NEVADA EDITION

providerINSIGHT®

SelectHealth® | June 2023

Welcome to the *Provider Insight* newsletter.

Here, you'll find medical, dental, and pharmacy information as well as updates to our plans:

> Commercial

> SelectHealth Medicare

We encourage you to read *Provider Insight* to stay up to date on policies affecting our members and your patients.

WHAT'S INSIDE

OTHER SELECTHEALTH PROVIDER PUBLICATIONS

- *Pharmacy and Therapeutics*
- *SelectHealth Policy Update Bulletin*

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selecthealth

SelectHealth® News

Alert: Changes to Carelon Preauthorization Process

Effective **June 30, 2023**, SelectHealth will assume responsibility for preauthorizations for radiation oncology, medical oncology, and genetic testing to improve turn-around times as well as provider and member communication.

Providers will be redirected to CareAffliate® for radiation and genetic preauthorization requests or to the SelectHealth pharmacy site for medical and oral oncology medications. **NOTE**: Genetic testing requests need to be submitted by the ordering provider and **not** by the genetic laboratory.

Medical policies will be available on the secure and public websites. For claims submitted prior to **June 30, 2023**, the last date of reconsideration is **July 10, 2023**, and last date of post-claim requests is **July 31, 2023**.

Questions? Contact your Provider Relations representative.

SelectHealth Medicare News

Change to Eligibility Criteria for Sacroiliac Joint (SIJ) Injections

The Centers for Medicare and Medicaid Services (CMS)/Noridian published a new LCD (L39464) for sacroiliac joint procedures, which was effective for services performed on or after **March 19, 2023**. This LCD outlines new criteria required for Medicare beneficiaries to be eligible for coverage of diagnostic and therapeutic SIJ injections as well as limitations to these procedures.

As a result, SelectHealth will follow CMS/Noridian guidelines to no longer cover SIJ RFA for SelectHealth Medicare Advantage PPO members and for all lines of business in Mesquite.

Please note that:

> As of **April 15, 2023**, SIJ radiofrequency ablation (RFA) is no longer covered for these members identified above as it is considered investigational.

> These new CMS requirements should be kept in mind when discussing treatment options with your Medicare patients.

> This procedure will still be available to Commercial and Medicaid members if policy criteria are met.

Correctly Coding Medicare Comprehensive Visits

Comprehensive visits occur when a Medicare annual wellness visit (AWV) occurs on the same date of service as a preventive visit. These combined visits help:

> Focus on preventive care as well as chronic conditions that have not been recently addressed

> Identify and address any developing problems early

> Improve outcomes measures when accurately coded and documented.

Learn more about coding these visits. Access the SelectHealth **Comprehensive Evaluation Visits** guide (see Other Resources).

Questions? Contact Provider Development at **800-538-5054**.

Practice Management Resources

COVID-19 Coverage Changes

Effective **May 11, 2023**, some benefits that were enhanced during the ongoing Public Health Emergency will change. Here's what you need to know:

> COVID-19 vaccinations rendered by in-network providers will continue to be covered 100%. Vaccines provided by out-of-network providers will no longer be covered, except for plans with an exception to cover preventive benefits. Normal cost sharing will apply.

> In-office COVID-19 tests administered by a provider will now be covered under a plan's minor diagnostic test benefit. COVID-19 provider screenings will be covered according to place-of-service benefit. Normal cost sharing will apply.

> Over-the-Counter (OTC) COVID-19 tests will no longer be covered or eligible for reimbursement through SelectHealth benefits. For up-to-date coverage information on in-office COVID-19 tests, visit **the COVID-19 coverage page**.

Questions? Call Member Services at **800-538-5038**, or visit **our COVID-19 coverage webpage**.

Please Use Online Preauthorization Self-Service Tools

We need to ensure that you are primarily using the online preauthorization tools (CareAffiliate® and PromptPA) as well as the Provider Benefit Tool to find codes, requirements, and member accumulators rather than calling the Member Services line. **The information on the following pages provides an overview for quickly accessing this information.**

Using these resources will help significantly reduce phone wait times for our members as well as for those providers who have questions that cannot be answered with self-service online tools.

Not yet a Provider Benefit Tool user? Find out how to **request access**.

