



PROVIDER CONNECTION

University of Utah Health Plans
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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 every 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

NEW SECURE PROVIDER PORTAL NOW AVAILABLE TO ALL PARTICIPATING PROVIDERS

We're pleased to announce the successful launch of the new, secure University of Utah Health Plans Provider Portal. The new portal replaces our previous secure portal, Link, to provide streamlined access to members' insurance information.

Within the coming weeks, we'll open registration opportunities to all participating provider clinics and facilities.

The Provider Portal offers providers contracted with U of U Health Plans networks a secure website to perform the insurance tasks you use the most. View member eligibility, claims, and remittance advices; submit and review prior authorization requests and documentation; and send secure messages to Customer Service through one easy-to-use online portal.

With Provider Portal, you can conduct your business at the time most convenient for your office. And, you can view information about any U of U Health Plans or Advantage U Medicare member with whom your office has a current or scheduled treatment relationship.

REGISTERING FOR THE PROVIDER PORTAL

For security purposes, choose who in your office should be the "gate keeper" to grant access to other users. This person will be the Local Administrator and should be the first person to register.

1. Visit [University of Utah Health Plans Provider Portal](#)
2. At the bottom of the Provider Login box, click **"Register Here"**
3. Complete the **"User Information"** form
 - i. Choose your own User Name and Password
 - ii. On the second screen, complete all information—including your Tax ID number and the name of the health plan for which you're registering.

Once the Local Administrator registers and receives their confirmation email, they are responsible to add additional Local Administrator(s) and User(s), as appropriate. In accordance with current HIPAA guidelines to ensure the security of your patients' personal information, only personnel who actively work with the information available in the portal should have access.

Note: If you work in an office that might have multiple portal users, please consult with the office or billing manager to learn who is, or should be, the Local Administrator. If there is already a Local Administrator in place, they will be able to obtain access credentials for you.



OPPORTUNITIES

In addition to you being able to review information about your patients, your patients would also like to view information about your clinic. If you have a clinic website you'd like us to publish in our online directories, please submit the web address (URL) via our [Provider Information Update Form](#).

This is also a good time to review your providers' information listed in our [online directory](#). You can update any incorrect or missing information on the same Provider Information Update Form.

Be sure to indicate whether your office is handicap accessible. Marking this as either "Yes" or "No" is required for practices accepting Medicaid or Medicare Advantage members (i.e., Healthy U and Advantage U).

QUESTIONS?

- » For help submitting your request or navigating the portal, email UofUHPPProviderPortal@umail.utah.edu.
- » For help logging in, call our Technical Support Desk at **877-814-9909**.
- » For general information about the Provider Portal, call or email Provider Relations at **801-587-2838**, **833-970-1848**, or provider.relations@hsc.utah.edu.

MAKE FAXING LESS TAXING

We get it. When you're in a hurry, you just want to do the task and be done. However, one-and-done isn't always a time saver. Faxing documentation to a payer is a prime example.

Please be aware that, whether received as paper or electronic files, there are size limits on your fax uploads. Faxes of more than 999 pages create a digital error that prevents the entire file from being downloaded into its proper system (such as appeals or prior authorization requests). Here are a few suggestions to avoid delays related to your documentation.

- » Verify the number to which you are faxing is secure and will arrive in the correct department.
- » Break large files into smaller faxes; to be safe, aim for no more than 900 pages per fax.
- » Attach a cover sheet to **each** fax file, identifying the claim or prior authorization number, the provider's name, contact name, phone, and email/fax.
- » Indicate on the cover sheet that this is a multi-part fax (e.g., "Pages 901 to 1,054" or "Part 1 of 3").
- » Check your fax-sent/received notices to ensure the correct number of pages were sent and that the transmission completed successfully (as opposed to an error message).



AVOID LAST-MINUTE PRIOR AUTHORIZATION REQUESTS

Increasingly, we receive prior authorization requests immediately prior to the scheduled procedure date. We understand the myriad reasons this happens, such as unexpected staffing shortages, unexpected volume of patients, or unexpected time needed with several patients. As a result, submitting prior authorization requests can get overlooked. These requests, however, are important steps to ensure certain procedures and services are covered by your patient's benefit plan.

