ProviderInsight®

Idaho Edition
August 2025

Welcome!

Find medical, dental, and pharmacy information as well as program and plan updates for:

- Commercial
- Select Health Medicare

Select Health

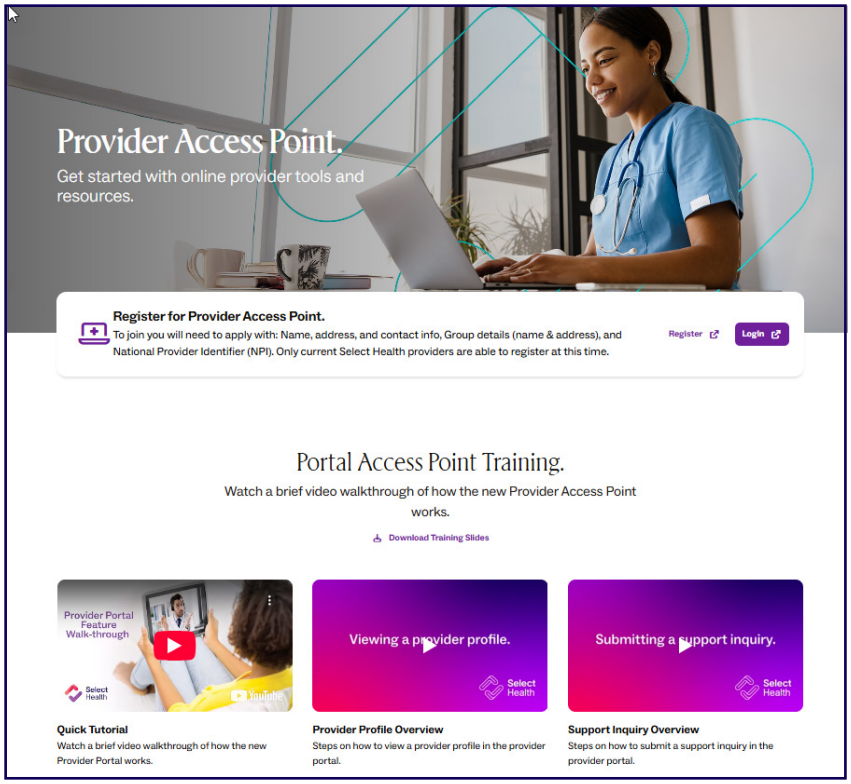
In this Issue

Select Health News and Networks

Introducing Select Health's New Provider Access Point

Select Health has recently launched its new **Provider Access Point** for contracted physicians and clinics. With the new Access Point, you now have one easy-to-use place to manage key aspects of your relationship with Select Health. Enhancements include:

- **Simple-to-use interface.** Enjoy more efficient claims and preauthorization management and quickly access online tools and the support you need.
- **Central login for online provider tools and portals.** Easily access Select Health's online preauthorization tool CareAffiliate® (soon to be Preauth & Care Plan Tool - see page 6), online claims Provider Benefit Tool, and other important online resources.
- **Enhanced and streamlined contracting and credentialing process**. Apply to join Select Health networks, see credentialing status, and upload important information..
- **Ability to manage your clinic roster.** Upload changes and get help fast when you need to update your clinic roster.
- **Simplified update process for demographic or practice information**. Access an easy-to-use online form for updating information.
- **Quicker, more responsive support.** Enjoy an expanded online help function to submit questions/requests securely.



See the new Provider Access Point in action!

No Medical AI-generated Calls

AI-generated calls can present regulatory, ethical, and consumer-related challenges. To best ensure HIPAA compliance and protect patient trust, Select Health Member Services will not share information with AI agents.

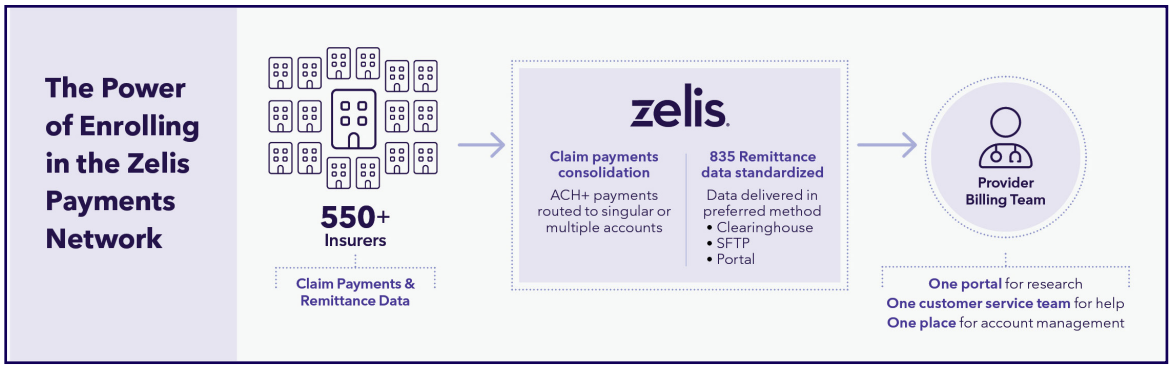
Instead, please use our online resources to quickly get the information you need. Access these tools from the secure Provider Access Point:

- Member ID Cards or the Provider Benefit Tool: Eligibility
- CareAffiliate: Preauthorization Requests
- The Provider Benefit Tool: Claims Status

Questions? Contact your Provider Development representative at provider.development@selecthealth.org.

Introducing Zelis for Provider Payments

In the coming months, Select Health will transition to using Zelis for claims payment. This change is part of Select Health's ongoing effort to simplify the payments process, expedite revenue disbursal, and reduce the administrative burden for our valued clinics. We are pleased to collaborate with Zelis – a recognized leader in modernizing healthcare payments – to bring greater efficiency and convenience to our providers.



WHAT DOES THIS MEAN FOR YOU?

You will have a choice between two electronic payment options. **NOTE**: If you do not enroll in either electronic payment option, you'll continue receiving paper checks. **Directions for enrollment in either option will be available in the coming months.**

1. **Zelis Payments Network (ACH+)**

   ACH+ offers a single secure portal to receive, manage, and gain insight into payments and remittances from Select Health. ACH+ is designed to significantly reduce manual work and operational costs associated with claim payments, while accelerating provider cash flow.

