UTAH EDITION

providerINSIGHT®

SelectHealth® | May 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

> SelectHealth Community Care® (Medicaid)

> Federal Employee Health Benefits (FEHB) plans

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*

To return to the Table of Contents, click on providerINSIGHT® at the top of any page.

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SelectHealth® News

Understanding Tiered Benefit Plans

SelectHealth now offers large employers a three-tier network solution designed to help members save money on health expenses while offering the greatest access to providers. The product features multiple networks tiered to optimize choice, cost, and quality. Each tier is tied to a different provider network(s) and specific benefits/limitations (see sample member ID cards in **Figure 1** below).

Members are encouraged to see providers on Tier 1 and use Tier 2 benefits only when a Tier 1 provider is unavailable.

Review the information in **Figure 2** on **page 3** to understand differences between the three tiers.

Due to differences in provider office software when verifying member eligibility, occasionally only one network will populate followed by the word "tiered" (e.g., SELECTHEALTH VALUE TIERED).

Figure 1. Member ID cards indicate tier networks and associated deductibles/out-of-pocket expenses

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INSIGHTS from our Executive Team

Nate Foco, Chief Marketing Officer

For me, joining SelectHealth is the culmination of a decades-long career in helping members and providers navigate the complexities of the health insurance industry.

SelectHealth has a unique position in the health insurance industry as a not-for-profit company founded on the principle of providing quality healthcare to our members at the lowest possible cost.

We are also dedicated to serving our communities beyond our healthcare offerings and continue to give back through service, sponsorships, and awards for local businesses and community organizations.

With the help of our providers, we have made a tremendous impact in our communities here in Utah, Idaho, and Nevada, and are thrilled to expand into Colorado to bring our culture of health to a new corner of the Intermountain West.

We appreciate the tireless efforts of our providers in serving our local communities. To make working with us as simple as possible, we are improving our online experience, including:

> Making intuitive navigational changes

> Upgrading our provider tools

> Simplifying how you access secure content

> Improving our credentialing procedures and claims tracking

We value your feedback because it enables us to stay true to our mission of helping our members live the healthiest lives possible.

SelectHealth News, continued

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To quickly determine member eligibility, use the **Provider Benefit Tool**, our online tool for tracking eligibility and claims status. You can find member search instructions by downloading this quick guide, ***Access the Provider Benefit Tool: Viewing Member Benefits and Eligibility***.

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

Figure 2. Overview of Tiered Networks Benefits/Limitations

TIER 1: SELECTHEALTH VALUE® NETWORK	TIER 2: SELECTHEALTH MED® OR CARE® NETWORKS	TIER 3: OUT-OF-NETWORK BENEFITS
• **Lower member cost-sharing:** Depending on the plan, members may pay less for care through copays, coinsurance, and deductibles. • **Lower overall costs:** Doctors and facilities on Tier 1 have agreed to accept a lower allowed amount as payment in full. • **Combined deductible/ out-of-pocket:** Expenses count towards their in-network deductible and out-of-pocket maximums. • **Prescriptions count:** Any money spent out of pocket to pay for covered prescriptions will count towards the member's in-network (Tier 1) deductible and out-of-pocket maximum.	• **Slightly higher member cost-sharing and overall costs:** Members pay a higher copay, coinsurance, and may have a higher deductible for services when compared to Tier 1. • **Greater access:** There are more in-network providers and more in-network facilities when compared to Tier 1. **Note**: These doctors and facilities have agreed to accept a higher allowed amount as payment in full. • **Combined deductible/ out-of-pocket:** Expenses count towards their in-network deductible and out-of-pocket maximums. • **Prescriptions count:** Any out-of -pocket expense for covered prescriptions will count towards the member's in-network (Tier 2) deductible and out-of-pocket maximum.	• **Total access:** Members can go to any provider or facility for covered services. • **Higher costs:** Copays, coinsurance, and overall costs for care will be higher when compared to Tiers 1 and 2; providers and facilities may balance bill when allowed under the No Surprises Act. • **Separate deductible/ out-of-pocket:** No out-of-pocket expenses incurred on Tier 1, Tier 2, or for prescriptions count toward Tier 3 deductible/out-of-pocket maximum. Also no expenses incurred on Tier 3 count toward Tiers 1 or 2 deductible/out-of-pocket maximum. • **Certain services not covered:** Some services (e.g., preventive care) are not covered when done by an out-of-network provider.

NOTE: When providers on **both** Tier 1 and Tier 2 networks see members with a tiered network plan, they will be paid according to the Tier 1 fee schedule.

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.

