



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

GET A JUMP ON THE NO SURPRISES ACT

At every opportunity, we urge providers to keep their office's demographic information updated in our provider directory; now directory accuracy is even more critical.

The Federal No Surprises Act went into effect January 1, 2022, bringing new requirements for health plans and providers. As inaccuracies in provider directories can create barriers to care for health plan members and your patients, provider directory accuracy is an important aspect of the Act.

Under the No Surprises Act, all healthcare providers and facilities must submit provider directory information to the health plan:

- » 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.

Here's how you can help:

1. Keep your clinic information up to date on CAQH to give most payers access to your clinic's most current information. This helps us keep directories updated and streamline the verification process.
2. Review your practice's listing(s) in our [Provider Directory](#). From the Network dropdown menu, choose one of the networks with which you are contracted.
3. If any information is not current, submit corrections on our [Provider Update Form](#).



To comply with the Act, U of U Health Plans is required to verify the accuracy of your provider or facility information in our provider directories at least every 90 days. To accomplish this, beginning in Spring 2022, you'll receive an email or Provider Portal prompt to verify your directory data—name, address, specialty, scheduling telephone number, and digital contact information—every 90 days. **It is your responsibility as a contracted provider to verify your directory information and attest that you've verified and/or submitted a correction to that information.**

To simplify the directory verification and attestation process, our new Provider Portal will be used to submit changes to the provider directory data we have on file as well as submit the attestation.

- » **If you do not already have an account for our new Provider Portal**, request registration information from uofuhpproviderportal@hsc.utah.edu. Please include your clinic/provider name, Tax ID, NPI, and the contact information for the person who will act as your office's provider portal administrator. This will ensure you are able to submit the attestation once it's available in the portal.
- » **Watch for the attestation email**, titled: Now available: U of U Health Plans Provider Directory Attestation.

If your provider or facility data is not verified within a reasonable period of time, you will be removed from our provider directories. Once the data is verified, you'll be reinstated in the provider directories. **It is critical you review and attest to your provider directory information to remain listed as a participating provider. Removal from the provider directory may cause significant confusion and disruption of care for your patients.**

U of U Health Plans will make best efforts to update any changes you submit within two business days of receipt.

Questions? Please 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.

REINSTATING PRE-COVID PRIOR AUTHORIZATION CRITERIA

To decrease administrative burden for our providers and facilities during the COVID-19 emergency, U of U Health Plans—while still requiring prior authorizations—relaxed selected prior authorization requirements. With COVID rates now declining, we returned to our pre-COVID medical necessity review processes, effective April 1, 2022. This includes, but is not limited to, a return to more thorough reviews of inpatient, skilled nursing facility, and behavioral health admissions; and home care, MRI, PET scan, solid organ transplant, and DME requests.

[General Services Requiring Prior Authorization](#) provides categories and specific codes of services that require prior authorization.

Coverage is determined by the member-specific benefit plan document and any applicable laws regarding coverage of specific services. Always consult with a Customer Service representative for the member's benefit plan to determine coverage and requirements for any service mentioned on the Prior Authorization list.

- » Commercial Group plans: **801-213-4008** or **833-981-0213**
- » Healthy U Medicaid plans: **801-213-4104** or **833-981-0212**
- » Individual and Family plans: **801-213-4111** or **833-981-0214**
- » Carson Tahoe Health plans: **801-213-0150** or **833-661-3915**
- » Mountain Health CO-OP plans: **844-262-1560**

UPDATED ACCESS STANDARDS

We are committed 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.

We've recently updated our Provider Manual with the following Access Standards. Please review these standards with the appropriate staff and incorporate any changes to your business practice 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			
<ul style="list-style-type: none"> » 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			
<ul style="list-style-type: none"> » 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 <ul style="list-style-type: none"> » 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.			

Access and Availability Standards (Continued)
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
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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 [Access Standards Policy](#) in its entirety in our Provider Manual.

IT PAYS FOR MEMBERS TO HAVE THEIR WELLNESS CHECKED

While "an apple a day keeps the doctor away" is sage advice for everyone, staying healthy is much easier for members who visit their healthcare provider for routine checkups. Some members of our Healthy U Medicaid and Individual/Family plans may not be aware of the importance of preventive visits, or that they're available with no out-of-pocket costs. Therefore, we offer the following incentives to encourage them to obtain these important services.

- » [Well-Child Visit Incentive](#) for Individual and Family Plan members and Healthy U Medicaid plan members: we have an incentive where children ages 3 to 17 can earn a \$25 gift card for a well-care visit.
- » [Adult Preventive Care Visit Incentive](#) (annual exam, wellness checkup). Adult Individual/Family plan members, age 18 and older, can earn a \$50 gift card when they have their preventive well care visit in the 2022 calendar year.
- » Additional incentives for various at different times of year: We just finished an incentive campaign to encourage members to receive their COVID vaccines and/or flu shots.