   ACH+ Key Features:

   - Single login to manage all TINs and payers
   - Easy payment tracking by claim
   - Ability to export data in 835, CSV, XLS, or PDF formats, or automate 835 delivery to your clearinghouse or via SFTP
   - Visual dashboards for revenue and claims insights
   - One support team for payment and remittance delivery questions for all payers using Zelis

2. **Select Health's ePayment Center**

   Also powered by Zelis, the ePayment Center will offer a **no-cost EFT option** that allows you to:

   - Receive Select Health payments directly to your bank account.
   - Access Select Health remittance data via a secure portal.
   - Deliver Select Health ERA/835s to your clearinghouse or via SFTP reducing the need for manual entry.

Already using Zelis? No action needed. Your Select Health payments will automatically route through your existing setup.

Compliance Matters

ADA Accommodations: Providing Equal Access for Those with Disabilities

Per CMS (42 CFR 438.206a), the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act, these standards require healthcare providers to provide individuals with disabilities full and equal access to their healthcare services and facilities.

Select Health includes specific ADA accommodations offered by provider locations in our Provider Directory. We gather this information from quarterly demographic attestations so that all our members can better find the providers whose practice location best meets their specific needs.

When you are completing the quarterly attestations, please update the specific ADA accommodations offered for those with disabilities along with clinic location to specify whether each location meets the ADA standards.

Below you will find the accommodations addressed in the quarterly attestation with key definitions of what qualifies for each. **Questions?** Contact your Provider Development representative.

EXAM TABLE AND SCALE

An accessible exam table or chair that can be lowered to the height of a wheelchair. It should have rails, straps, cushions, or other parts that support a patient during transfer and while they're on the table. An accessible scale should be large enough to fit a wheelchair and have a weight capacity high enough to include the wheelchair.

INTERIOR BUILDING

An accessible interior building has clear floor paths through all the areas that a patient would need to access. To make sure the paths are accessible, there may be handrails, ramps, walks, elevators, platform lifts, stairways, landings, and entries wide enough for wheelchairs, as needed.

SIGNS

All permanent rooms and spaces should have signs that are accessible for people who are blind or have low vision. Accessible signs have visual and/or tactile letters, are positioned at an accessible height and location, and meet all the ADA requirements.

EXTERIOR BUILDING

An accessible exterior building has a clear path to enter and exit the building. Parking spaces and access aisles should be set up so that parked cars and vans won't block accessible routes. To make sure the path is accessible, there may be handrails, ramps, walks, sidewalks, and parking access aisles as needed.

BATHROOMS

Accessible bathrooms have enough turning space for a person using a wheelchair to maneuver into position and have seats and grab bars at the right height and

Continued on page 5...

position. Convenience fixtures like baby changing tables should also be accessible to people with disabilities.

EXAM ROOM

An accessible exam room allows patients with mobility disabilities, including those using wheelchairs, to get the care they need. There should be an accessible route to the exam room and enough clear floor space inside the room for side transfers and use of lift equipment. The room should have accessible hardware and examination equipment too.

PATIENT LIFTS

Providers can use a lift to safely transfer a patient from a wheelchair to the exam table. Medical staff can position a sling under the patient while they're sitting in the wheelchair, attach the sling to the lift, and use the lift to lower the patient onto the exam table. Once the patient is secure, staff can detach the sling from the lift.

RADIOLOGIC EQUIPMENT

Most radiologic exams, such as x-rays and CT scans, require the patient to lie still on a flat surface. To transfer a patient in a wheelchair onto the exam surface, a provider may use adjustable-height equipment, patient lifts, or gurneys and stretchers. If a patient needs help keeping still, medical staff can support them with pillows or wedges.

GURNEYS AND STRETCHERS

An accessible gurney (a table on wheels) or stretcher can be lowered to the height of the patient's wheelchair seat and raised to transfer the patient safely onto an exam table or other surface.

PARKING

Accessible parking includes accessible spaces, access aisles, and at least one accessible route to the building entrance, all clearly marked. In parking facilities where the accessible route crosses traffic lanes, the street crossings should be marked as well.

Learn more. Check out these national resources:

- Access Board - Standards for Accessible Medical Diagnostic Equipment
- Access Board – Health Care
- ADA National Network - Accessible Medical Diagnostic Equipment
- Department of Justice - Access to Medical Care for Individuals With Mobility Disabilities
- The Barrier Free Healthcare Initiative

Get Ready for the Preauth & Care Plan Tool — Coming September 15th

Effective **September 15, 2025**, Select Health moves to a new online tool for medical preauthorization requests. The Preauth & Care Plan Tool will bring a variety of updates and features to the online preauthorization process, including:

- Enhanced workflow automation
- Added case management functionality
- Improved dashboard experience
- And more

WHAT TO EXPECT DURING THE TRANSITION

If you are already registered to use Select Health's online tools, you can access the new preauthorization tool through the Provider Access Point, using your current username and password. CareAffiliate will continue to be available in view-only mode for three months after September 15.

If you are not currently registered to use our online tools, we encourage you to register now to avoid delays once the new Preauth & Care Plan Tool becomes available. Register Now

ACCESS ONLINE TRAINING AND RESOURCES.

Get ready to start using the Preauth & Care Plan tool by checking out helpful information and FAQs on the Select Health website.

You can also find on-demand training videos or register for one of our live virtual training sessions to help you get up to speed and answer any questions you may have. **Upcoming sessions will take place on the following dates:**

- Tuesday, September 2, 11:00 a.m. to 12:00 p.m. MST (Download/Add to Calendar)
- Wednesday, September 3, 12:00 p.m. to 1:00 p.m. MST (Download/Add to Calendar)
- Monday, September 8, 2:00 p.m. to 3:00 p.m. MST (Download/Add to Calendar)
- Thursday, September 11, 1:00 p.m. to 2:00 p.m. MST (Download/Add to Calendar)

Questions? Contact us at web.preauth.support@selecthealth.org.

Quality Improvement Programs

Quality Provider Program (QPP): The Fall Gather & Grow Conference

Join us **October 1, 2025,** for the QPP fall Gather & Grow Conference featuring sessions on diabetes care and risk adjustment as well as a clinic highlight on pediatric well-care visits.

These conferences provide an opportunity for us to review program updates, share best practice, and connect clinics to discuss common barriers and solutions.

Be sure to save the date for **October 1** and watch your email for more details!

Focus on Controlling High Blood Pressure

The Quality Provider Program (QPP) added a new measure in 2025: **Hypertension — Controlling High Blood Pressure**. Part of the primary care and nephrology programs, this measure evaluates the percentage of members ages 18 to 85 with hypertension (HTN) whose blood pressure (BP) was adequately controlled (i.e., <140/90 mm Hg).