Every prior authorization request we receive is reviewed for medical necessity and benefit coverage by a qualified professional. Depending on the proposed service, and whether complete documentation is received with the request, it can take up to 15 calendar days for a request to be reviewed and a determination reached. If a prior authorization request is denied, and the service was performed or supply delivered before the request was reviewed, you and/or the patient would be financially liable for the expense.



Expedited prior authorization requests are defined as “medical services that are needed in a timely or expedited manner that would subject the member to adverse health consequences without the care or treatment requested.” Requests will not be expedited because the decision to treat a non-urgent condition was made the day before surgery, or because the person responsible to obtain prior authorization requests in your facility delayed submitting the request in a timely manner. Documentation is required with the request to evaluate if the request meets the above definition of medical urgency. As documented in several places throughout our materials, University of Utah Health Plans reserves the right to classify expedited requests as standard requests when this definition is not met.

Don't risk having a procedure denied for no prior authorization. We've included the following tools on our [Provider Website](#):

- » Lists of procedures, services, and supplies or medications requiring prior authorization
- » A link to submit the request online
- » Links to facility-specific request forms to fax
- » Fax numbers for the departments that review requests
- » And, if you are registered for our secure [Provider Portal](#), submitting a prior authorization request is that much easier (refer to the cover article in this edition for more information about the Provider Portal)

We are eager to support you in providing our members with the care they need. Please take a few moments to review with your staff the prior authorization tools available.

NEW POST-SERVICE CLAIMS PROCESS FOR MEDICAL DOCUMENTATION

Effective August 1, 2022, U of U Health Plans is implementing the following process changes to post-service claims that require additional documentation for medical review.

Post-service claims that require medical decision making, and additional documentation to perform a review, will deny for "Missing Documentation/Orders/Notes/Summary/Report/Chart (MDOC)."

- » The Remittance Advice(s) and Explanation(s) of Benefits will display Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) informing providers that medical records are needed.
- » The denial reason code will be **252** *"Attachment/Other Documentation Is Required to ADJ"* or **M127** *"Missing patient medical record for this service."*

Note: These denial reason codes will allow providers to submit the documentation without a member consent form. Providers must attach the [Clinical Documentation Submission Form](#) when submitting additional documentation for these denied claims, and fax the completed form to the applicable U of U Health Plans department:

- » Medical claims—**801-587-4813**
- » Pharmacy claims—**801-213-7545**

Once the additional documentation is received, U of U Health Plans will review the information and make determination for medical necessity.

Note: Documentation must be received within the benefit plan's timely claim filing period to be considered for medical necessity review.

- » If services are approved, the claim will be paid.
- » If denied as not medically necessary or for lack of timely filing, appeal rights are maintained and the provider—on behalf of the member—can appeal and submit additional documentation for review by including a signed member consent form.

We anticipate this process will significantly expedite the review process and reduce denials due to lack of medical documentation.



UPDATED PRIOR AUTHORIZATION FOR CPAP, BIPAP/ASV DEVICES

University of Utah Health Plans is updating documentation and prior authorization requirements for Continuous or Bilevel Positive Airway Pressure (CPAP or BiPAP)/Adaptive Servo Ventilation (ASV) therapy.

- » Effective September 1, 2022, we will require prior authorization for initial and continued requests for noninvasive airway assistive devices and associated supplies. This includes CPAP, BiPAP, and ASV.
- » Requests for new (initial) noninvasive airway assistive devices must be submitted with clinical documentation that supports the medical need for the device, including a recent sleep study.
- » Requests for continuation of services must include a compliance report demonstrating the member is appropriately using the device.

To maximize the efficiency with which your prior authorization requests are processed, please keep in mind the importance of always submitting sufficient clinical documentation to review the request.

KIDNEY HEALTH – NCQA STANDARD FOR TESTING

The National Committee for Quality Assurance (NCQA) updates effectiveness measures every year in order to stay current with recognized health-quality standards.