Review and share the information on the next page with your colleagues and staff.

Other questions? Please use the Provider Benefit Tool self-service FAQ page or the CareAffiliate online preauthorization tool **before** contacting Member Services (**800-538-5038**) or Provider Development (**providerwebservices@selecthealth.org**).

Watch for **upcoming enhancements** to the Provider Benefit Tool, which include adding:

> Claim reason codes (GC/CARC/RARC) descriptions, which helps providers understand denial codes. This will reduce the number of clicks required to locate claim information.

> The ability to view online and download a member's ID card, making it easier for providers to access a patient's ID card if a member does not have a physical copy with them.

> A tooth chart history, which allows the provider to view 5-year history, including procedure codes, begin/end teeth, surfaces, etc. This will help dental providers when submitting claims and/or documents.

> An active primary care provider (PCP) view for members, which will help providers identify the member's chosen PCP or if a PCP assignment still needs to be made.

> A reference chart for claim status explanations, which will give providers a dynamic resource for any claim status wording they encounter.

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Practice Management Resources, Continued

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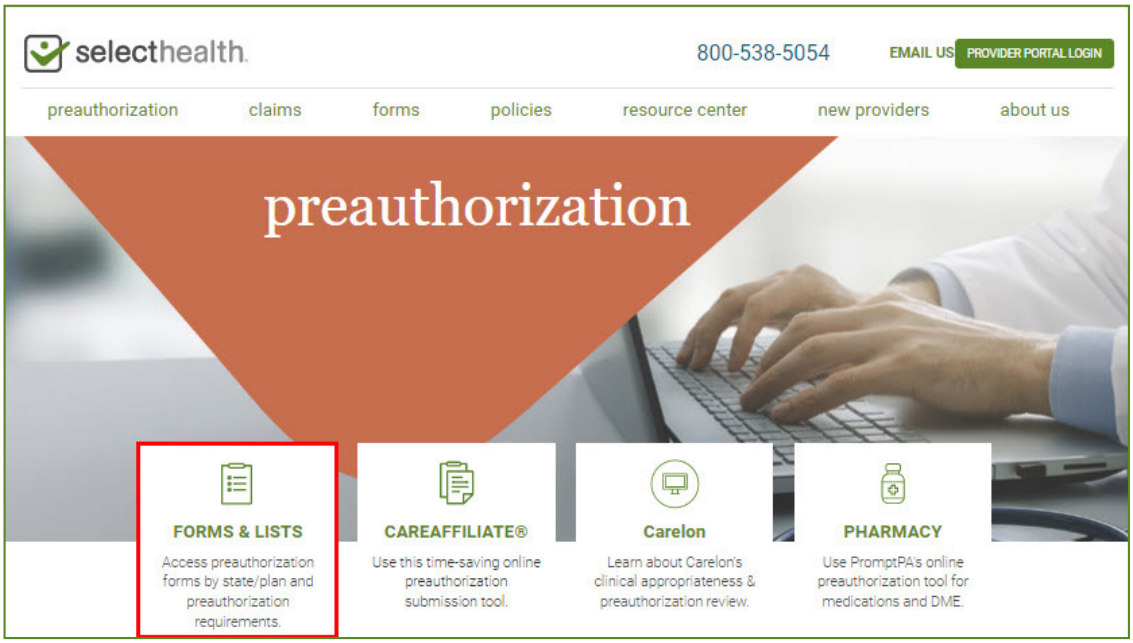
Preauthorization self-service tools: A quick guide

