PROVIDER CONNECTION

University of Utah Health Plans
Provider Publication
May 2023

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.**

INSIDE THIS EDITION

HEALTH PLANS
UNIVERSITY OF UTAH

To return to this page, click on "Provider Connection" at the top of any page.

NEW PHONE TREE OPTIONS

Did you notice our new phone options? In mid March, we updated the Provider Relations phone options to better route the calls we receive. When calling our Provider Relations phone number, **801-587-2838** or **833-970-1848**, choose from the following options to be connected with the assistance you need:

Option	Department
1	Claim status, eligibility, and benefits
2	Provider Relations
3	Provider Credentialing
4	Provider Contracting
5	Mountain Health CO-OP Provider Relations†
6	Provider Portal

† University of Utah Health Plans is the third-party administrator for Mountain Health CO-OP in Idaho, Montana, and Wyoming.

If you prefer, email your question to us and we'll respond as soon as possible.

Department	Email Address
Claim status, eligibility, and benefits	N/A
Provider Relations	provider.relations@hsc.utah.edu
Provider Credentialing	provider.credentialing@hsc.utah.edu
Provider Contracting	providercontracting@hsc.utah.edu
Provider Portal	uofuhpproviderportal@hsc.utah.edu

COMMUNITY ASSISTANCE FOR YOUR PATIENTS

HAVE YOU HEARD ABOUT "FINDHELP"?

Findhelp powers a free digital network, called **findhelp.org**, where people can search for and connect to social care programs quickly and easily. The **findhelp.org** network makes it easy for people to connect with resources, and for the organizations offering these programs to follow up with care. Providers or their patients can visit findhelp.org to see food programs, housing assistance, health resources and more—all just a click away. Their network includes thousands of verified organizations dedicated to helping people in every community in America, including yours.

ANNUAL NOTICES

DOCUMENTING BLOOD PRESSURE READINGS TO SUPPORT HEDIS PERFORMANCE

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

MEASURE DEFINITION

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

This measure includes all of our health product plans for Commercial groups, Individual and Family plans, Healthy U Medicaid, and Advantage U (Medicare PPO).

TIPS FOR DOCUMENTING BLOOD PRESSURE READINGS

- Record all blood pressure readings. If a patient with hypertension has a BP reading above 140/90 mm HG on any given visit, take the blood pressure again, before the patient leaves the office, to see if the pressure decreases. Record both readings.
- Patient-reported blood-pressure readings from any digital device are acceptable, as long as the BP reading is documented in the patient's medical record.
- The patient is "non-compliant" if there is no BP reading documented during the year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).
- A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. Ranges and thresholds do not meet compliance criteria for this measure.

Examples:

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

BEST PRACTICES FOR IMPROVING HEDIS SCORES

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

CODING BLOOD PRESSURE AND HYPERTENSION

Description	Codes
Hypertensive Diseases – Controlled and Uncontrolled*	ICD-10: I10 to I15
Outpatient Visit Codes	CPT: 99202 to 99205, 99211 to 99215, 99241 to 99245, 99347 to 99350, 99381 to 99387, 99391 to 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483, 99341 to 99345 HCPCS: G0402, G0438, G0439, G0463, T1015**

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

** In the HCPCS codes listed for Outpatient Visit Codes, the **Gxxxx** codes apply to Advantage U (Medicare) claims only, and **T1015** applies only to Healthy U (Medicaid) claims.

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

APPOINTMENT ACCESS STANDARDS

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

The following Appointment Access Standards are established in our Provider Manual. Please review these standards with the appropriate staff and incorporate any changes to your business practices as may be warranted.

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, and Advantage U (Medicare)** – Not life-threatening » **Medicaid** – 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** Within 2 days	**Specialty Care Provider** Within 2 days	**Behavioral Health Provider** 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** – Includes school physicals » **Medicaid only** – Includes symptoms generally less intrusive and less serious than those requiring urgent care.			
Access Standard:	**Primary Care Provider** Within 30 days	**Specialty Care Provider** Within 30 days	**Behavioral Health Provider** » 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			
In Need of Medical Attention (Advantage U Medicare) Not urgent or emergent services, but in need of medical attention.			
Access Standard	**Primary Care Provider** Within 1 week	**Specialty Care Provider** Within 1 week	

Note: Medicaid members must be offered appointments during the same hours of operation offered to commercial members or Medicaid FFS 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.