DID YOU KNOW?

According to the [July 16, 2020 NCQA blog](#), “Kidney disease affects 37 million American adults, but 90 percent are unaware they even have it.” To counter this astonishing statistic, NCQA retired the Healthcare Effectiveness Data and Information Set (HEDIS) measure “Comprehensive Diabetes Care – Medical Attention for Nephropathy.” The retired measure is replaced by Kidney Health Evaluation for Patients with Diabetes (KED).

The KED measure tracks the “percentage of members 18–75 years of age with type 1 or type 2 diabetes who received a kidney health evaluation, defined by an **estimated glomerular filtration rate (eGFR)** and a **urine albumin-creatinine ratio (uACR)**, during the measurement year.” The Centers for Medicare and Medicaid Services (CMS) will report the measure on its 2022 star ratings display page and consider adding it to Star Ratings in the future.

WHY IT'S IMPORTANT

As this measure is being monitored by CMS, it may affect STARS scores—which can influence provider reimbursement. You can impact this measure by at least annually assessing eGFR and uACR. Remember, it must be done at least once during the measurement year (January to December) to meet the measurement standard.



QUALIFYING KIDNEY-HEALTH TESTING AND ASSOCIATED BILLING CODES:

Estimated Glomerular Filtration Rate (eGFR)			
CPT CODES	DESCRIPTION	CPT CODES	DESCRIPTION
80047	Basic metabolic panel (Calcium, ionized)	80053	Comprehensive metabolic panel
80048	Basic metabolic panel (Calcium, total)	80069	Renal function panel
80050	General health panel		

Urine albumin-creatinine ratio (uACR)	
CPT CODES	DESCRIPTION
82043	Urine microalbumin
82570	Urine creatinine

It is important to note that eGFR is a calculated value and is included in the various panels listed above by nearly all laboratories performing these tests. Please make sure it is included in the panels you obtain.

As previously mentioned, of the 37 million American adults affected by diabetic kidney disease, 90 percent of them are unaware they even have it. Of that 90 percent, approximately half have advanced kidney disease. Identifying patients with diabetic kidney disease can help improve the health of your patients and prevent patients from moving on to end-stage renal disease, dialysis, or even renal transplants. We hope you'll partner with us to identify and care for those who otherwise may progress to needing dialysis or a transplant to survive. Two simple tests can make a huge difference.

ADDITIONAL INFORMATION

- » Visit [ncqa.org/kidney-health-toolkit](https://www.ncqa.org/kidney-health-toolkit) to access the Kidney Health Toolkit with several helpful aids, posters, pamphlets, and PDFs to engage with your patients about kidney health.
- » Learn more about [Talking With Your Patients About CKD](#).

REFERENCES

"Kidney Health: A New HEDIS Measure." NCQA BLOG. National Committee for Quality Assurance (NCQA). <https://blog.ncqa.org/kidneyhealth/>. 21 June 2022.

"Leading the way to advance early diagnosis of chronic kidney disease." CKDIntercept: Laboratory Engagement Plan. National Kidney Foundation. <https://www.kidney.org/CKDintercept/laboratoryengagement>. 21 June 2022.

COMPLETE AND ATTEST TO ADA ASSESSMENT TODAY

We are dedicated to ensuring our members have access to network providers who comply with Americans with Disabilities Act (ADA) standards. These requirements include appropriate physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. We include in our provider directories this information 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.

IS IT TIME FOR A CULTURAL COMPETENCY REFRESH?

Cultural Competency training for health professionals has increased in relevance as our population becomes increasingly diverse. Knowing how to communicate with your patients and coworkers is critical to optimal outcomes.

An [article in PubMed Central](#), a publication from the National Library of Medicine, asserts that “Physicians who are aware of their own and their patients’ cultural backgrounds, along with the values that are often implicit in current medical models, are better able to achieve mutual understanding within the patient encounter and to focus on culturally appropriate health care interventions.”