Intermountain Health News

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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Intermountain Health News, continued

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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.

New Intermountain House Calls Pilot Program for SelectHealth Medicare™ Members

SelectHealth is launching a new pilot program in May in partnership with Intermountain House Calls to provide home medical visits for SelectHealth Medicare members after their enrollment. The pilot will begin with a limited number of Utah SelectHealth Medicare members.

Our goal with this program is to provide our Medicare members with comprehensive care and support at the beginning of their policy, particularly those members who may have difficulty accessing care due to mobility or transportation challenges.

These visits will not replace the role of a primary care provider or a primary care provider annual exam. All information collected during the appointment will be shared with the member's primary care provider through iCentra.

We believe that this new program will help support our shared mission to provide Medicare members with the highest level of care possible.

Questions? Contact Aaron Christensen at **aaron.christensen@selecthealth.org**.

Quality Provider Program News

Your Role in Quality Healthcare

Provider and staff engagement is vital to the success of any healthcare unit, facility, or care site. For a care team to feel engaged, they need to understand the importance of their work and how they contribute to the goals of the team.

Effective communication is the essence of providing high quality care. Without it, the cost of healthcare and negative patient outcomes would increase.[1]

Improving staff member communication and expectations will help employees feel more engaged in clinic goals. According to a Milliman White Paper study submitted to the National Committee for Quality Assurance, this engagement has the potential for the following benefits:[2]

> Reduced specialty visits, total costs of care, and hospital admissions

> Increased cancer screenings and other preventative measures

> Improvement in patients with chronic illnesses

> Enhanced patient satisfaction

All members of the healthcare staff play a crucial part in providing high-quality care. Front-line staff members are the face of the organization. Therefore, it is crucial that they represent the organization's values and mission; every person the patient interacts with can help improve a patient's experience. Engaging staff members in providing high-quality care can help an organization achieve and maintain their competitive advantage.

Engaged staff lead to higher patient satisfaction rates, increased patient safety, improved quality of care, and reduced costs associated with malpractice claims.[3] Improving and maintaining staff engagement is an essential investment in the long-term goals of a healthcare clinic.

Increasing Staff Engagement

The level of engagement staff members feel depends on the culture of the organization. Poor communication is the greatest obstacle to achieving staff engagement. Engaging staff members begins from the top of the organization by cultivating relationships, building trust, setting clear goals, offering support and mentorship, recognizing staff members, and most importantly, building a culture of listening.[3]

In helping the organization implement quality improvement goals, encouraging staff members to be critical thinkers and practice autonomy will not only increase engagement but also enhance patient care outcomes.[3]

By utilizing the skills and knowledge of the whole clinic team, providers are better able to practice at the top of their license and prioritize their time with patients. **Review "Tips for Engaging Staff in Quality Healthcare" on the next page.**

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Learn more about the Quality Provider Program

Contact your Provider Relations representative at **provider.development@selecthealth.org** for information on how to participate. We can now add clinics throughout the year.

Clinics that participate in this program strive to meet annual clinical goal thresholds as well as a series of participation requirements (outlined at an orientation meeting), such as:

> Educating patients on how to engage in their own healthcare plan

> Screening patients for social determinants of health (SDoH)

> Using community resources

> Following up with patients after discharge from an inpatient setting

Current program participants, contact your Quality Provider Program representative for more information.

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Tips for Engaging Staff in Quality Program Goals

> Communicate to staff that the organization is taking part in a quality program and what part they will play in helping to achieve program goals. Create and establish clear roles for staff members, such as those shown in **Figure 4** below.

> Share quality program goals in department staff meetings, and regularly follow up on the progress of these goals.

> If the clinic has a newsletter, include goals in a section to share with all staff.

> Offer ideas to improve communication during staff meetings.

> Assign or hire a staff member or group to be the care coordinator(s) to assist the organization in achieving established quality improvement goals.

> If a clinic is small or cannot afford to hire a new employee, disseminate care coordination duties across your quality improvement team.

Figure 4. Summary of Care Coordination Roles/Duties and Results[4]

Roles/Duties	Description	Results
Pre-visit Planning	Confirm visits, schedule preventive services, order all labs in advance per protocol, conduct medication reconciliation, order refills	Fewer no-shows, higher visit volume, improved staff satisfaction, increased adherence and revenue, improved outcomes
Care Gap Management	Follow-up with patients who are overdue for services or whose measures are out of range, particularly for chronic illnesses	Increased adherence and revenue, improved outcomes
Transition of Care Contacts	Call patient upon discharge	Increased follow-up with primary care provider, decreased readmissions

Table adapted from *The benefits of using care coordinators in primary care: A case study. Family Practice Management,* published by the American Academy of Family Physicians.