- » Preventive care usually costs members nothing! Most members have no out-of-pocket costs for preventive services rendered during a routine annual wellness visit. Naturally, services or tests administered outside the scope of preventive care will be processed with the member's usual benefits; check your patients' benefit summary, or call Customer Service for the member's health plan to determine which services are covered as preventive for their plan.

Preventive care is the best way to ensure any conditions of concern are treated early—when treatment is easiest and most successful. We invite you to partner with us in reminding members, your patients, of the importance of regular wellness visits. And while we're on the topic, when's the last time you had a wellness visit?

WHEN MEMBERS NEED URGENT CARE

Does your practice offer urgent care? When non-emergent illness or injury strikes unexpectedly, members need care quickly. Emergency departments frequently see patients who don't need the level of care offered in an ED, because they didn't know where to find urgent care. The cost of this care is much greater—to the hospital, payer, and member—when provided in an ED than it would be if provided in an urgent care setting.

In addition to cost savings, urgent care services within a provider practice create an opportunity to enhance a trusted relationship between your practice and your patients, or to create a new relationship.

If your practice offers urgent care services and hours, check your listing in our [Provider Directory](#) to be certain you're listed as an Urgent Care Facility. If needed, email provider.relations@hsc.utah.edu to inquire about adding Urgent Care to your clinic's specialties.

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, Medicaid, and Medicare Advantage.

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
<i>Essential (primary) hypertension</i>	ICD-10: I10
<i>Systolic greater than/equal to 140</i>	CPT-CAT-II: 3077F
<i>Systolic less than 140</i>	CPT-CAT-II: 3074F, 3075F
<i>Diastolic Greater than/ Equal to 90</i>	CPT-CAT-II: 3080F
<i>Diastolic 80-89</i>	CPT-CAT-II: 3079F
<i>Diastolic Less than 80</i>	CPT-CAT-II: 3078F
<i>Remote Blood Pressure Monitoring Codes</i>	CPT: 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474
<i>Outpatient Visit Codes</i>	CPT: 99201 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

We are committed to working 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 CPB HEDIS measures.

CORRECT METHOD TO AMEND CLINICAL DOCUMENTATION

Most providers are so busy with clinical practice that documentation is secondary to their care of patients. Busy days of patient care can sometimes result in documentation of the patient's visit that lacks details necessary for subsequent authorizations for reimbursement of procedures, treatments, or other care.

In these circumstances, providers may wish to modify documentation to more accurately reflect what occurred in the care of the patient. Correctly modifying clinical documents can result in more rapid adjudication of claims and approval of pre- and post-service coverage requests. It can also avoid the appearance of fraud and associated consequences.

HOW TO CORRECTLY MODIFY CLINICAL RECORDS

Some electronic medical records allow for opening previously "locked" clinical notes, making it easy to modify notes as if they are part of the original documentation. Though this appears harmless, in some circumstances, the practice can be interpreted as fraudulent—especially if done days or weeks after the original documentation. Deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. The appearance of modifying a document can open an unnecessary and disruptive investigation into your clinic.

Carefully marking modifications with their correct "reason" label can help prevent the appearance of fraud. The accepted modification labels include Late Entry, Addendum, or Correction. These reasons for modifying a medical record are legitimate occurrences in documentation of clinical services.

Note: For every reason listed below, the modification must include the current date of that entry and be signed by the person making the addition or change.

Late Entry – A late entry supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information, and signs the late entry.

Example: A late entry following treatment of multiple trauma might add: "The left foot was noted to be abraded laterally. John Doe MD 06/15/09"

Addendum – An addendum provides information that was not available at the time of the original entry. The addendum should also be timely, bear the current date and reason for the addition or clarification of information being added to the medical record, and be signed by the person making the addendum.

Example: An addendum could note: "The chest x-ray report was reviewed and showed an enlarged cardiac silhouette. John Doe MD 06/15/09"

Correction – When making a correction to the medical record, never write over or otherwise obliterate the erroneous entry in a medical record. Draw a single line through the inaccurate information, keeping the original entry legible. Sign or initial and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Correction of electronic records should follow the same principles of tracking any modification, in both the original entry and the correction. When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

References:

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ANNUAL REMINDER: 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 want to give our members the best care and service. U of U Health Plans members have the right to:

- » Get information about the organization, plan, 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) they use to care for members, and our confidentiality policy.

If members need help understanding any of this information, call us at **833-981-0213**.

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 U of U Health Plans Member Services at **833-981-0213**.
- » 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 members 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 the Health Plans and to treating providers in order to provide care.
- » Let the group administrator know if member moves, changes phone number, get married or divorced, have 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.