Using claim/encounter data, we look at the qualifying members who had at least 2 outpatient, telephone, or virtual check-in visits on different dates of services with a diagnosis of hypertension. We compare that number with the members whose most recent BP level reading is <140/90 mm Hg (the limit defined as "normal"). Both visits must occur either in the prior measurement year or by June 30 of the current measurement year, allowing six months for lifestyle and/or medication changes to lower BP.

Learn about allowable corrections and exclusions by accessing page 9 of the Primary Care Measurement Booklet.

BEST PRACTICES FOR BP GATHERING:

Allow patient to sit quietly for a few minutes before taking BP.

- Do a repeat BP if > 140/90.
- Document any repeat BPs where they can be captured for QPP payment.
- Use CPT II codes for BP in visit claims. (See article page 19.)
- Document patient-reported BPs where they can be captured for QPP payment.

HOW CAN CLINICIANS HELP PATIENTS BETTER CONTROL HIGH BLOOD PRESSURE?

To significantly improve long-term blood pressure control, clinicians can focus on a combination of:

- Lifestyle modifications (e.g., weight loss, physical activity, and dietary changes like reducing sodium and increasing potassium intake)
- Medication management and adherence (e.g., simplifying medication regimens, addressing barriers to adherence, and monitoring for side effects)
- Patient education, such as on how to self-monitor blood pressure (SMBP)
- Providing support for lifestyle changes

Continued on page 8..

Lifestyle Modifications

Strategies include:

- **Weight Management:** Advise overweight or obese patients to strive for a healthy BMI (18.5-24.9 kg/m^2) and maintain it through a healthy diet and regular physical activity. Remind patients to eat a diet rich in fruits, vegetables, and low-fat dairy products. Weight reduction can help patients reduce their blood pressure by about 5 mm Hg.[1]

  Consider referring the member to a dietitian (a certain number of visits are covered as preventive on many Select Health plans for eligible members) to help members limit sodium and fat intake, especially saturated fats, and increase their potassium intake.

- **Physical Activity**: Encourage members to engage in regular aerobic exercise, such as brisk walking (for at least 150 minutes per week) and to explore new ways to exercise with friends and family (e.g., yoga, swimming, pickle ball).

- **Smoking, Alcohol, and Stress Management:** Advise patients to quit smoking and limit alcohol consumption (i.e., no more than 1 drink/day for women; 2 drinks/day for men). Talk to members about local smoking cessation and fitness programs. Help members try techniques to better manage stress (e.g., deep breathing, yoga, mindfulness, or meditation).

Medication Management

Strategies include:

- **Medication Adherence:** Emphasize the importance of taking medications as prescribed and, if possible, simplify medication regimens by using single-pill combinations or once-daily medications to improve adherence. Identify and address any barriers members have to taking their medications as prescribed, (e.g., cost, side effects, or lack of understanding).

- **Monitor Effectiveness:** Regularly monitor blood pressure and adjust medications, as needed, to achieve target blood pressure levels. Practice shared decision-making discussions with members about balancing effectiveness, side effects, costs, etc.

Patient Education

Provide education and support for members, such as:

- **Self-Measured Blood Pressure (SMBP):** Encourage and support patients at home to monitor their blood pressure regularly. Provide comprehensive education about hypertension, its risks, and the importance of lifestyle modifications and medication adherence.

- **Team-Based Care:** Involve nurses, pharmacists, and other healthcare professionals to support and educate members.

- **Shared Decision Making:** Engage patients in shared decision-making regarding their treatment plan, promoting them taking an active role in their care.

WHY IS A FOCUS ON CONTROLLING HIGH BLOOD PRESSURE SO IMPORTANT?

In 2023, high blood pressure was a primary or contributing cause of 664,470 deaths in the United States.[2] **Figure 1** on the next page illustrates where hypertension is more prevalent throughout the country.

According to the Centers for Disease and Prevention (CDC):[3]

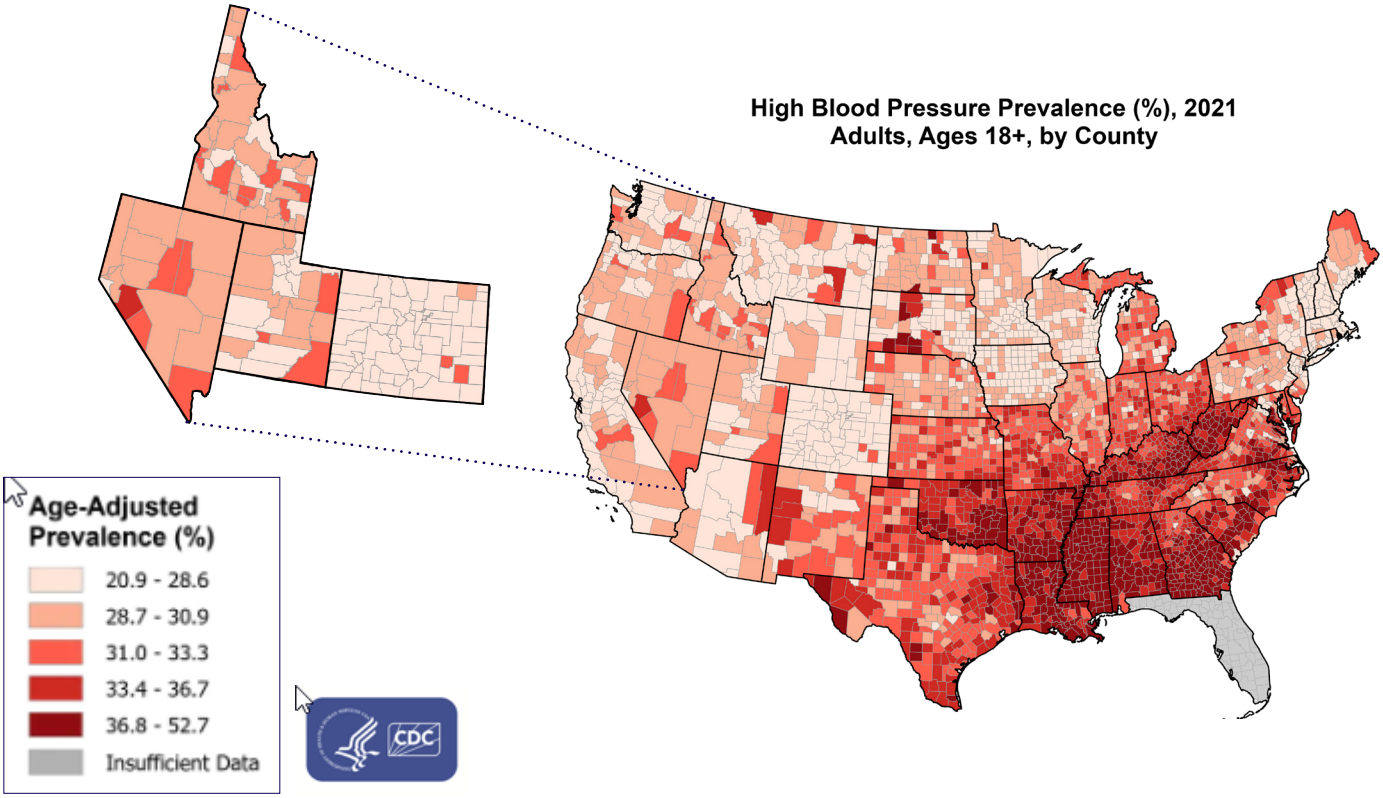
- About 1 in 4 adults with high blood pressure has their blood pressure under control (22.5%, 27.0 million).
- Those with uncontrolled high blood pressure (140/90 mm Hg or higher) total 37 million U.S. adults.
- An additional 34 million adults (45%) should be taking medication but have not yet filled nor started taking their prescriptions.