Engaging Providers

You cannot put a price tag on provider engagement in the clinical setting. Health plan studies have shown that engaged providers lead to better clinical outcomes, health plan quality ratings, member retention and more overall efficacy than their unengaged colleagues.[5]

Provider engagement focuses on the building of strong relationships and aligning physicians with the values, vision, and mission of healthcare administrators. With a continual increase in healthcare costs in America, an engaged provider can help hospitals and clinics work toward the goal of establishing more reasonable patient care models. Engaged physicians are more productive, acquire an increase in revenue, lower patient outflow, close care gaps, and reduce unnecessary treatment.[6,7] Additionally, engaged physicians play a pivotal role in helping healthcare administrators manage healthcare reform.

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Quality Provider Program News, Continued

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Increasing Provider Engagement

Increasing provider engagement starts with promoting effective communication between providers and system administrators. Encourage physician involvement with hospital administration and ensure provider opinions are heard. Having a provider attend the monthly Quality Provider Program meetings can be a great platform to increase provider engagement. Improving physician engagement not only leads to increased revenue from higher physician productivity and referral, but it also promotes higher quality patient care.[7]

Tips for Engaging Providers in Quality Program Goals

> Invite providers to attend quality improvement team meetings regularly.

> Send quality improvement program updates to your provider liaison.

> Regularly share program data with providers during provider meetings.

> Schedule a 1:1 with the provider liaison to update them on quality goals.

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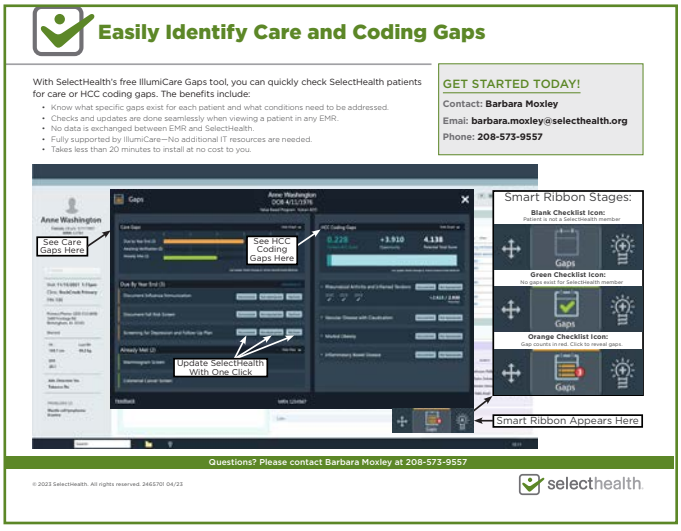
Illumicare Gaps Tool Makes Identifying Gaps in Care Easy

SelectHealth has partnered with Illumicare to offer providers a tool for quickly identifying care and coding gaps.

Access a quick guide, **Easily Identify Care and Coding Gaps,** to learn more about how this tool can help your practice and what information the app displays. Then, contact Barbara Moxley either at **Barbara.Moxley@selecthealth.org** or by calling **208-573-9557** to get started.

NOTE: The app is not offered on a typical online app store, so you will need to contact Barbara to get set up and learn how to use the Illumicare tool.



SelectHealth Medicare News

New Medicare Reimbursement and Claims Payment Approach

We are excited to announce that, effective **April 1, 2023**, SelectHealth has teamed up with Optum to use their system for pricing, payment, and claims editing and adjudication. For Medicare reimbursement and claims payment, this will help us better align with The Centers for Medicare and Medicaid Services (CMS) payment methodologies.

This update applies to all contracted and non-contracted CMS providers. Hospitals are excluded at this time. Changes will only affect SelectHealth Medicare.

Potential Billing Changes Needed

Providers may need to make some changes to their billing to be more in line with Medicare. One area of specific impact is the use of LT, RT, and 50 modifiers. Please note that:

> You will need to bill 50 modifiers instead of LT/RT as outlined by CMS.

> SelectHealth will pay 50 modifiers in accordance with CMS guidelines.

> If an LT and an RT are billed, the claim may be tagged with Medically Unlikely Edit (MUE) and denied. In this case, a 50 modifier may need to be billed instead.

Multiple Procedure Discounting Update

The Optum Physician Pricer applies many different types of multiple procedure discounting, just like CMS, to physician and non-physician practitioner claims, including endoscopic, diagnostic imaging, therapy service, surgical, cardiovascular, and ophthalmology discounting.