ANNUAL REMINDER: 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 and 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. You may also email your request for criteria to UUHP_UM@hsc.utah.edu.

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	<i>Assessment of and care planning for a patient with cognitive impairment</i>	One per month
99484	<i>Care management services for behavioral health conditions</i>	One per month
99492	<i>Initial psychiatric collaborative care management</i>	One per member per lifetime per clinic
99493	<i>Subsequent psychiatric collaborative care management</i>	One per month
99494	<i>Initial or subsequent psychiatric collaborative care management</i>	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 AssociationSM.

HEALTHY U MEDICAID

MEDICAID ELIGIBILITY AND THE PUBLIC HEALTH EMERGENCY

To ensure Medicaid beneficiaries did not lose medical insurance because of changing circumstances during the coronavirus pandemic, everyone who was on Medicaid stayed on Medicaid without needing to renew. Now that the public health emergency and government funding are waning, this grace period may soon change.

Please help us make sure eligible beneficiaries do not lose their Medicaid coverage. We're outreaching to our Medicaid members to let them know they should get at the head of the line and complete their renewal as soon as possible.

If you have a patient who may be at risk of losing coverage, or perhaps are unaware of the need to check their enrollment, please inform them of the following options, as opportunities arise:

- » If beneficiaries feel comfortable renewing on their own, they can do that by calling the Department of Workforce Services (DWS) at **801-526-0950** to check their eligibility and enroll, if appropriate.
- » If beneficiaries have questions about their Healthy U Medicaid plan, they can call **833-981-0212**.
- » **If beneficiaries do not renew, they may lose their Medicaid coverage.**

Healthy U also partners with Take Care Utah to help beneficiaries complete their renewal. If anyone has questions or would like help renewing, they can visit takecareutah.org to schedule an appointment, or call **801-433-2299**. Assistance through Take Care Utah is completely free.

Advantage | _____

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**
- » 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.



AUTOIMMUNE DISEASE MEDICATIONS FOR HEALTHY U MEDICAID:

The preferred/non-preferred status of medications for autoimmune diseases **for Healthy U Medicaid members** is changing, **effective June 1, 2022**. The changes, listed below, are also available in our [Pharmacy Policies](#). **These changes only apply to new starts.**

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
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	

COSENTYX UPDATE FOR COMMERCIAL AND INDIVIDUAL/FAMILY PLANS (DOES NOT APPLY TO MEDICAID)

Effective July 01, 2022, Cosentyx will no longer be covered, and Taltz will be the preferred medication for Commercial and Individual/Family plan members. We will outreach to members currently on Cosentyx for conversion to Taltz. Providers may consider a loading dose when switching members from Cosentyx to Taltz.

Reminders:

- » Pharmacy Prior Authorization forms are available online with specific requirements for use and limitations listed in the form. Visit our [Pharmacy Coverage Policies](#) 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 the Web page. 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.

CODING CORNER

REPORTING COLORECTAL CANCER SCREENING – TIPS FOR ACCURATE CODING

Colorectal Cancer Screening is an important, often life-saving benefit available to our members, and is considered a “preventive” measure by the United States Preventive Services Task Force (USPSTF) for all adults ages 50–75 years. Qualifying screening procedures are mandated and regulated by the Affordable Care Act of 2010 (ACA); therefore, they are offered as an "essential benefit" for many commercial group health plans as well as Individual/Family plans with no out-of-pocket cost for the member. (Self-funded, Medicare, and Medicaid plans may be exempt from this requirement.)

We support you in encouraging appropriate members to receive colorectal cancer screening. Because of the different types of screenings available, anesthesia options, and possible adjunct procedures, reporting colonoscopies correctly continues to challenge even the most experienced coding staff.

To help ensure your patient's colorectal cancer screening is reported and applied correctly as a preventive benefit, here are a few things to remember:

- » Only colonoscopies intended as screening procedures, reported with the appropriate ICD-10 CM code, will be applied to the preventive benefit. These are the only ICD-10 codes that will be considered:

Code Description	ICD-10 CM Codes
<i>Encounter for screening for malignant neoplasm</i>	Z12.10 to Z12.12
<i>Family history of malignant neoplasm of digestive organs, colonic polyps, or other diseases of the digestive system</i>	Z80.0, Z83.71, and Z83.79
<i>Genetic susceptibility to other malignant neoplasm</i>	X15.09

- » While colonoscopies are the most common screening procedure, there are several methods that will be considered as a preventive screening. Only the following CPT codes will be applied to the preventive benefit and only when reported with one of the ICD-10 codes listed above; otherwise, it will be applied to the medical benefit.