High blood pressure costs the U.S. about $131 billion each year, averaged over 12 years from 2003 to 2014.[4]

Continued on page 9...

High blood pressure is more common in some areas of the United States. The map in **Figure 1** shows the self-reported rate of hypertension by county in adults ages 18 and older. Note that data for the intermountain west is better than for the lower Midwest and south; however, this map likely underreports the true effect of hypertension in each state, because about 1 in 5 adults with high blood pressure is unaware of it and would not report having it.[5]

Figure 1. Regional and National Self-Reported High Blood Pressure (2021)[6]



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1. Berg S. 5 changes your patients can make to improve BP control. *American Medical Association Prevention & Wellness.* AMA-assn.org website. https://www.ama-assn.org/delivering-care/prevention-wellness/5-changes-your-patients-can-make-improve-bp-control#:~:text=Weight%20reduction,especially%20if%20they%20have%20prediabetes. Accessed August 4, 2025.
2. National Center for Health Statistics. *Multiple Cause of Death 2018–2023 on CDC WONDER Database.* Accessed February 1, 2025. https://www.cdc.gov/nndss/infectious-disease/weekly-and-annual-disease-data-tables.html. Accessed August 5, 2025.
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4. Kirkland EB, Heincelman M, Bishu KG, et. al. Trends in healthcare expenditures among US adults with hypertension: national estimates, 2003-2014. *J Am Heart Assoc.* 2018;7:e008731.
5. Farley TA, Dalal MA, Mostashari F, Frieden TR. Deaths preventable in the US by improvements in the use of clinical preventive services. *Am J Prev Med.* 2010;38(6):600–609.
6. Centers for Disease Control and Prevention. *High Blood Pressure Facts.* cdc.gov website. January 28, 2025. https://www.cdc.gov/high-blood-pressure/data-research/facts-stats/index.html#cdcreference_1. Accessed August 1, 2025.

Pharmacy

Improving Patient Outcomes: Opioid Education and Substance Use Disorder Awareness

Substance use disorders (SUDs), including opioid and benzodiazepine misuse, are prevalent and growing concerns across all age groups. The HEDIS measures for **Diagnosed Substance Use Disorders (DSU)** and **Deprescribing of Benzodiazepines in Older Adults (DBO)** highlight the importance of identifying, educating, and supporting patients at risk.

Proactive education and documentation can help reduce misuse, improve patient safety, and support better health outcomes—especially in older adults who are more vulnerable to adverse effects.

IDENTIFYING AND EDUCATING AT-RISK PATIENTS

Best practices and tips include:

- Educating patients on the risks of opioid and benzodiazepine use, including dependency, cognitive impairment, and overdose. Tailor education to age and risk level.
- Using electronic medical record (EMR) alerts to flag patients who are prescribed opioids or benzodiazepines, especially those 67+ years old, to assess for deprescribing opportunities.
- Checking Idaho's Controlled Substance Database to avoid duplicate prescribing or unintentional co-prescribing of high-risk medications with the member's other providers.
- Contacting patients diagnosed with substance use disorders (SUDs), especially those with opioid or alcohol use disorders, to offer support and resources.
- Documenting opioid education and addiction prevention efforts in the EMR, including discussions, handouts provided, and referrals to behavioral health or pain management.

FREE IDAHO PROVIDER RESOURCES

- National Deprescribing Resource
- Idaho Opioid Resources
- Prescription Drug Monitoring Program (PDMP) Statistics Dashboard

QUESTIONS?

Contact a Select Health Quality Consultant RN:

- Amber Naluai RN: amber.naluai@selecthealth.org
- Amber Wray RN: amber.wray@selecthealth.org

Metformin Extended Release: Improved Medication Adherence and Tolerability

Based on improved tolerability and patient satisfaction, we encourage you to consider switching **eligible** patients from metformin immediate-release (IR) to metformin extended-release (ER) formulations. This recommendation is supported by internal adherence data and clinical evidence.

Our recent analysis of Select Health members on metformin IR monotherapy revealed that less than 60% of these members were taking the prescribed amounts each day. Many of these cases are linked to missed second doses or discontinuation due to side effects. Transitioning to ER may help address these issues.

DOES SELECT HEALTH COVER METFORMIN ER?

Select Health covers metformin ER at Tier 1 ($0) on most plans, ensuring that there will be no change in cost for the member. **NOTE**: The modified version and the osmotic version of metformin are not covered.

WHAT ARE THE BENEFITS OF METFORMIN ER?

Improved Patient Adherence:

- Metformin ER is absorbed more slowly, which can reduce gastrointestinal side effects such as nausea, diarrhea, and abdominal discomfort, which are common reasons patients discontinue or underuse metformin IR.
- ER formulations are typically dosed once daily, compared to the twice-daily regimen of IR. This simplification can significantly improve adherence, especially in patients who struggle with complex regimens or forget to take their second dose.

Clinical Effectiveness:

Studies have shown that metformin ER provides comparable or even superior glycemic control and lipid profile improvements compared to IR formulations.[1]

HOW CAN SELECT HEALTH PHARMACY SERVICES HELP?

If appropriate, consider initiating a switch to metformin ER for patients experiencing adherence challenges or side effects. Our Pharmacy Services team is available to support this transition and can assist with patient education and follow up.

This initiative aligns with Select Health's mission to "Help people live the healthiest lives possible®" by supporting evidence-based prescribing and improving medication adherence across our membership.