NOTE: SelectHealth is not currently applying some of these discounts. Payments may differ from what you have been seeing.

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).

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 and will no longer cover SIJ RFA for SelectHealth Medicare members. Please note that:

> As of **April 15, 2023**, SIJ radiofrequency ablation (RFA) is no longer covered 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.

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

SelectHealth Community Care® (Medicaid) News

Mental Health Outlook: The Need for Timely Post-Discharge Follow Up

The National Institute for Mental Health (NIHM) reports that in 2020, among the 52.9 million adults with a diagnosed mental illness, 46.2% received mental health services in the past year. Mental health services are inpatient or outpatient treatment and/or medication for mental illness.

Each year, over 2 million admissions for mental illness occur. Research suggests that timely follow-up care for patients after a hospitalization for mental illness is linked to:

> Fewer repeat emergency department visits

> Avoidable readmissions

> Improved physical and mental function

> Increased compliance with follow-up instructions

> A reduction in suicidal ideation, suicidal attempts, and death by suicide

HEDIS Measure: The importance of 7- and 30-day follow up after discharge

The National Committee for Quality Assurance's (NCQA) Follow-Up After Hospitalization for Mental Illness (FUH) HEDIS measure assesses adults and children, six years of age and older, who were hospitalized for treatment of mental illness or intentional self-harm and subsequently had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization. The measure identifies the percentage of members who received follow-up services from a behavioral health provider within 7 days and within 30 days of hospital discharge. It is important for individuals to have both follow-up appointments with the 7-day follow up visit being of utmost importance.

What qualifies as a follow-up visit?

Per NCQA, a follow-up appointment after hospitalization for mental illness may include any of the following:

> An outpatient visit

> An intensive outpatient program visit

> Partial hospital program visit

The visit must be with a behavioral health provider (i.e., psychiatrist, psychologist, psychiatric advance-practice nurse, clinical social worker, or other therapist). Telemedicine visits with the appropriate codes also meet the follow-up criteria.

How is SelectHealth Community Care® (Medicaid) performing on this measure?

For the Measurement Year 2021, SelectHealth's Community Care® (Medicaid) FUH for 7-day follow up performed in the 66.67th percentile, with 38.24% of eligible encounters meeting the 7-day follow-up requirement.

Ultimately, high-performing healthcare organizations strive to be in the 90th percentile. To reach that goal, SelectHealth Community Care needs to take incremental, consistent, and persistent steps. There are also ways SelectHealth providers can positively impact these patients getting timely post-discharge behavioral health care.

What is the role of primary care providers (PCPs) in facilitating follow up?

PCPs can play an integral role in helping to increase compliance with behavioral health follow up within 7 days of discharge and provide ongoing support that helps improve treatment outcomes by:

> Educating patients and families about the importance of a behavioral health follow-up appointment within 7 days after discharge for mental illness

> Scheduling a phone call or telemedicine appointment with the patient following discharge from hospital to ensure that the patient has a follow-up appointment scheduled with a behavioral health provider

> Facilitating in-person/telemedicine appointments (if necessary) with a behavioral health provider

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How can behavioral health providers support transitions from inpatient hospitalization to outpatient care?

Patients who do not attend follow-up appointments after a hospitalization for mental illness are likely to be readmitted. Therefore, timely behavioral health follow-up is key to ensuring sustainable change.

Outpatient behavioral health providers can be instrumental in the successful transition of these patients from inpatient hospitalization to outpatient care by:

> Seeing patients in person or via a telemedicine appointment within 7 days following discharge for a mental illness.

> Proactively contacting patients prior to the appointment to confirm attendance, and within 24 hours if the patient does not keep the appointment to reschedule.

> Contracting with SelectHealth's Quality Provider Program that rewards behavioral health provider efforts and successes at closing the FUH 7-day gap. For more information, contact Kelli Burnham at **Kelli.Burnham@selecthealth.org**.

New Behavioral Health Quality Measures

Check out the new Quality Provider Program for Behavioral Health. View **online information**, including the 2023 **Performance Measures Booklet** and **Quick Guide**.

What is the role of SelectHealth behavioral health navigators and care managers?