Code Description	CPT Codes
<i>Sigmoidoscopy, flexible</i>	45330, 45331, 45333, 45338, 45346
<i>Colonoscopy, flexible</i>	44388, 44389, 44392, 44394, 45378, 45380, 45381, 45384, 45385, 45388,
<i>Colorectal cancer screening</i>	G0105, G0120 to G0122

- » In some circumstances an intended screening procedure may identify polyps or other lesions requiring biopsy or removal. In these circumstances, we will still apply the procedure as a preventive benefit if it is reported with one of the screening ICD-10 codes listed above in combination with one of the sigmoidoscopic or colonoscopic interventional CPT codes listed above (e.g., **ICD-10 Z83.71** with **CPT 45385** *Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique*). If other code(s) are reported with a screening ICD-10 code, they will be applied to the medical benefit and most members will be responsible for their medical cost share.
- » Increasingly, providers are employing general anesthesia with colorectal screening procedures instead of conscious sedation. To facilitate proper coding, the AMA-CPT published **CPT 00812** *Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy* to report anesthesia for screening colonoscopies. Because this code is specific to screening colonoscopy, we will only cover **00812** if the anesthesia is billed with the appropriate ICD-10 and procedure codes to identify this encounter as a screening procedure.

Use of **CPT 00811** *Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified* will not be covered when reported with screening codes, but can be reviewed by appeal on a case-by-case basis, if billed with **Modifier PT or 33**.
- » The standard interval recommended for a screening colonoscopy is generally every 10 years. However, as many screening colonoscopies identify small polyps or other lesions which require a follow up study to ensure a previous biopsy or polypectomy has removed all lesions, we will apply the ‘surveillance’ study to the preventive benefit if it is performed five or more years after the identifying screening procedure.

COVERAGE 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 Coverage 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		
<i>Policy Number</i>	<i>Policy Name</i>	<i>Effective Date</i>
Admin-008 (New)	Custodial/Respite Care	03/26/2022
Commercial Plan: U of U Health Plans does not cover custodial or respite care. Please see the policy for examples of excluded services that are considered custodial and respite care. Please note: This coverage statement does not apply to Madison Memorial Hospital members, please refer to the MMH Summary of Plan Description to determine coverage.		
Admin-016 (New)	Hospice Eligibility Determination Policy	03/26/2022
Commercial Plan: U of U Health Plans covers hospice care consistent with CMS guidelines for coverage when specific eligibility criteria are met. Please see the policy for specific criteria used with various conditions.		
MP-040 (New)	Low-Dose Computed Tomography for Lung Cancer Screening	03/26/2022
Commercial Plan: This policy outlines the circumstances in which U of U Health Plans may cover annual low-dose computed tomography (LDCT) scanning as a screening test when certain criteria are met. Please see the policy for specific criteria details.		
MP-069 (New)	Serologic Testing for Liver Fibrosis	03/26/2022
Commercial Plan: U of U Health Plans does NOT cover serum marker tests of hepatic fibrosis, used to produce a predictive score indicating the probability of liver fibrosis, as they are considered investigational and not medically necessary in the diagnosis and monitoring of individuals with chronic liver disease.		
REVISED POLICIES		

<i>Policy Number</i>	<i>Policy Name</i>	<i>Effective Date</i>
Admin-015 (Revised)	Category III CPT Codes	01/26/2022
Commercial Plan: Added new category III CPT codes, with the removal of deleted codes.		
MP-003 (Revised)	Chromosomal Microarray (CMA)/Comparative Genomic Hybridization (CGH) Testing for Developmental Delay and Fetal Demise	03/19/2022
Commercial Plan: Coverage has opened up for patients that do not present with a Well-Delineated Genetic Syndrome and cannot be identified by a clinical evaluation alone or specific chromosomal analysis.		
MP-048 (Revised)	Phototherapy, Photochemotherapy or PUVA, and Excimer Laser Therapy for Dermatologic Conditions	03/19/2022
Commercial Plan: Prurigo Nodularis has been added to the list of dermatological conditions that may be covered if certain criteria are met. Additional research found that after failure, intolerance, or contraindication to conventional medical management prurigo nodularis may improve with Phototherapy, Photochemotherapy or PUVA, and Excimer Laser Therapy.		

REIMBURSEMENT POLICY UPDATES

NEW POLICIES		
<i>Policy Number</i>	<i>Policy Name</i>	<i>Effective Date</i>
Reimb-035 (New)	External Breast Prosthesis	03/26/2022
Commercial Plan: U of U Health Plans has moved these items from requiring prior authorization to cover with specific coverage limits for various items. This policy outlines the annual limits established for external breast prostheses. Please see the policy for details.		
REVISED POLICIES		
<i>Policy Number</i>	<i>Policy Name</i>	<i>Effective Date</i>
No revised reimbursement policies at this time.		