If you have any questions or would like assistance identifying patients who may benefit from this change, please contact Select Health Pharmacy Services at:

- Phone: **800-442-5214**
- Fax: **385-297-2692**

REFERENCE:

1. Derosa G, D'Angelo A, Romano D, Maffioli P. Effects of metformin extended release compared to immediate release formula on glycemic control and glycemic variability in patients with type 2 diabetes. *Drug Des Devel Ther.* 2017 May 16;11:1481-1488.

Behavioral Health

Applied Behavior Analysis (ABA) Preauthorization Changes in 2026

ABA helps individuals with autism spectrum disorder (ASD) to make changes in their behaviors, with the typical goal to either increase life skills, such as verbal communication, or reduce behavioral excesses, such as aggression. Services are provided by a Board Certified Behavior Analyst (BCBA) or Licensed Behavior Analyst (LBA) who is a master-level clinician.

Select Health covers these services for members diagnosed with ASD.

POLICY CHANGES

On **July 1, 2025**, the ABA medical policy was revised with comprehensively updated criteria for coverage and included language regarding exceptions for members on FEHB plans.

Effective **January 1, 2026**, preauthorization will be required for all ABA services to ensure alignment with best practices and clinical guidelines across the industry. Required preauthorization is not intended to reduce or eliminate benefits or ABA services. Currently, Select Health offers voluntary preauthorization for ABA services and treatment.

LEARN MORE

Access the full Select Health ABA medical policy**.**

Questions about ABA services or coverage? Please contact Member Advocates at **800-515-2220**.

HEDIS Updates: Follow-up Care After Discharge Measures (FUM and FUH)

Please be aware of **important changes** that started in 2025 to the FUH and FUM HEDIS measures.

A key change is the follow-up visit can be performed by any healthcare provider (e.g., primary care provider) as long as billing requirements are met and a mental health diagnosis is included in any position on the claim.

NCQA publishes HEDIS measures that Select Health behavioral health services tracks. Follow-up care measures are for members who experience an intensive level of care for a mental health and/or substance use diagnosis:

- **As a hospital inpatient (FUH measure); OR**
- **During an emergency department (ED) visit (FUM measure)**

In addition, peer support and psychiatric residential treatment services were added to the follow-up visit types. The changes also included removal of the mental health diagnosis requirement for partial hospitalization/intensive outpatient and community mental health center visits as well as electroconvulsive therapy (ECT).

Read more about these changes in NCQA's Summary Table of Measures, Product Lines and Changes.

Pediatric and Adolescent Mental Health Series

Part 1: Adolescent Residential Treatment

For primary care and mental health providers helping families determine the best approach to care for youth suffering from a mental health crisis, understanding what residential treatment entails and best practices are critical components for optimum outcomes.

The Pediatric and Adolescent Mental Health Series features four articles focusing on best practices and treatment approaches for youth experiencing a mental health crisis.

Part 2: Stabilization and Mobile Response Teams will appear in the November *Provider Insight*.

WHAT QUALIFIES AS A RESIDENTIAL TREATMENT CENTER?

Adolescent residential treatment centers (RTCs) or psychiatric residential treatment facilities (PRTFs) are licensed residential facilities that provide an out-of-home placement offering medical monitoring and 24-hour individualized treatment to adolescents with mental health and/or substance use disorder diagnoses. These facilities provide structured therapeutic programming delivered by licensed clinicians 7 days a week, along with:

- Psychiatric and psychosocial assessment and management
- Parent and/or family training or therapy
- Academic and/or vocational programming
- Medical/nursing oversight 24 hours a day

IS RESIDENTIAL TREATMENT TYPICALLY THE BEST OPTION?

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommendations center on a youth crisis care that:[1]

- Keeps youth in their home and avoids out-of-home placements, as much as possible.
- Provides developmentally appropriate services and supports that treat youth as youth, rather than expecting them to have the same needs as adults.

Continued on page 14...

- Integrates family and youth peer support providers and people with lived experience in planning, implementing, and evaluating services.
- Meets the needs of all families by providing culturally and linguistically appropriate, equity-driven services.

Although treatment decisions should be based on the adolescent's needs, there is lack of effectiveness evidence to support this level of treatment over less-restrictive care levels for individuals with a viable living environment. Thus, residential treatment is only recommended in cases where an adolescent cannot be managed safely in the community, yet doesn't require the services of an inpatient hospitalization.

American Academy of Child and Adolescent Psychiatry (AACAP) recommendations for duration of treatment in a residential facility are that:[2]

- The duration of residential treatment for adolescents varies, but it generally ranges from **30 to 90 days**, with some programs extending longer.
- The specific length of treatment depends on the individual adolescent's needs and the severity of their condition(s).
- Discharge planning for residential treatment should be a comprehensive and ongoing process, starting at admission to the residential facility and continuing throughout the adolescent's stay. It should also address all aspects of the child's needs, including continuing treatment, supportive services, and aftercare plans, with the goal of a smooth transition back into the community.

In other research, a retrospective analysis of patient data (over a 15-year period from January 1, 2001, to December 31, 2016) found that a residential treatment of stay of **60–89 days was associated with a reduced risk** of being convicted for any crime, violent or non-violent, and for being hospitalized for substance use up to 15 years following treatment exit.[3] Of those studied (who were in residential treatment for **90–120 days**), there was no link with lowered conviction or hospitalization rates for the extended time in the program.

DOES SELECT HEALTH COVER RESIDENTIAL TREATMENT?

Select Health covers evidence-based residential treatment that meets medical necessity. Coverage can vary depending on plans and locations. Currently, we use voluntary preauthorization for these services and do not deny a claim solely based on lack of preauthorization.

For any questions about adolescent residential treatment services or coverage, please contact Member Advocates at **800-515-2220**.

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1. Substance Abuse and Mental Health Services Administration. *National Guidelines for Child and Youth Behavioral Health Crisis Care.* Publication No. PEP22-01-02-001. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2022. https://www.samhsa.gov/data/. Accessed August 5, 2025.
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Select Health Medicare News

Partnering for Outcomes: The Select Health STARS Team

At Select Health, our STARS team plays a vital role in improving member health outcomes and supporting Centers for Medicare and Medicaid Services (CMS) quality measures.

HOW DOES THE STARS TEAM SUPPORT MEMBERS?

Each year, our dedicated agents proactively contact members to:

- Verify key health information
- Educate members on benefits like 100-day supplies and Intermountain Home Delivery
- Encourage adherence to medications, such as statins and diabetes therapies

Higher ratings not only reflect better quality of care but also lead to increased financial incentives that benefit both the health plan and participating providers.

HOW DOES THE STARS TEAM SUPPORT PROVIDER OFFICES?