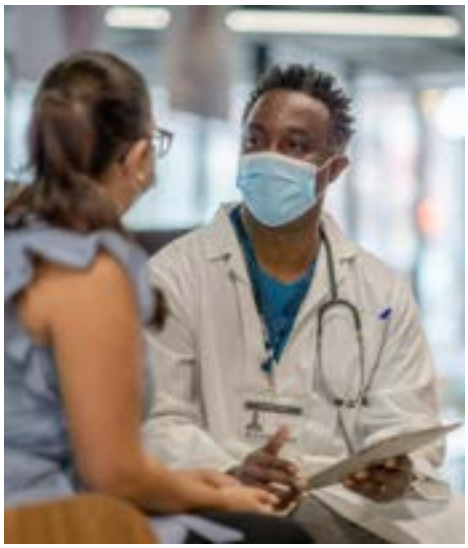
The provider's telephone system must be sufficient to manage the volume of calls coming into the office.

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

MEMBER RIGHTS AND RESPONSIBILITIES

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

WHAT ARE MEMBER RIGHTS?



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

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

Plan Name	Wasatch Front	Toll-free
Healthy U - Medicaid	801-213-4104	833-981-0212
Commercial groups	801-213-4008	833-981-0213
Individual and Family plans	801-213-4111	833-981-0214
Advantage U (Medicare)	801-893-6645	855-275-0374

WHAT ARE MEMBER RESPONSIBILITIES?

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

- 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.
- 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.
- Understand member's health problems, work with member's provider to develop agreed upon treatment goals, and do all members can to meet goals.
- Keep appointments or let the provider's office know as soon as possible if member can't make it.
- Supply information needed to Health Plans and to treating providers in order to provide care.
- Let the group administrator know if member moves, changes phone number, gets married or divorced, has a baby, or someone in the family dies.
- Respect the staff and property at their provider's office.
- Stay fit and well by taking care of themselves and their family.
- 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.

REPORTING BEHAVIORAL HEALTH CARE COORDINATION

Recognizing that mental health is an integral part of a person's overall health, we encourage PCPs and behavioral health professionals to coordinate care of at-risk individuals. To facilitate integrated care coordination, we cover the following services:

COVERED BEHAVIORAL HEALTH CARE COORDINATION CODES		
CPT	**Brief Description**	**Limitations**
99483	Assessment of and care planning for a patient with cognitive impairment	One per month
99484	Care management services for behavioral health conditions	One per month
99492	Initial psychiatric collaborative care management	One per member per lifetime per clinic
99493	Subsequent psychiatric collaborative care management	One per month
99494	Initial or subsequent psychiatric collaborative care management	One per month – Can only be billed in conjunction with 99493

- Learn more about Behavioral Health Integration Services.
- Visit Learn About the Collaborative Care Model from the American Psychiatric Association℠.

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.

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

HEALTHY U MEDICAID

FOLLOW UP – MEDICAID TRANSITION TO PRISM

After many years of planning, Utah Medicaid processes were fully transitioned from the Medicaid Management Information System (MMIS) to the Provider Reimbursement Information System for Medicaid (PRISM) tool. Beginning February 27, new claims criteria were implemented for all Healthy U claims **adjudicated on or after February 27, 2023**, regardless of the date of service. Eligibility and other enhancements were released with the full PRISM "go live" on April 3.

To help providers contracted with Healthy U and Healthy U Behavioral networks prepare for the transition, we published a Special Medicaid Edition of the Provider Connection newsletter. Some of the more impactful changes for providers are noted below.

PAPER CLAIM SUBMISSION

Utah Medicaid no longer accepts Fee-For-Service (FFS) claims submitted on a paper claim form. Paper claims sent directly to Medicaid are destroyed, and providers are not notified when this occurs. While University of Utah Health Plans will continue to accept paper claims for Healthy U services, enrolling in Electronic Data Interchange (EDI) transactions takes the guesswork out of your billing practices and ensures every claim is processed as efficiently as possible. Visit the EDI page on our Provider Website to learn more about EDI and enroll.

PROVIDER ENROLLMENT REQUIREMENT

Providers must be enrolled with Utah Medicaid prior to rendering service to ANY Medicaid member, including Healthy U or other ACO-plan members, to ensure claims are processed appropriately. Enrollment with Medicaid does not mean you must care for Medicaid FFS members, or any ACO with which you are not contracted. Once enrolled, you can choose with which managed-care network(s) you wish to contract. However, if you see any Medicaid-eligible member prior to enrolling with Utah Medicaid, those claims will be denied.