We have created a [short training presentation](#) to provide your office with important information, tips for improved communication and service, and provider and office responsibilities. In-service or other staff meetings provide a great opportunity to review culturally appropriate communication techniques, as well as provider and office responsibilities to ensure your patients are understanding the care you provide.

If it's been a while, schedule a few minutes in the near future to ensure patients continue to feel welcome and respected in your office.

REFERENCE:

“Cross-cultural communication: Tools for working with families and children.” PubMed Central. National Institutes of Health. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5815116/>. 21 June 2022.

NEW LOOK FOR PROVIDER EDUCATION SUMMIT

The Provider Education Summit offers provider office staff the opportunity to meet face-to-face with representatives from major payers and suppliers in one convenient location. New this year, the Utah Health Information Network (UHIN) will combine the summit with their Health Information Technology (HIT) Conference in a single event. Scheduled for **November 10, 2022** at the Salt Lake City (downtown) Marriott, the conference will include:

- » A variety of topics related to HIT
- » The always-popular Payer Panel
- » Important presentations from previous summits
- » Payer presentations regarding utilization management (e.g., case management, care management, quality programs)

The single location on a single day will allow for a larger networking event, greater access to keynote sessions, and possibly CEU credits for attendees. The conference will be offered as a hybrid event where many sessions and keynotes will be available online as well as in person.

Watch for more information coming from UHIN, or visit uhin.org to learn more and register.

IMAGING FOR LOW BACK PAIN: WHY IT MATTERS

How often do you evaluate a patient with low back pain? According to an NCQA article, “Approximately 2.5 million Americans visit outpatient clinical settings for low back pain each year.” Often, the first course of treatment is to send the patient for imaging even when there is no indication of an underlying condition. Current HEDIS scores indicate that Utah ranks well above the national average in imaging (X-ray, CT scans, and MRI) for low back pain.

Not only does unnecessary imaging possibly expose your patient to needless radiation, evidence indicates routine imaging for low back pain “is not associated with improved outcomes.” For most patients with low back pain, symptoms will improve within the first two weeks without imaging or additional treatment. Therefore, the clinical practice recommendation is that imaging should not be done for low back pain within the first six weeks unless there is concern of a serious underlying condition.

While there are many situations where imaging is appropriate, NCQA offers this reminder: “Avoiding imaging for patients when there is no indication of an underlying condition can prevent unnecessary harm and unintended consequences to patients and can reduce healthcare costs.”

We appreciate your efforts to ensure our members, indeed all of your patients, are not subjected to the potential harms and financial burden of needless imaging for any condition.

Learn more from the American Academy of Family Physicians: [Imaging for Low Back Pain](#).

REFERENCE

“Use of Imaging Studies for Low Back Pain.” HEDIS Measures and Technical Resources. NCQA.

<https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain>. 22 June 2022.

COORDINATE WITH OUR COMPLEX CARE AND DISEASE MANAGEMENT TEAMS

Have you utilized our Care Management programs for Complex Care Management and Disease Management for members with asthma 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 the treating provider and/or PCP to help our members reach optimal health.

Reach out to our care managers 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 nursing services. To refer a patient, contact us at **801-213-4008**, Option 2.

Learn more about available [Care Management services](#).

GATE UTAH: CONNECTING THE PATH BETWEEN MEDICAL AND MENTAL HEALTH CARE

U of U Health Plans partners with Huntsman Mental Health Institute to offer a web-based system for PCPs to consult with a psychiatrist about members' behavioral health concerns. Pioneered by a group of physicians in the Division of Child Psychiatry at the University of Utah, Giving Access to Everyone (GATE) Utah is an innovative program that aims to "improve access to mental health services, improve collaboration between primary care physicians and mental health professionals, and enhance knowledge of how to manage mental health conditions in the primary care setting." Visit gateutah.org today for information for providers and members.