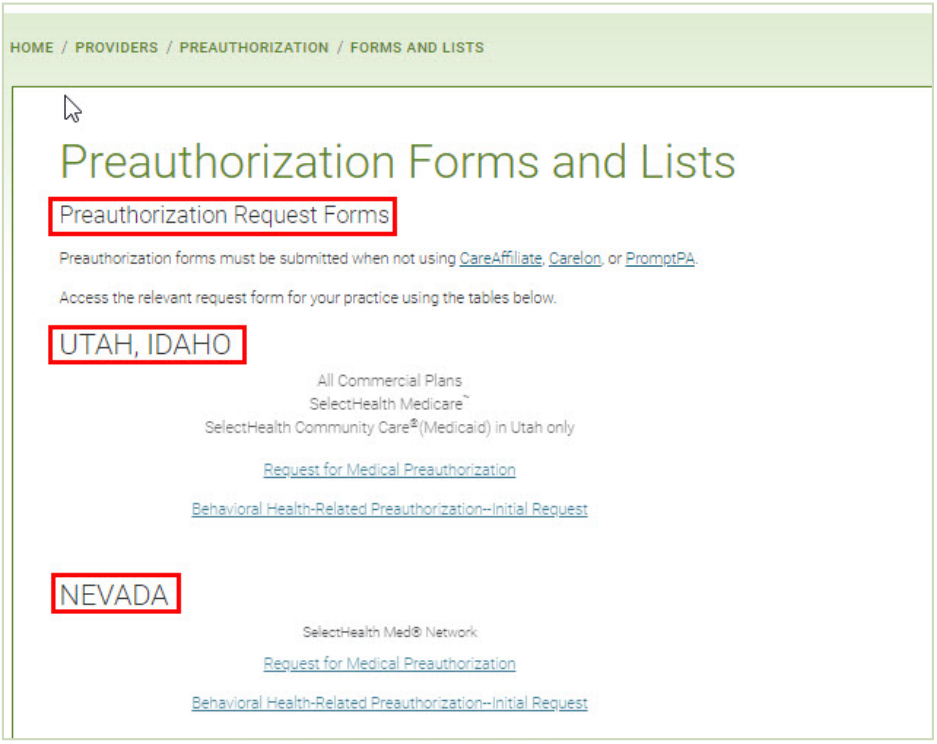
Get the answers you need quickly. Follow the steps below to find codes, requirements, and member accumulators.

1 Access the **preauthorization area** of the SelectHealth provider website, and then click on Forms and Lists. **NOTE:** SelectHealth requires pre-authorization for inpatient services; maternity stays longer than two days for a normal delivery or longer than four days for a cesarean; durable medical equipment; home health nursing services; and pain management/ pain clinic services.



We maintain current lists of services/procedures that require preauthorization as well as downloadable request forms that need to be submitted if not using one of our online preauthorization tools: **CareAffiliate®** or **PromptPA**.