Our outreach efforts support provider offices by aligning efforts, minimizing duplication, and streamlining communication. Our agents follow structured scripts, document all interactions, and coordinate closely with pharmacists to ensure consistency in messaging — especially around statin adherence and exclusions. By sharing updates and working in tandem, we can help offices improve patient outcomes.

Our goal is to ensure that providers have the information and support they need to address these measures effectively during patient visits and elevate our shared performance on STARS metrics.

HOW WILL THE STARS TEAM FOCUS EFFORTS ON STATIN ADHERENCE?

We recognize that collaboration is key to success. To further support adherence and SUPD (Statin Use in Persons with Diabetes) measures, the STARS team will soon be contacting provider offices to:

- Coordinate a pre-visit for reviewing member gaps
- Share exclusion lists to avoid redundant efforts
- Collaborate on statin start plans

Questions?
Contact the STARS team for support at **800-442-5214** or email nakisa.mirrafie@selecthealth.org.

Immunization Updates and ACIP Highlights

The newly formed Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) met on June 25–26, 2025, for its triennial vaccine meeting.

Figure 2 below and on the next page summarizes the votes, key guidance, evaluations, and discussions from these meetings related to influenza and respiratory syncytial virus (RAV) as well as COVID-19, chikungunya, anthrax, and measles, mumps, rubella (MMR) vaccines.

Learn more by accessing:

- Related details: Review the full report (vaccine evidence presented, committee discussion, and votes) for each recommendation summarized in **Figure 2** (and for previous updates).

The report also details **evaluation and discussion of topics not covered** at the meeting as well as an overview of the **ACIP Committee restructure**. Access archived reports from past meetings.

- 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.

Questions about immunization? Contact Tamara Sheffield, MD, MPA, MPH, Medical Director, Immunization Programs, Intermountain Health, at **801-442-3946**.

Figure 2. Vaccines Guidance Summary

VOTES TO RECOMMEND OR APPROVE	
INFLUENZA VACCINES	**Approved the following:** • The 2025–2026 influenza vaccine recommendation statement, which includes the trivalent vaccine composition for the upcoming season • Expanded age indication for Flublok from 18 years and older to 9 years and older • FluMist for self- or caregiver-administration • **Removed thimerosal in multi-dose influenza vaccines**: ACIP voted to remove recommendations for multi-dose influenza vaccines containing thimerosal for administration to children, pregnant women, and adults.
RESPIRATORY SYNCYTIAL VIRUS (RSV) VACCINES: MATERNAL/ PEDIATRIC	Added clesrovimab RSV monoclonal antibody as a recommended option for RSV prevention to be administered to infants younger than age 8 months born during or entering their first RSV season, one dose preferably in the first week of life. Clesrovimab was approved for use in the federal Vaccines for Children (VFC) program.

Continued on page 17...

Figure 2. Vaccines Guidance Summary, continued.

NO VOTE: EVALUATIONS AND DISCUSSIONS	
COVID-19 VACCINES	Due to the removal of the prior ACIP committee members, the Work Group was unable to meet to create a final recommendation (see April 2025 meeting report) to bring to ACIP for vote in the June meeting. No future COVID-19 vaccine vote was mentioned, but there is a proposed September/October ACIP meeting on the ACIP website that could be used for a COVID vaccine vote. Implications are unknown if an ACIP vote does not occur in connection with the new 2025–2026 formulation, given the May 2025 HHS directive for changing the vaccine schedule without an ACIP vote.
CHICUNGUNYA VACCINES	Chikungunya vaccines are recommended for use in travelers and laboratory workers. Evidence to recommend for use in U.S. territories and states at risk of the virus-like particle and live, attenuated chikungunya vaccines will be presented at a future meeting. In the meantime, there is a safety pause issued by the CDC and FDA against use of live-attenuated vaccine for those ages 60+ while awaiting FDA investigation of serious adverse events.
ANTHRAX WORK GROUP	A workgroup is being formed to evaluate the use of licensed anthrax vaccine adsorbed, adjuvanted (AVA,A: Cyfendus) for domestic post exposure prophylaxis (PEP).
MEASLES MUMPS RUBELLA (MMR) AND VARICELLA COMBINATION (MMRV) VACCINE	The ACIP committee chair, Dr. Martin Kulldorff, proposed that, since there exists a safe, equally effective alternative of using separate MMR and varicella vaccines, that the ACIP should recommend that MMRV vaccine not be administered to children under age 47 months. The committee plans to discuss this at a future meeting.

ANTICIPATED TOPICS THAT WERE NOT COVERED (SEE FULL REPORT FOR MORE INFORMATION.)

Meningococcal ACWY Vaccine: In the absence of a CDC director, the ACIP April meeting recommendations for use of the pentavalent meningococcal ACWY + meningococcal B vaccine (Men ABCWY:Penmenvy®), which was licensed in February 2025, has not been ratified by the USHHS secretary. Meningococcal vaccines were not discussed in the June 2025 ACIP meeting.

Respiratory Syncytial Virus (RSV) Vaccines – Adults:

- There was no discussion of adult RSV vaccines in the June 2025 ACIP meeting.
- In April, the committee voted to approve the use of one lifetime dose of Abrysvo® and Arexvy® RSV vaccines in persons at risk for lower respiratory disease caused by RSV ages 50 through 59 years. In the absence of a CDC director, that recommendation has not yet been ratified by the USHHS secretary.

Anticipated Votes: HPV vaccine recommendation changes, pneumococcal vaccine recommendation clarifications, and outbreak recommendations for adolescents for Mpox vaccine. Those topics were not addressed in the June 2025 ACIP meeting.

U.S. Measles Update: No update was provided.

For updates and guidance, the Idaho Department of Health and Welfare recommends following reputable sources like the CDC, the American Academy of Pediatrics, and local public health districts for the latest information about measles cases in Idaho.

Questions regarding immunization?
Contact Tamara Sheffield, MD, MPA, MPH, Medical Director, Immunization Programs, Intermountain Health, at **801-442-3946**.

Practice Management: HEDIS Measure Updates

Eye Exam Documentation for Members with Diabetes

Diabetic retinopathy, a common complication of diabetes, underscores the importance of regular retinal eye examinations. These exams aid in early detection and timely intervention and are crucial for preventing vision loss. Given the prevalence of diabetes, primary care providers play a pivotal role in encouraging the importance of these exams and meticulous documentation of exam results.

The HEDIS measure, Diabetic Eye Exam (EED) addresses this need.

Why use CPT II codes (see **Figure 3** below):

- Streamline administrative processes, which will decrease the need for record abstraction throughout the year.
- Provide more accurate medical data.
- Identify and close gaps in care more accurately and quickly.
- Improve patient outcomes.