While hospitalized in a behavioral health inpatient unit, Intermountain Health **behavioral health navigators** follow patients, seeing them within 24 hours of admission. Patients who have received behavioral health services prior to admission are more likely to attend a follow-up visit after discharge. These navigators facilitate follow-up visit attendance by:

> Discussing whether the patient either has an established behavioral health provider or a preference for their outpatient appointment

> Addressing any barriers that the patient may have with attending a follow-up appointment within 7 days after discharge

> Calling the identified behavioral health provider to schedule an appointment within 7 days of the anticipated discharge

> Providing the appointment information to the patient

> Calling the patient again within 24 hours after discharge to review this information and address any barriers to attending the follow-up appointment

After discharge, a **SelectHealth behavioral health care manager** follows the patient for 30 days to make sure the patient has everything needed: scheduled follow-up appointment or appointments, transportation, support, and medications. The first contact is made within 72 hours of discharge and then weekly for the next 30 days. These care managers can arrange for a SelectHealth pharmacist to contact the patient to assist with medication questions if needed. In addition, they assist patients with scheduling any appointments that may be urgently needed. After these initial 30 days, patients with more complex needs will continue to be followed by SelectHealth behavioral health care managers with the goal to prevent a readmission for mental illness.

SelectHealth Community Care (Medicaid) News, Continued

Medicaid Policy and Requirements Updates

Qualifying clinical trials policy update

As part of the updates to Qualifying Clinical Trials made in 2022, the National Clinical Trial Number must be included on the Medicaid attestation form. Not all services that are a part of the clinical trial may require preauthorization; however, when they do, providers must include the Medicaid attestation form along with the preauthorization request form. Review the frequently asked questions online: **Qualifying Clinical Trials and Medicaid**.

Questions? Contact Member Services at **800-538-5054**.

Updates to transgender care

Effective **January 28, 2023**, Medicaid policy prohibits certain gender dysphoria treatments for patients under age 18. Also, effective **January 1, 2024**, providers will be required to complete a Transgender Treatment Certification to treat these patients. For details and exceptions on the policy, please read the **February Interim Medicaid Information Bulletin**.

Identify your PRISM provider type, specialty, and subspecialty

To become a billing, rendering, referring, or ordering provider for Medicaid, it's crucial to identify your provider type, specialty, and subspecialty (PT/SP/SSP). Medicaid's PRISM system requires this information to process and pay claims accurately.

If you have not already defined your provider type, specialty, and subspecialty in the Medicaid system, please review the **PRISM Provider Type, Specialty, and Subspecialty Update** and complete the form on the second page of that document.

Retro Enrollment for PRISM Program Extended to October 5, 2023

Practitioners not yet enrolled in the PRISM program can still do so. Utah Medicaid has temporarily extended the enrollment window from **April 3, 2023,** to **October 5, 2023**. Retro enrollments may be granted for:

> Up to 12 months for ordering, referring, prescribing (ORP) providers

> Up to 7 months for billing providers

If you have not done so already, enroll in PRISM before the deadline by visiting the **Utah Medicaid PRISM site**. **NOTE**: Enrollment is contingent on the provider meeting all credentialing and licensing requirements for the requested retro effective date.

Questions? Contact Nathan Garlick at **nate.garlick@selecthealth.org**.

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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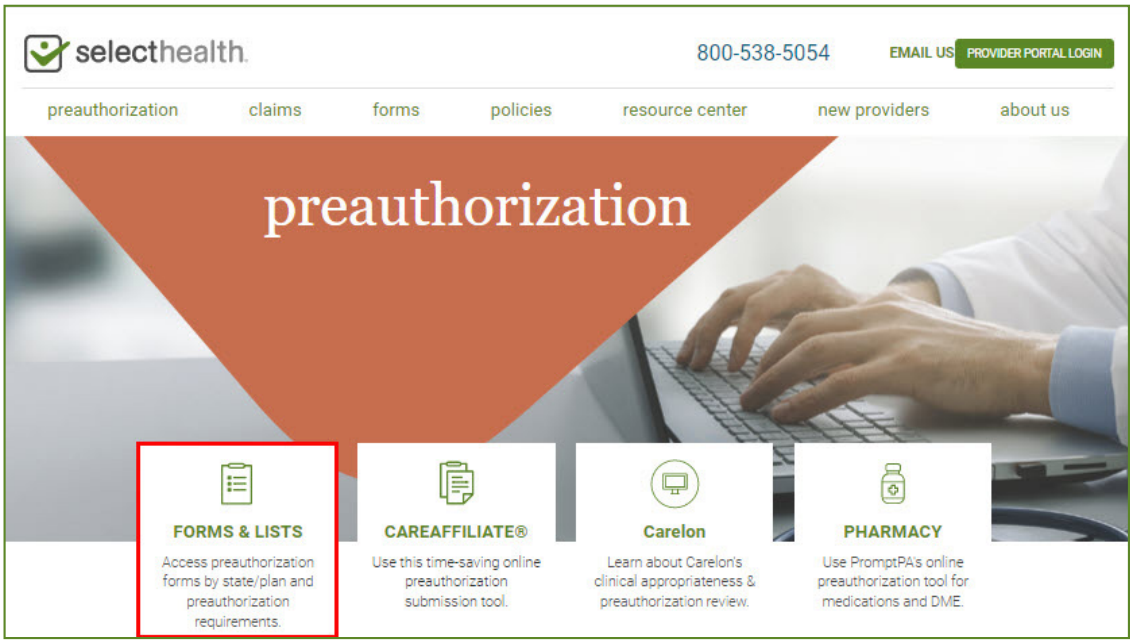
Preauthorization self-service tools: A quick guide