2 On that page, you will be able to view and download preauthorization forms by state.



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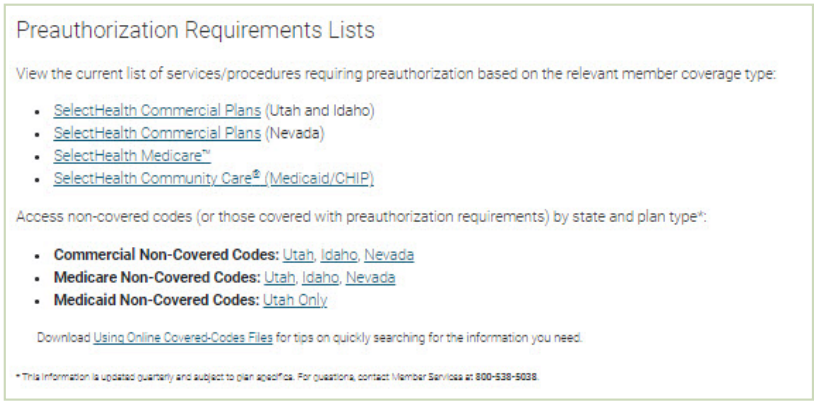
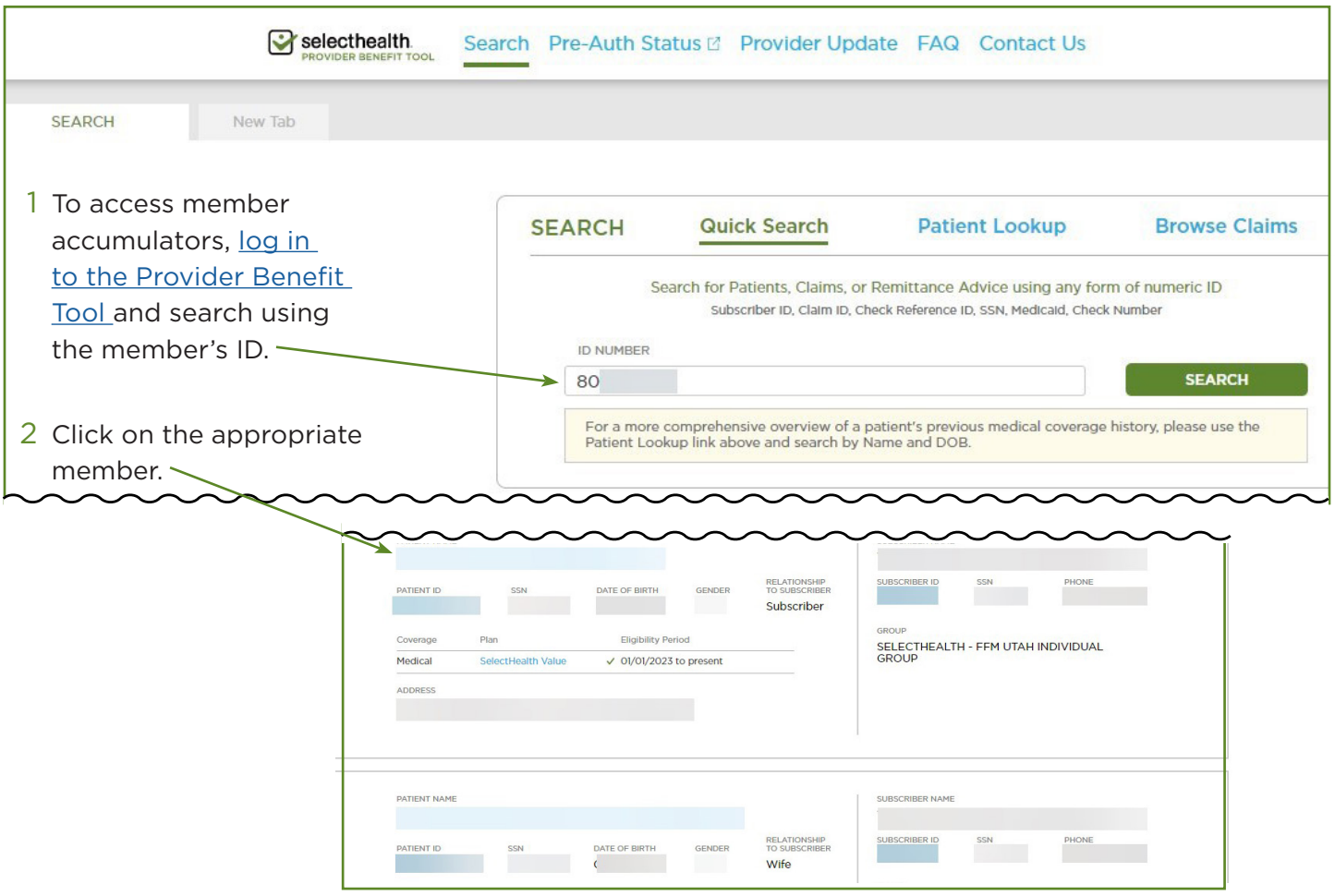
3 Further down on that same page, you will see preauthorization requirements lists that contain the current services and procedures requiring preauthorization based on plan type.

4 In addition, SelectHealth updates lists of non-covered codes and associated preauthorization requirements quarterly. These lists are by state and plan type.



To find information on a member's policy (such as accumulators, copayment, and coinsurance), use the Provider Benefit Tool. **Not a Provider Benefit Tool user yet?** Find out **how to request access**.