BEST PRACTICES & TIPS FOR MEETING THE DIABETIC EYE EXAM (EED) MEASURE:

- Educate patients on risk of diabetic eye disease and encourage annual retinal eye exams.
- Use EMR alerts to flag patients due for a retinal eye exam
- Consider outreaches to patients who haven't had a recent retinal eye exam
- Document exam details if a report isn't available - include date, eye care provider's name/type, and results (e.g., "Last retinal eye exam with John Smith, OD, was June 20XX – no retinopathy.")
- Use fax-back forms to collect exam results from optometrist/ophthalmologist. Download Select Health's preferred communication form.
- In-office retinal imaging (e.g., RetinaVue) is an option **BUT** images must be read by an optometrist or ophthalmologist. (AI interpretation will count for 1 year only.)

Figure 3. CPT II Codes for use by Primary Care Providers

CPT II Code	Definition
Eye Exam Without Evidence of Retinopathy (All options MUST be interpreted by an ophthalmologist or optometrist)	
2023F	Dilated retinal eye exam without evidence of retinopathy
2025F	7 standard field stereoscopic retinal photos without evidence of retinopathy (RetinaVue/Aurora/ Smartscope in office)
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
Eye Exam With Evidence of Retinopathy (All options MUST be interpreted by an ophthalmologist or optometrist)	
2022F	Dilated retinal eye exam with evidence of retinopathy
2024F	7 standard field stereoscopic retinal photos with evidence of retinopathy
2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy

Continued on page 19...

EYE EXAM DOCUMENTATION AND CODING

Submit claims with either the correct procedural OR CPT II codes to reduce work for you and your office staff as indicated below:

- For a primary care provider (PCP) billing for retinal imaging performed in their office, USE:
  - — Procedure codes **92227** or **92228** to close the gap of a diabetic eye exam without further action (counts for 1 year only).
  - — CPT II result codes(e.g., **2023F**, **2025F**, **2033F**, etc.) if you document results from an eye specialist's examination (counts for up to 2 years, depending on the unspecified findings).
- For an ophthalmologist or optometrist billing, USE procedure code 92250. (This code does not count when used by a PCP.)

Questions? Contact Select Health Quality Consultant RN: Amber.Wray@selecthealth.org

Claims Coding for HEDIS Measure Controlling Blood Pressure (CBP)

Each year Select Health participates in the HEDIS audit with some HEDIS measures also impacting our STARS rating. **Controlling blood pressure (CBP**) is one of these measures.

In our efforts to improve the rating of this measure along with the health of our members, we are looking to simplify the way we collect information for us and for clinics to comply with this measure.

The CBP measure requires nurse reviewers from Select Health to request and review patient charts to abstract blood pressure readings. This is time consuming for reviewers and requires clinics to take time to provide access to the required charts.

In the past, we requested patient charts by directly accessing clinic EHRs, asking clinics to pull and send charts, or having our reviewers come to the clinic to gather needed charts. That process required a great deal of time for clinic staff as well as Select Health nurse reviewers.

Now, when a claim is submitted with CPT II codes for blood pressure, the codes are captured administratively, and no further action is needed. There is no need for either the clinic to send a chart or for the Select Health nurse auditor to review the chart.

If your clinic is not already submitting CPT II codes for blood pressure readings, please consider implementing this change to decrease workload for clinics and for Select Health. It will also allow us to target education and resources to those members most in need.

Figure 4 below indicates the CPT II codes that should be used when submitting claims.

Figure 4. Claims Coding for Blood Pressure

CPT Code	Blood Pressure Reading
SYSTOLIC	
3074F	Less than 130
3075F	130-139
3077F	Equal to or greater than 140
DIASTOLIC	
3078F	Less than 80
3079F	80-89
3080F	Equal to or greater than 90

Questions? Contact Amber Naluai at **385-563-2992** (amber.naluai@selecthealth.org).

Update to Statin Exclusion Coding

The Pharmacy Quality Alliance (PQA) has removed the ICD-10 code of **T46.6X5A** from the eligible rhabdomyolysis myopathy exclusions. Please refer to **Figure 5** below for updated appropriate statin exclusions. Note that a statin allergy diagnosis does not count as an exclusion unless a claim for one of the following codes is submitted.

REMOVING A PATIENT FROM A STARS MEASURE

Providers may use virtual care to confirm and document the exclusion diagnosis in the medical record. They should then bill the non-reimbursable HCPCS code **G9781** for $0.01 with the applicable ICD-10 code attached to process the claim and remove the patient from the Star measure.

As a reminder, exclusion coding must be submitted in a claim EACH year for the patient to be removed from statin measures. Charting a statin intolerance in the EMR does not remove a member from the statin measures.

Figure 5. Qualifying Statin Exclusions to be Coded

Diagnosis	Applicable/Non-Applicable Codes
Cirrhosis	**Refer to your usual diagnostic coding reference.**
Dialysis	
End-Stage Renal Disease (ESRD)	
Hospice Care	
In-Vitro Fertilization (IVF)	
Lactation	
Pregnancy	
Myalgia	**NOT APPLICABLE**: M79 codes for Medicare Diabetes
Myopathy	**G72** codes
Myositis	**M60** codes
Palliative Care	**NOT APPLICABLE**: For Medicare Diabetes
Prediabetes	**R73.03**, **R73.09** codes for Medicare Diabetes **only**
Polycystic Ovary Syndrome (PCOS)	**E28.2** codes for Medicare Diabetes **only**
Rhabdomyolysis	**M62** codes

Improving Antibiotic Stewardship

The National Committee of Quality Assurance (NCQA) estimates that about a third of antibiotics given in an outpatient setting are potentially inappropriate – unnecessary or incorrectly dosed.[1] This not only exposes patients to avoidable side effects, but it also contributes to the rise of antibiotic-resistant infections.

To address this, NCQA developed HEDIS measures focused on antibiotic stewardship. The **Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB) HEDIS measure** is a key tool for promoting responsible antibiotic prescribing in outpatient settings.

