Vestibular Evoked Myogenic Potential (VEMP) Testing**	**07/03/2024**
Commercial Plan: Coverage policy now changed to allow coverage of vestibular evoked myogenic potential (VEMP) testing for the evaluation of individuals with suspected superior canal dehiscence syndrome (SCDS) when neuroimaging is inconclusive for that diagnosis. All other indications remain noncovered.		
MP-076 **(Revised)**	**Sacral Nerve Stimulation for Pelvic Floor Dysfunction**	**03/20/2024**
Commercial Plan: U of U Health Plans added onabotulinumtoxinA injections to the list of conventional therapies for urinary incontinence that need to be tried and failed before meeting criteria for a trial period of sacral nerve stimulation (neuromodulation).		

Reimbursement Policy Updates begin on next page

REIMBURSEMENT POLICY UPDATES

NEW POLICIES		
Policy Number	***Policy Name***	***Effective Date***
REIMB-008 **(New)**	**Miscellaneous Surgical Supplies - A4649**	**06/24/2024**

Commercial Plan:

U of U Health Plans considers the miscellaneous surgical supply code A4649 to be a bundled code into the service performed and will deny the line when it is not designated to be billed separately through the Hospital Outpatient Prospective Payment System (OPPS) guidelines.

REVISED POLICIES		
Policy Number	***Policy Name***	***Effective Date***
REIMB-009 **(Revised)**	**Preventive Care Screening**	**04/28/2024**

Commercial Plan:

Changes to the policy include:

- Addition of coverage for an annual 1-year subscription to the new fertility app (Natural Cycles®), which can be used as a method for birth control, has been added to the policy for women 18 years of age or older; and
- Modifications to guidance on coverage of anxiety testing based on new guidelines determined by the USPSTF.

Please see the member's individual Summary of Plan Description (SPD) for confirmation of specific preventive service coverage.