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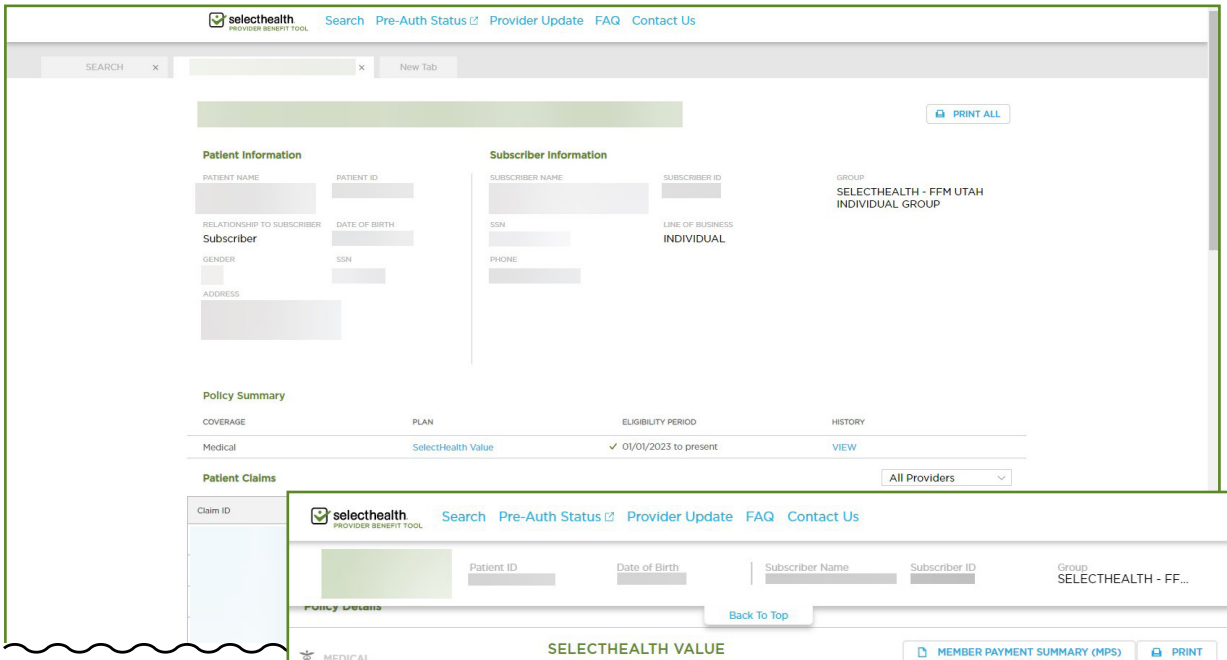
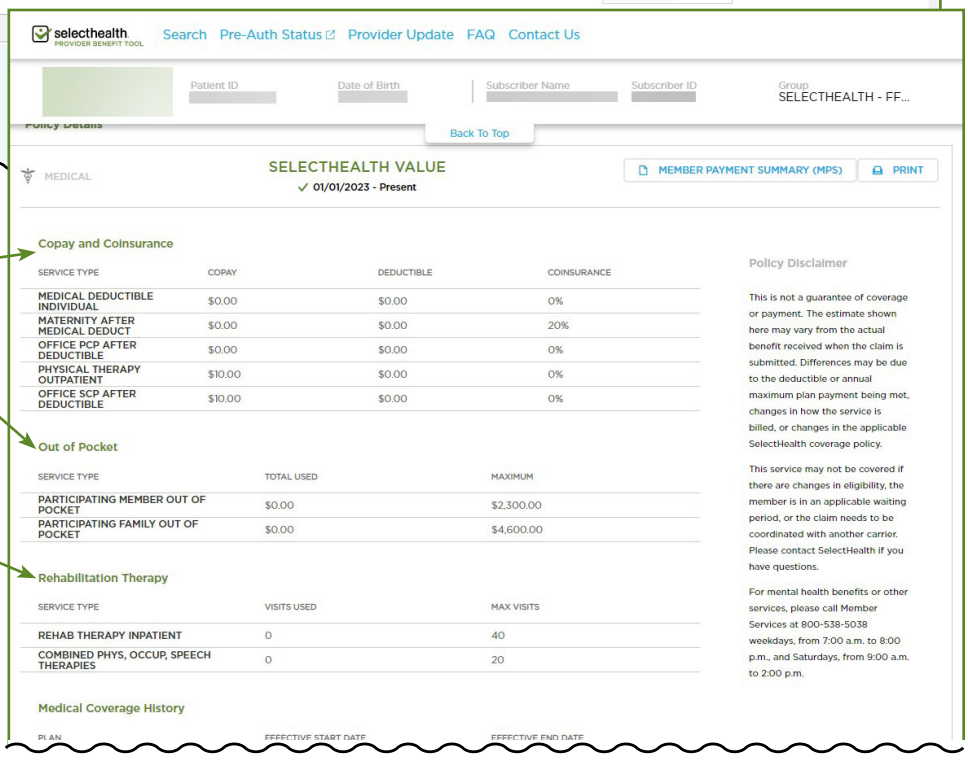
3 The member's policy information and claims will then open.