AAB MEASURE DESCRIPTION

Current guidance from the Centers for Disease Control and Prevention (CDC) recommends against antibiotic use for acute bronchitis or bronchiolitis unless a comorbid condition or competing diagnosis is also present (e.g., pneumonia).[2] Key parameters for this measure include:

- **Population**: Patients aged 3 months and older
- **Condition**: Acute bronchitis or bronchiolitis (ICD-10CM diagnosis measure codes are **J20.3-J20.9**, **J21.0**, **J21.1**, **J21.8**, **J21.9**.)
- **Goal**: No antibiotic dispensing on **or** within 3 days of diagnosis
- **Settings**: Outpatient, telephone, e-visits, virtual check-ins, or ED visits
- **Scoring**: Inverted rate – higher score indicates appropriate treatment (no prescribed antibiotic)

ANTIBIOTIC STEWARDSHIP: BEST PRACTICE AND MEASURE TIPS

- Avoid prescribing antibiotics unless there is clear evidence of bacterial infection.
- Submit comorbid condition codes (e.g., COPD, cystic fibrosis, HIV, malignant neoplasms) on the same claim to exclude the episode from this measure.
- Include competing diagnoses (e.g., pharyngitis, otitis media) that warrant the antibiotic use.
- Implement EHR alerts to flag antibiotic prescriptions for bronchitis and prompt real time decision support.
- Share provider-level performance reports to encourage peer benchmarking and continuous improvement.
- Educate patients on symptom duration, supportive care, and when to seek follow-up.
- Use patient-facing educational materials to help explain why antibiotics are not needed. The CDC offers various free patient education materials on this topic available at CDC Patient Education Resources.

Promoting Antibiotic Awareness

Each year, the Centers for Disease Control and Prevention (CDC) leads the **U.S. Antibiotic Awareness Week** from **November 18–24**.

This national campaign raises awareness about the importance of appropriate antibiotic use and the growing threat of antimicrobial resistance. It's a great opportunity for healthcare providers to engage patients, reinforce stewardship practices, and align with national messaging.

Keep checking the CDC website to see this year's theme and ways you can incorporate the events into your practice.

LEARN MORE

For full lists of competing diagnoses, comorbid conditions, or the AAB Antibiotic Medication List, contact Stacey Merrill at **stacey.merrill@selecthealth.org**.

REFERENCES:

1. National Committee for Quality Assurance (NCQA). *Overview* (Antibiotic Use). NCQA website. 2022. https://antibiotics.ncqa.org/overview. Accessed August 1, 2025.
2. U.S. Centers for Disease Control and Prevention. *Antibiotic Prescribing and Use: Outpatient Clinical Care for Adults.* April 16, 2024. https://www.cdc.gov/antibiotic-use/hcp/clinical-care/adult-outpatient.html#:~:text=Healthcare%20professionals%20should%20encourage%20watchful,Options%20for%20symptomatic%20therapy%20include:. Accessed August 1, 2025.

Care Management Services: Frequently Asked Questions

HOW DO SELECT HEALTH CARE MANAGEMENT SERVICES WORK?

Select Health provides care management services for Select Health members. Care managers:

- Work closely with the Intermountain Clinical Program work groups
- Stratify members using multiple tools
- Contact those found to be at risk

We also support members who have less-complicated health issues but are struggling to manage their health by:

- Coaching for health habits
- Resolving short-term barriers to care
- Helping guide complex referrals to providers and services
- Finding resources

HOW DO WE SUPPORT YOUR PRACTICE?

The following services are currently provided:

- Proactive outbound call support
- Needs assessments performed by a nurse
- Individual member coaching
- Educational materials mailed to the member's home
- Referral to facility-based classes
- Assistance with medication compliance, equipment, and supplies
- Help with insurance benefit questions

HOW DOES CARE MANAGEMENT SUPPORT URGENT AND SPECIAL MEDICAL NEEDS?

This is a vital resource for dealing with the overwhelming stress of **urgent or special medical needs**. Whether it's a new diagnosis or a major injury, specially trained care managers can help members:

- Navigate through the healthcare system
- Maximize self-care by assessing needs and designing and executing a member-centric care plan
- Ensure that immediate and ongoing needs are met and best possible care received by acting as a liaison between the member and providers

HOW DOES CARE MANAGEMENT SUPPORT MEMBERS WHO NEED HELP ADHERING TO A TREATMENT PLAN?

Care management focuses on members who repeatedly cycle through the healthcare system without lasting benefit and/or are unable to adhere to a treatment plan without help.

We seek to **identify and intervene with members**, such as those who:

- Have medically complex and impactable needs
- Struggle to use healthcare resources appropriately
- Experience comorbid behavioral health and medical conditions or a catastrophic health event (e.g., multiple trauma, new disability)
- Have significant and complex social drivers of health needs

Treating a Select Health member where a care manager could help?
Contact our Care Management Department at **800-442-5305**, **option 2**.

Navigate! How can we help you today?

Start with Select Health online self-service solutions. Access our provider website (selecthealth.org/providers) for the quickest way to get your questions answered. Direct links are in purple type.

Do you need to:	Go to:
Find member ID card information?	https://selecthealth.org/providers/claims/id-guides
Access non-covered codes/ preauthorization requirements?	https://selecthealth.org/providers/preauthorization/forms-lists
Request preauthorization?	https://selecthealth.org/providers/preauthorization
Appeal a claim?	https://selecthealth.org/content/dam/selecthealth/Provider/PDFs/forms/Provider-Appeal-Form.pdf
Find pharmacy resources?	https://selecthealth.org/providers/programs/pharmacy
Access dental provider resources?	https://selecthealth.org/providers/programs/dental
Access Select Health policies (medical, dental, coding/reimbursement)?	https://selecthealth.org/providers/policies
Learn about our secure provider tools (Provider Benefit Tool, CareAffiliate®)?	https://selecthealth.org/providers/provider-access-point

Contact us when you can't find answers online. We're here to help, Monday through Friday, 8:00 a.m. to 5:00 p.m. unless otherwise indicated below. Phone and email requests are answered in the order they are received.

When you need to:	Access:
Verify member benefits or get help with claims payment issues and information.	Use the Provider Benefit Tool (see above) or call Member Services: **800-538-5038** (available 7:00 a.m. to 8:00 p.m. on weekdays, 9:00 a.m. to 2:00 p.m. on Saturdays.) For Federal Employee Health Benefit members, contact **844-345-FEHB (3342)**.
Resolve issues with provider setup or directory listing.	Provider Development: IDProviderRelations@selecthealth.org
Get help with access to tools on our secure Provider Portal and online tools (Provider Benefit Tool, CareAffiliate).	Provider Web Services: providerwebservices@selecthealth.org
Resolve claims appeals/preauth issues.	Compliance and Appeals: **844-208-9012**
Manage Electronic Funds Transfer (EFT).	EDI Department: **800-538-5099** (fax: **801-442-0372**); edi@selecthealth.org
Change passwords, reactivate accounts, resolve issues with 2-Step Authentication (PingID).	Account Help Desk: **801-442-7979, Option 2**
Request fee schedules (contracted providers only).	Provider Development: SHFeeScheduleRequests@selecthealth.org

Select Health