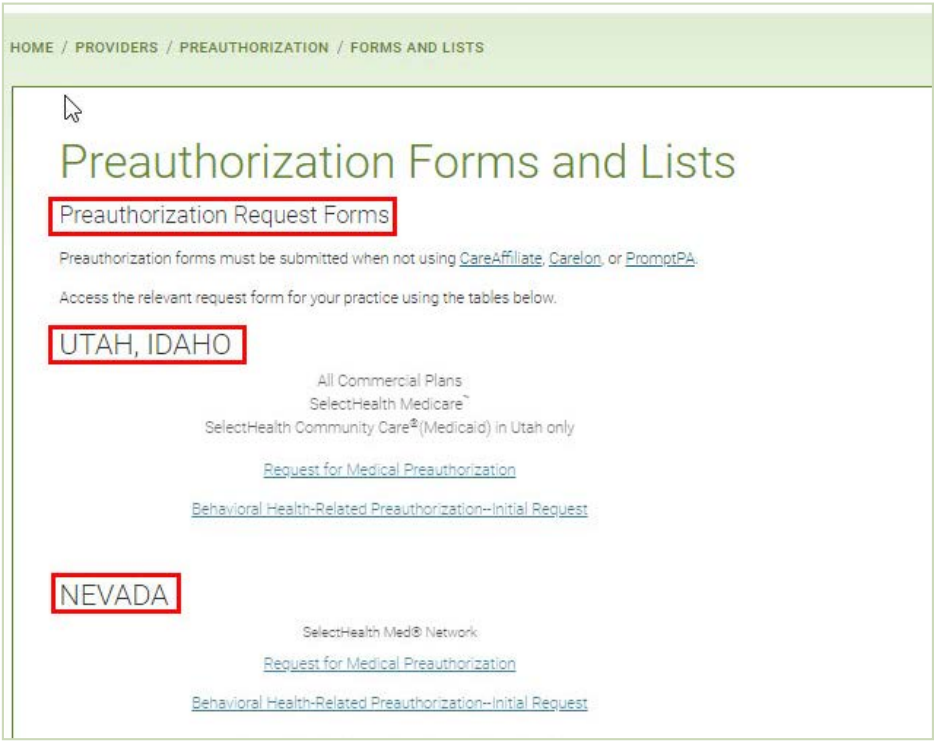
Get the answers you need quickly. Follow the steps below to find codes, requirements, and member accumulators.