4 Scroll down to find the member's copay, coinsurance, out-of-pocket maximums and use totals as well as rehabilitation service accumulators.

Still have questions? Contact Member Services at **801-442-3692** or email **Provider Web Services.**

Practice Management Resources, Continued

Automate SelectHealth Preauthorization: Switch to CareAffiliate®

CareAffiliate is our online preauthorization tool. It enables you to submit preauthorization requests and supporting for Medicare PPO and Commercial Med plans online rather than through fax or email. You may also submit for Medicare HMO and Commercial Value plans if in the Mesquite exception area.

Let us help you become a CareAffiliate "super user" in 2023!

Why? Because as the industry moves to online preauthorization, there will come a time when faxing requests is no longer a viable option for payers and providers. **Learn more**.

Why should I use CareAffiliate?

Compared to faxed and emailed requests, using the CareAffiliate tool offers many benefits, such as:

> Requiring fewer steps overall

> Eliminating duplicative efforts and potential errors when staff enter information from a paper form

> Decreasing response time

> Reducing follow-up calls and decision delays due to missing information

> Eliminating the risk of faxed member information being lost or sent to the wrong fax number

> Enabling automatic review and preauthorization decisions for many procedures

How do I access CareAffiliate?

To request access to the SelectHealth physician portal and CareAffiliate, visit our **online instructions**.

Where can I learn more?

Learn more by reading the CareAffiliate **Frequently Asked Questions** or by visiting our **online training area**. **Questions?** Email **careaffiliate@selecthealth.org**.

CareAffiliate Recent Updates

> New Request Types:

- Behavioral health office/specialty - For TMS, ECT, and any in-office therapy service that requires preauthorization
- Dental anesthesia
- Hyperbaric oxygen therapy
- Transplant - For bone marrow, heart, kidney, liver, lung or pancreas
- Behavioral health social detox
- Rehab PT/OT/ST Outpatient - Individual request types for outpatient therapies have been combined into this one request type

> Updated survey questionnaires to reflect current criteria and improve user experience for these request types:

- Hysterectomy
- Varicose vein

Practice Management Resources, Continued

Great news! We are Improving our Online Provider Experience

In the coming months, SelectHealth will release a new update that will give you, our valued providers, improved access to everything you need from SelectHealth.

For example, we are making significant upgrades to our contracting and credentialing processes, adding a secure inquiry feature, and implementing one central login for all our secure tools and applications, like CareAffiliate® and the Provider Benefit Tool. This change will ultimately deliver an easier to use integrated online experience for all our providers.

We will be sharing more about these improvements in the coming weeks, as well as sharing how you can seamlessly switch to the upgraded platform. Please watch your email for future updates.

Substance Use Disorders: Documentation and Coding Guidelines for Patients Admitted to Rehab Facilities

SelectHealth has developed tips and strategies for diagnosing and coding substance use disorders. It is important that providers take the following steps when admitting a patient to a rehab facility:

1. Identify patients who qualify for treatment.
2. Schedule each patient for an evaluation and management (E/M) visit with the treating practitioner.
3. Submit a professional claim to SelectHealth that includes appropriate coding (CPT and ICD10 codes), which accurately represents the diagnosis given to the patient that justifies the need for residential treatment (see information below on the next two pages). NOTE: Providers will receive reimbursement based on CPT codes billed.

SelectHealth will offer virtual trainings soon to provide more in-depth information; providers will be contacted to schedule that training.

Use disorders are typically, "...chronic, relapsing illnesses, associated with significantly increased rates of morbidity and mortality."[1] Patients engaging in behaviors, such as misuse, substance diversion, or the use of illicitly obtained substances, should be screened for a substance use disorder. **Figure 1** provides an overview for documenting an SUD. **Figure 2** on the next page offers documentation examples.