HEALTHY U MEDICAID

REMIND MEDICAID MEMBERS TO UPDATE STATE CONTACT INFORMATION

At the beginning of the COVID-19 pandemic, the federal government issued a Public Health Emergency (PHE) allowing for continuous coverage of Medicaid without requiring beneficiaries to complete an annual review. The PHE may end later this year, which means Medicaid needs current beneficiary information on file to resume the annual reviews. We need help making sure eligible beneficiaries do not lose their Medicaid coverage when the PHE ends.

WHY IT MATTERS

Uninsured people are markedly less likely than Medicaid beneficiaries to get care, and significantly more likely to [delay or go without needed care](#), according to data from the Kaiser Family Foundation. Reminding patients to update their contact info with Medicaid helps ensure these patients have continuity of care. It's a chance to show concern and empathy for the patient and to build the doctor/patient relationship.

Additionally, payment for services provided to Medicaid beneficiaries is sent directly to provider offices. If a Medicaid member's eligibility is not renewed, you may no longer see that patient or be faced with trying to recoup payment for their uninsured services.

HOW YOU CAN HELP

Providers and frontline staff can encourage all Medicaid patients to update their contact information with the Department of Workforce Services (DWS), especially if the patient has moved within the last two years. This ensures that DWS can contact them when it's time to complete their review. To update their contact info, Medicaid patients can call DWS at **866-608-9422** or visit jobs.utah.gov/mycase.

REFERENCE

"Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid." KFF Medicaid Issue Brief. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid>. 29 June 2022.

BEHAVIORAL HEALTH CRISIS AND TELEPHONIC CARE ACCESS STANDARDS

The following is a correction to an article that appeared in a previous edition of Provider Connection.

Members of Healthy U Behavioral, as well as all members of the Healthy U community, have access to crisis response programs to provide immediate behavioral therapy—even if their established behavioral health professional is not available.

1. **Initial Screening** – If it appears patients need emergency behavioral health therapy care, the provider practice should conduct an initial screening **within 30 minutes of the patient’s call** requesting emergency care.
2. **Face-to-Face Visit** – Following the telephonic emergency care assessment, if the provider determines **the patient needs emergency services**, the provider should arrange **a face-to-face visit within an hour**.
3. **Following the telephonic emergency care assessment** – If the provider determines the patient needs **urgent care**, the provider should arrange a **face-to-face visit within 5 days**.

The following options are provided by the HMHI 24 hours a day, 365 days a year:

- » **HMHI CrisisLine** – **800-273-8255** – Crisis intervention and suicide prevention
- » **HMHI WarmLine** – Triaged through the CrisisLine – Noncrisis support by Certified Peer Specialists offering engagement, a sense of hope, and self-respect
- » **HMHI Receiving Center** – Triaged through the CrisisLine – Therapeutic crisis management, assessment, and discharge planning in a short-term setting (up to 23 hours)

For Immediate Outpatient Assessment and Stabilization – Call our dedicated Advanced Practice Registered Nurse (APRN) at **801-585-1212**, 24 hours a day, 365 days a year.



There are currently no new updates for Advantage U, but we’re always available to answer your questions:

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 **833-970-1848**
- » 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 site](#) at least quarterly to view the most recent information.

PHARMACY UPDATES

FORMULARY UPDATE: TERIPARATIDE REPLACING FORTEO AS PREFERRED

Effective October 1, 2022, FORTEO® 600 MCG/2.4ML soln. pen will no longer be covered on the Commercial, Individual/Family or Healthy U formularies. Due to significantly increased cost-effectiveness, the preferred alternative is **Teriparatide** (recombinant) 620 MCG/2.48ML soln. pen. This change aligns the formulary with the prior authorization policy. Despite its generic name, **Teriparatide** (recombinant) is considered a brand name medication in the formulary. It is not interchangeable with Forteo. Members who currently use Forteo will receive a letter to notify them of this change.

UPDATE TO ONLINE PRIOR AUTHORIZATION SUBMISSION TOOL

The 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."

REMINDERS

The preferred/non-preferred medications for autoimmune diseases for Healthy U members were updated on June 1, 2022. These changes apply only to new starts. The updates are listed below and are also [posted online](#).