Claims submitted for any Medicaid FFS or ACO plan, such as Healthy U, must meet the following requirements or they will be denied.

- **Operating providers** are required to be enrolled with Medicaid.
- **Billing providers** are required to be enrolled with Medicaid.
- **Mental Health and Substance Use Disorder providers – every claim submitted must include the servicing/rendering provider AND the provider must be enrolled with Utah Medicaid**.

Recently Updated Information

From April 17, 2023, through August 31, 2023, Utah Medicaid will **not** enforce this portion of their previously stated requirement; however, **beginning September 1, 2023**, the following rule will be implemented.

- **The ordering/referring provider and their NPI** is required, **AND** the provider must be enrolled with Utah Medicaid for the following claim types:
  - Home health
  - Durable medical equipment
  - Hospice
  - Lab and x-ray

The delay provides additional time for impacted facilities to review their received orders and outreach to referring providers who have not enrolled in Medicaid. Healthy U will review and reprocess any claims denied for this reason during the pause period. We also will make best efforts to contact providers who will be impacted when we resume implementing this requirement, to educate them on how to enroll with Utah Medicaid. We appreciate your assistance with this outreach.

QUESTIONS?

U of U Health Plans PRISM Resources

- Many additional changes are noted in the Special Medicaid Edition of the *Provider Connection* newsletter. Be sure to study the information therein, and discuss it with providers and staff in your clinic.
- If you have questions specific to our Healthy U or Healthy U Behavioral plans, please call Healthy U Customer Service at **801-213-4104** or **833-981-0212**.

Utah Medicaid Resources

- PRISM Project Go Live
- PRISM Provider Training
- Medicaid System Freeze – FAQ
- 2023 Medicaid Information Bulletins
- Utah Medicaid Enrollment - **801-538-6155** or **800-662-9651** option 3 then 4

COORDINATING SECONDARY CLAIMS SUBMISSION

Prior to the PRISM implementation, if a U of U Health Plans benefit plan was the **primary** plan and a Healthy U Medicaid plan was **secondary**, we were able to automatically process the secondary claim without the provider needing to submit the primary remittance advice (RA) to Healthy U. Unfortunately, with PRISM, that 'crosswalk' functionality is not available at this time. While we work on a solution, you will need to resubmit the claim—along with the **primary** remittance information—for us to process the **secondary** benefits separately. The infographic PRISM Update - COB Claim Sharing provides a handy reminder to print and post in the back-desk area of your office.

REMIND MEDICAID MEMBERS TO UPDATE STATE CONTACT INFORMATION

At the time of this writing, the Public Health Emergency (PHE) is scheduled to expire on May 11, 2023. Please review this article from our August and November editions of *Provider Connection* to ensure your patients don't lose Medicaid coverage.

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. 23 Mar 2017. Accessed on 09 Sept. 2022.

EDUCATIONAL CONTENT AVAILABLE ONLINE

We are developing content to address questions specific to our Healthy U Medicaid lines of business, such as the PRISM Update - COB Claim Sharing infographic. Please contact your Provider Relations consultant to pose questions. We will post informational content to our Provider Website, under the "Educational" tab, as needed.

Advantage U

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 . . . . . **801-587-2838** | **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.

(View next page for Formulary Updates)

FORMULARY UPDATES

Effective April 1, 2023 the following products were excluded from all formularies. No significant clinical differences have been found between these drugs and the preferred alternatives listed. Due to significant cost differences found, and in an effort to maximize our use of the most cost-effective alternative, these drugs have been excluded.

LABEL NAME	PREFERRED ALTERNATIVE
Alphagan® P 0.1% solution	Brimonidine tartrate 0.2% solution
Brimonidine tartrate 0.15% solution	Brimonidine tartrate 0.2% solution
Testosterone 25 mg/2.5 gm (1%) gel	Testosterone 12.5 mg/act (1%) gel
Testosterone 50 mg/5 gm (1%) gel	Testosterone 12.5 mg/act (1%) gel
Testosterone 20.25 mg/1.25 gm (1.62%) gel	Testosterone 20.25 mg/act (1.62%) gel
Minocycline HCL tabs 75 mg	Minocycline HCL caps 75 mg
Tetracycline HCL caps 500 mg	Tetracycline HCL caps 250 mg x 2
Doxycycline hyclate tabs 150 mg	Doxycycline hyclate caps 50 mg; doxycycline hyclate caps 100 mg

HYDROXYPROGESTERONE CAPROATE

Effective April 1, 2023, all formulations of hydroxyprogesterone caproate (solution, oil, and compounded 17P) **were excluded from the formularies**. The FDA Committee recommended this drug be pulled from the market after confirmatory trial(s) failed to verify the clinical benefit of Makena®, and generic formulations, for neonatal outcomes or preventing preterm birth. Makena's manufacturer announced it is withdrawing the product.