Figure 1. Documenting an SUD

Identify Substance (3rd Character)	> Alcohol (F10) > Opioid (F11) > Cannabis (F12) > Sedative, hypnotic or anxiolytic (F13) > Cocaine (F14)	> Other stimulant (F15) > Hallucinogen (F16) > Inhalant (F18) > Other psychoactive substance (F19)
Identify Severity (4th Character)	> Abuse, mild (-.1x) > Dependence, moderate, severe (-.2x) > Use (-.9x)	
Identify Clinical Presentation/ Manifestation (5th & 6th Characters)	> Uncomplicated (-.x0) > In-remission (-.x1) > With intoxication (-.2) > With withdrawal (-.x3) > With mood disorder (-.x4) > With psychotic disorder (-.x5)	> With persisting amnestic disorder (-.x6) > With persisting dementia (-.x7) > With anxiety/sexual dysfunction/ sleep/other disorder (-.x8) > With unspecified disorder (-.x9)

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Identifying Symptoms and Severity

Diagnoses can be made based on ≥2 of the following characteristics for ≥12 months:

> Taking in **larger amounts** than intended

> **Desire to control** use or **failed attempts** to control use

> **Significant time** spent obtaining, using, or recovering from the substance

> **Craving** for the substance

> **Obligation failure** (e.g., work, school, home)

> **Social and interpersonal problems**

> **Activities** (e.g., social, occupations, recreational) given up or reduced

> **Physically hazardous** use (e.g., driving, swimming while under the influence)

> **Physical or psychological problems** likely caused by use

> **Tolerance** (e.g., increased amounts needed, diminished effect of substance)

> **Withdrawal** (i.e., withdrawal symptoms or substance taken to avoid withdrawal symptoms)

Specify severity based on number of symptoms:

> **Mild**: 2–3 symptoms
> **Moderate**: 4–5 symptoms
> **Severe**: ≥6 symptoms

Documenting "In Remission"

Documenting patients who are "in remission" requires that:

> Patient previously met full criteria for a use disorder.

> The term is used for the life of the patient, unless relapse occurs; qualifiers are:

- **Early remission**: None of the criteria have been met (exception of craving) for **at least three months but less than 12.**[1]
- **Sustained remission**: None of the criteria have been met (exception of craving) for **12 months or longer**.[1]

> Severity must be specified with a remission status.

> Use disorders should not be documented with "history of" because they are considered chronic diseases.

Figure 2. Documentation Examples

EXAMPLE	SCENARIO	DOCUMENTATION/CODING
No Use Disorder	52 y/o male with chronic back pain. Started on opioids following injury, taking as prescribed. DOPL checked and appropriate. Managed by pain clinic.	Long-term opiate use (**Z79.891**) — followed by pain clinic, continue current dose.
Current Alcohol Use Disorder	48 y/o female who admits to drinking 12 beers and ½ bottle of whiskey every night for "as long as I can remember." Patient has attempted to cut back on drinking with no success and has withdrawals when she does not drink. The patient states she occasionally drives to work while intoxicated.	Moderate alcohol use disorder (**F10.20**) — risks of alcohol use discussed, referral to behavioral health.
Use Disorder in Remission	65 y/o female with long-standing use disorder completed rehab program and has been completely off opioids for the last 6 months. Urine screen negative.	Opioid use disorder, moderate, in early remission (**F11.21**) — no use for 6 months, patient coping with cravings; states getting better with time.

[1] Strain E., Opioid use disorder: Epidemiology, pharmacology, clinical manifestations, course, screening, assessment, and diagnosis. In: Post T, ed. *UpToDate*. Waltham, Mass.: *UpToDate*; 2020. **https://www.uptodate.com/contents/opioid-use-disorder-epidemiology-pharmacology-clinical-manifestations-course-screening-assessment-and-diagnosis**. Accessed August 07, 2020.

Practice Management Resources, Continued

Immunization Updates and ACIP Highlights

The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) met virtually on **February 22, 2023**, for its regular triennial vaccine meeting with an additional meeting **February 24, 2023**, to discuss bivalent COVID-19 vaccines.

Figure 3 below summarizes the key guidance from these meetings related to monkey pox (mpox), influenza, pneumococcal, meningococcal, RSV, and COVID-19 vaccines.

The ACIP also discussed **polio vaccine for adults, Dengue vaccine, and Chikungunya vaccine as well as varicella vaccine impact and CDC respiratory season dashboards**.

Learn more by accessing:

> **Related details** (vaccine evidence presented, committee discussion, and votes) for each recommendation summarized in **Figure 3** can be found on the SelectHealth provider website at **ACIP Meeting Updates**.