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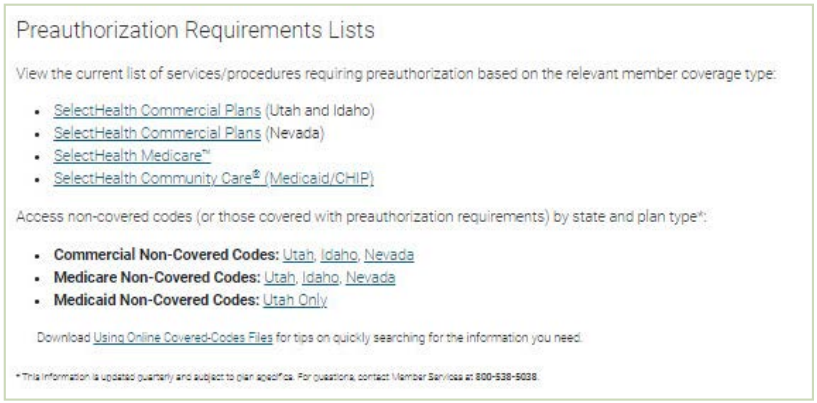
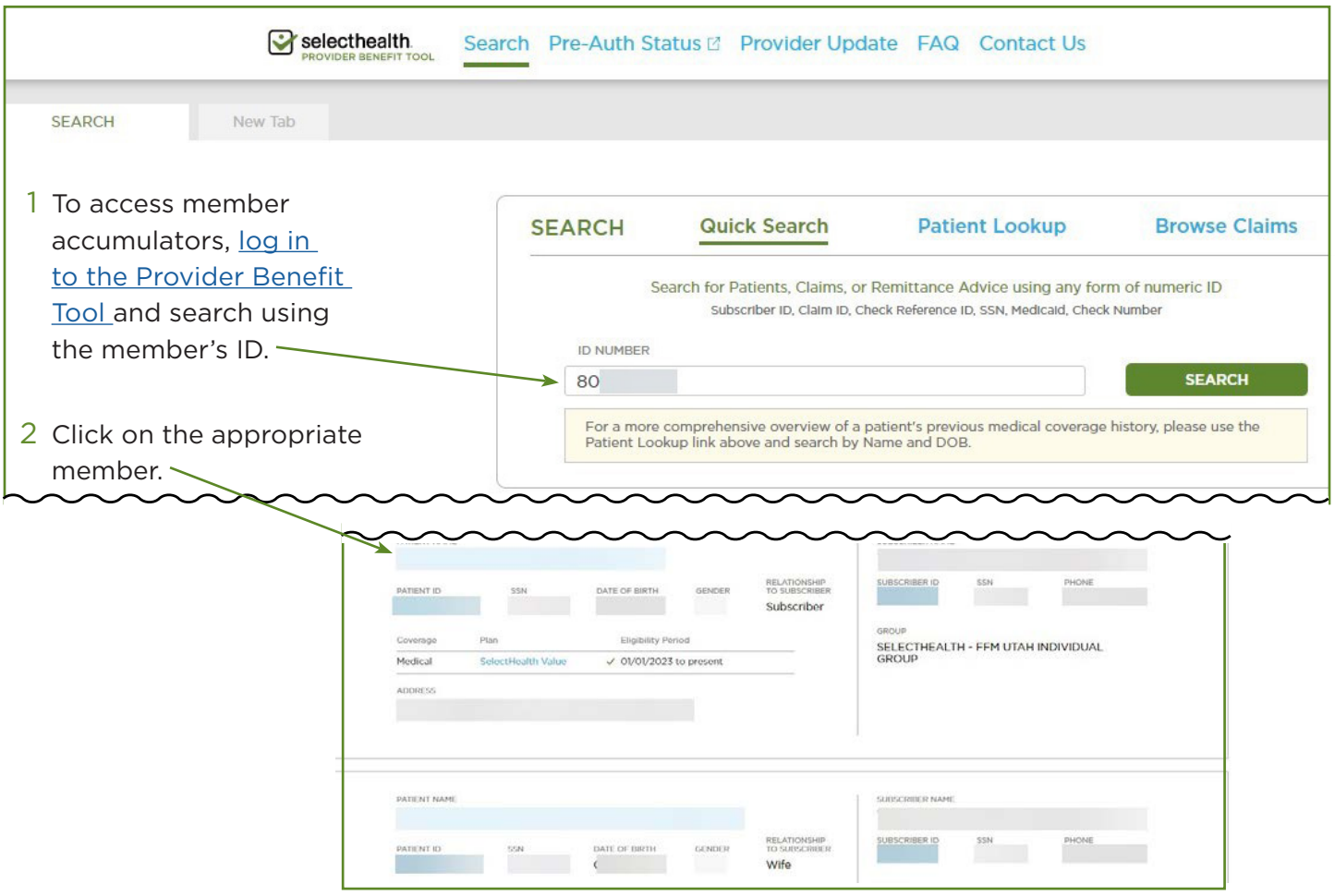
3 Further down on that same page, you will see preauthorization requirements lists that contain the current services and procedures requiring preauthorization based on plan type.