GLUCAGON-LIKE PEPTIDE 1 (GLP-1) AGONISTS UPDATE

Effective February 1, 2023, GLP-1 Receptor Agonists (e.g., Bydureon BCise®, Ozempic®, Rybelsus®, Trulicity®, Victoza®) and GLP-1/glucose-dependent insulinotropic polypeptides (GIP) (i.e., Mounjaro™) **will now require Prior Authorization** rather than step therapy. Current utilizers will be grandfathered until April 1, 2023. If confirmation of an FDA-approved and health plan-covered indication is not confirmed by that date, members seeking GLP-1 therapy will be subject to prior authorization (PA) criteria. If an appropriate diagnosis is confirmed, members will be grandfathered through April 1, 2024.

The PA requirement is necessary due the high demand for use in weight loss, which is not a covered benefit. Because certain GLP-1s are being used off-label for weight loss, PA is required to verify diagnosis and appropriate use. High demand for weight loss has also led to drug shortages and has caused access to care issues for diabetics utilizing these drugs appropriately.

Criteria includes:

1. Member must have a diagnosis of type 2 diabetes, **AND**
2. Documentation must show member has completed a 90-day trial and failure of metformin or a metformin-containing combination.

REMINDERS

- Notice of upcoming changes to the formulary are available on the Pharmacy website.
- 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 policies, including medication use, is displayed in the left navigation bar. Bookmark these links in your Internet favorites for quick access to submit pharmacy prior authorization requests.
- Formulary updates for retail and specialty pharmacy medications can 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.
- The Retail Pharmacy Online Prior Authorization Submission tool has been updated to allow prior authorizations 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."

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 MEDICAL POLICIES		
Policy Number	***Policy Name***	***Effective Date***
MP-031 **(New)**	**High Frequency Chest Wall Compression (e.g., The Vest® Airway Clearance System)**	**03/25/2023**
Commercial Plan: U of U Health Plans covers high frequency chest wall compression therapy in limited clinical circumstances. Please see the policy for specific coverage criteria.		
MP-074 **(New)**	**Platelet-Rich Plasma (PRP) for Orthopedic Indications**	**03/25/2023**
Commercial Plan: U of U Health Plans does not cover the use of platelet-rich plasma (PRP) for orthopedic indications or any other indication as it is considered unproven, investigational, or experimental.		
REVISED MEDICAL POLICIES		
Policy Number	***Policy Name***	***Effective Date***
MP-002 **(Revised)**	**Gender Affirming Surgery**	**03/25/2023**
Commercial Plan: U of U Health Plans has added insertion of penile prosthesis as a covered procedure for female-to-male gender affirming surgery.		
MP-016 **(Revised)**	**Infertility Testing and Treatment**	**03/25/2023**
Commercial Plan: The following tests were recommended to be added as not covered: 1. Embryoscope™ or time-lapse imaging of embryos 2. Receptiva™ (BCL6 assay) used for undiagnosed endometriosis The literature demonstrates that they are considered experimental/investigational; therefore, not medically necessary.		
MP-005 **(Revised)**	**Balloon Dilation of the Eustachian Tube**	**05/06/2023**
Commercial Plan: Balloon dilation of the eustachian tube is now covered when certain criteria are met. Please see the policy for coverage details.		

REIMBURSEMENT POLICY UPDATES

NEW REIMBURSEMENT POLICIES		
Policy Number	***Policy Name***	***Effective Date***
Reimb-037 **(New)**	**Billing for Gender Discordant Claims**	**03/25/2023**
Commercial Plan: This policy clarifies the requirements for claims related to services discordant to the gender of record.		
REVISED REIMBURSEMENT POLICIES-N/A		

Provider Connection newsletter is published by University of Utah Health Plans.