> **Archived meeting minutes and slides** are available on the **ACIP meeting website** (click on "Meeting Materials").

> **COVID Vaccine Recommendations** are available on the CDC's **Clinical Considerations** website.

Figure 3. Vaccines Guidance Summary

Mpox Vaccine Vote	Human monkeypox virus has been renamed "mpox." ACIP voted to recommend the use of JYNNEOS orthopoxvirus vaccine in persons ages 18 and older at risk of mpox during outbreaks.
Influenza	Preliminary vaccine effectiveness results for the **2022–2023** season, and U.S. influenza activity showed high effectiveness during this season in which the vaccine was well matched to the circulating virus strains.
Pneumococcal	Evidence to Recommendation (EtR) pneumococcal conjugate vaccine 20-valent (PCV20:Prevnar20) for the standard pneumococcal series in children age <2 years and for children ages 2–18 years with chronic medical conditions was presented for a recommendation vote in **June 2023**, pending FDA approval
Meningococcal	Pfizer pentavalent (subtypes A, B, C, W, Y) meningococcal vaccine clinical trial data was presented in anticipation of a potential recommendation in **October 2023**. Recommendation for the GSK candidate A, B, C, W, Y meningococcal vaccine will potentially follow in **2024**. A dosing schedule for a combined Men B vaccine with Men A, C, W, Y vaccine has not yet been determined.
RSV	• **Infant:** Cost-effectiveness analyses and EtR were presented for Nirsevimab Respiratory Syncytial Virus (RSV) monoclonal antibody pre-exposure prophylaxis to be administered to all infants during their first year of life and to high-risk infants in their second year. • **Maternal:** Pfizer presented the safety and efficacy data from the randomized control trial of their RSV bivalent prefusion F (RSVpreF) vaccine for use in pregnant women given as a single dose at 24–36 weeks gestation to prevent lower respiratory tract infections in infants due to passive maternal antibody transfer in utero. • **Adult:** Cost-effectiveness and EtR for GSK's candidate adjuvanted RSV vaccine and Pfizer's candidate non-adjuvanted RSV vaccine for adults aged 60 and older were reviewed.

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Figure 3. Vaccines Guidance Summary, Continued

COVID-19 Vaccines	• ACIP continues to recommend Pfizer mRNA COVID-19 vaccine after reviewing a safety monitoring signal for ischemic stroke in persons ages 65 and older after receiving a bivalent booster dose and discussing its benefits and risks. • ACIP discussed and supported transitioning from monovalent to bivalent COVID-19 vaccines for the primary series once FDA provides authorization and transitioning to an annual bivalent COVID-19 booster, but members wished to allow flexibility for more frequent administration to highest risk patients, such as the immunocompromised, at provider discretion.

Appeals and the Provider Benefit Tool

SelectHealth has enhanced our Provider Benefit Tool (secure login required) to include the option to submit member appeals, provider appeals, and medical records. Select the appropriate option under "Document type" to start the process.

What to include with your submission

When submitting an appeal, the correct appeal form must be filled out along with any supporting documentation regardless of how they are submitted (via online or mail).

Ensure your appeal (provider versus member) gets to the appropriate department. If the remittance advice is denying with a:

> CO as provider liability, use the **Provider Appeal Form**.

> PR patient responsibility, use the **Member Appeal Form**.

When submitting notes or records (not appealing a denial), please specifically convey the intent of the notes or records and advise what should be reviewed (e.g., claim lines, denial reasons, CPT/HCPCS codes, diagnoses etc.)

Email all completed documentation to **providerwebservices@selecthealth.org**.

How to get access to the Provider Benefit Tool

If you already have secure access, login to the **Provider Benefit Tool**. You can also access related frequently asked questions from the login page.

Not yet a Provider Benefit Tool user? The SelectHealth Provider Portal requires a secure login and 2-step authentication to use the Provider Benefit Tool for verifying member eligibility and tracking claims. To get started for a new account, complete and submit BOTH:

> **Information Technology Services Agreement (ITSA)**

> **Login Application**

To add a new user on an existing account, submit ONLY the **Login Application**.

Learn more about **cybersecurity and 2-step authentication.**