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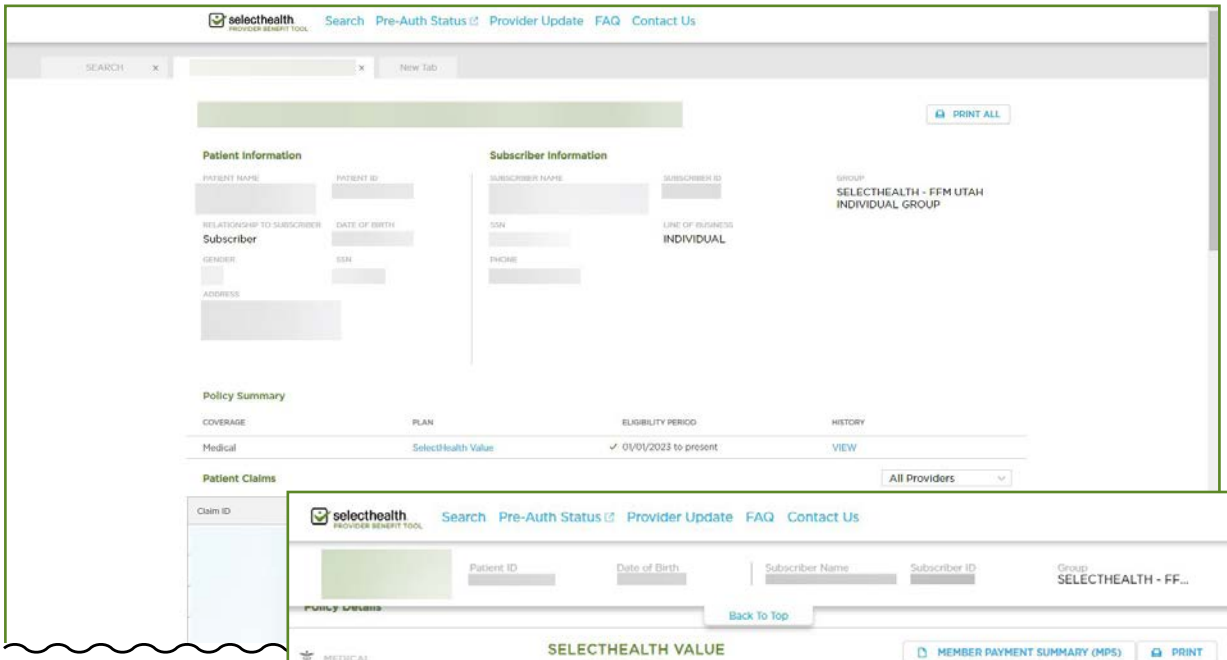
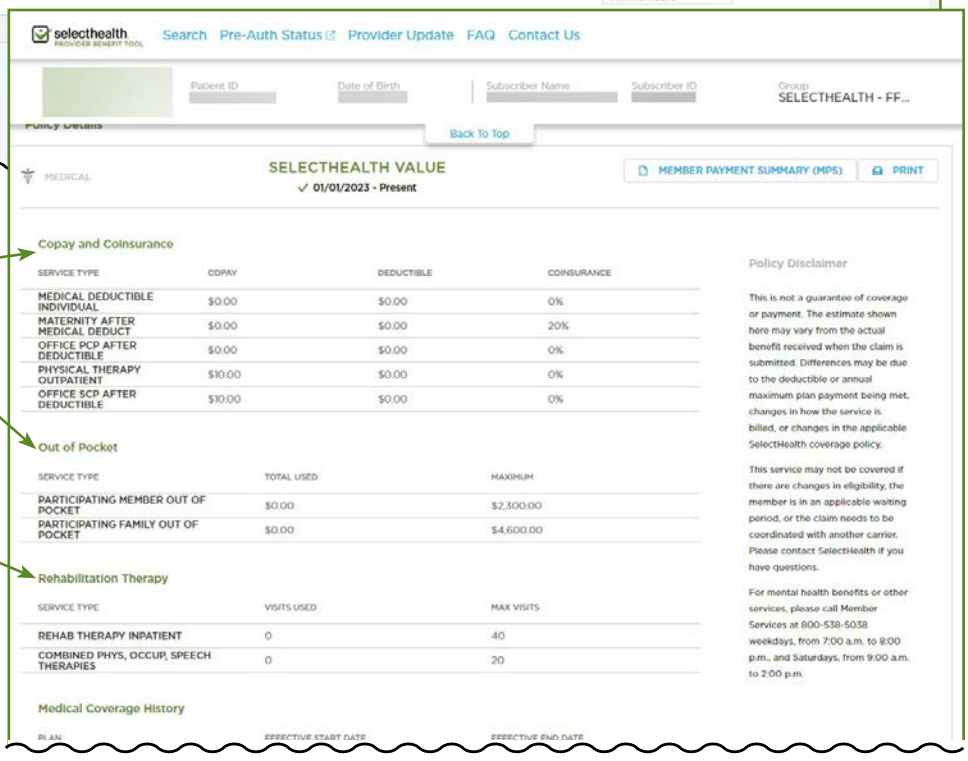
3 The member's policy information and claims will then open.





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 documentation online rather than through fax or email. This electronic functionality improves security and the speed at which requests are reviewed.

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 5** provides an overview for documenting an SUD. **Figure 6** on the next page offers documentation examples.

Figure 5. 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 6. 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

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.**