Disease State	First line preferred	Second line preferred; after trial and failure of one first-line agent	Non preferred; requires trial and failure of one first-line and two second-line agents
Rheumatoid Arthritis	Preferred infliximab products and preferred rituximab products	Actemra®, Cimzia®, Humira®, Kevzara®, Olumiant®, Orencia®, Xeljanz®/XR	Enbrel®, Kineret®, Rinvoq®, Simponi®
Ankylosing Spondylitis	Preferred infliximab products	Cimzia, Humira, Taltz®, Xeljanz/XR	Enbrel, Cosentyx®, Simponi
Psoriasis	Preferred infliximab products	Cimzia, Humira, Otezla®, Taltz	Cosentyx, Enbrel, Ilumya®, Siliq®, Stelara®, Skyrizi®, Tremfya®
Psoriatic Arthritis	Preferred infliximab products	Cimzia, Humira, Orencia, Otezla, Taltz, Xeljanz/XR	Cosentyx, Enbrel, Rinvoq, Simponi, Skyrizi, Stelara, Tremfya
Crohn's Disease	Preferred infliximab products	Cimzia, Entyvio®, Humira	Stelara

Updates to preferred/non-preferred medications for autoimmune diseases for Healthy U members, continued from page 12:

Disease State	First line preferred	Second line preferred; after trial and failure of one first-line agent	Non preferred; requires trial and failure of one first-line and two second-line agents
Ulcerative Colitis	Preferred infliximab products	Entyvio, Humira, Xeljanz/XR	Simponi, Stelara
Juvenile Idiopathic Arthritis	Preferred infliximab products, Actemra, Orencia	Humira, Xeljanz/XR	Enbrel
Hidradenitis Suppurativa	Preferred infliximab products	Humira	

- » **Effective July 1, 2022**, Cosentyx is no longer covered and Taltz is the preferred medication for Commercial and Individual/Family members. Members currently on Cosentyx were notified of this change and encouraged to discuss with their provider whether conversion to Taltz is appropriate for them. Providers may consider a loading dose when switching members from Cosentyx to Taltz.
- » Upcoming changes to the formulary are placed on the [Pharmacy website](#) for review.
- » 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. The link for Pharmacy Medication Use Policies is on the left side of your screen. Bookmark these links in your internet favorites for quick access to submit pharmacy prior authorization requests.
- » Formulary updates for retail and specialty pharmacy medications may be viewed on the [Preferred Drug List \(PDL\)/Formulary](#). 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.

MEDICAL AND REIMBURSEMENT 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
	No New Medical Policies	
REVISED POLICIES		
Policy Number	Policy Name	Effective Date
MP-019 (Revised)	Invasive Procedures for the Treatment of Glaucoma	07/18/2022
Commercial Plan: After reviewing new and updated literature, U of U Health Plans now covers the Hydrus® Microstent when specific criteria are met. Please see the policy for details.		

REIMBURSEMENT POLICY UPDATES

NEW POLICIES		
Policy Number	Policy Name	Effective Date
Reimb-010 (New)	Home Health Aide Services	05/23/2022
Commercial Plan: U of U Health Plans may cover certified home health aide services, if coverage is specified in the member's contract and certain criteria are met. Please see the policy for specific details.		
Reimb-021 (New)	Modifiers -54, -55, -56	08/09/2022
Commercial Plan: This policy outlines the circumstances for which modifiers -54, -55, and -56 are reimbursed and the associated reduction in fee schedule when circumstances of their billing meets CMS guidelines for coverage, in addition to demonstrating invalid procedure code split modifier combinations. Please see the policy for details.		
REVISED POLICIES		
Policy Number	Policy Name	Effective Date
Reimb-014 (Revised)	Modifier -25	08/01/2022
Commercial Plan: After reviewing new and updated literature, U of U Health Plans will recognize modifier -25 if the medical record demonstrates appropriate documentation to specifically support both the E/M and other services as separately identifiable services based on AMA CPT CCI coding guidelines. Please see the policy for specific details.		