ProviderInsight®

Idaho Edition
May 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

Managing All Aspects of the Business

Providing exceptional healthcare at a reasonable cost is a challenging venture. This is especially true as we continue to grow as a company. Select Health relies on you, our providers, to deliver great care while we work hard to make the process as simple and easy as possible, so your team can continue to focus on what you do best.

Jon Griffith, Chief Operations Officer for Select Health, recently said "Select Health has made several improvements to continue as a best-in-class health plan and prepare for the future." Some of these improvements for providers relate to significant upgrades to our provider portal and our website interface. The good news is that these upgrades are nearly ready to launch network-wide, which will greatly enhance all provider's ability to get the information and support they need with less effort.

In terms of growing our network, Select Health currently operates in four states: Colorado, Idaho, Nevada, and Utah, each of which has different rules for expansion. "Each state has specific regulations and guidelines Select Health follows in order to operate in these states," Griffith said. "As we think about our plans for growth, understanding these complex parameters is crucial to our serving prospective providers better. The more we can facilitate the process of joining the network, the better it is for new providers entering the system.

Jason Eckersley, AVP of Business Development and Strategy said, "We're optimistic that health insurance will become a seamless part of the overall health care experience. We envision an even stronger connection with providers, allowing this collaboration to manage care and costs in a way that supports success for all involved." Eckersley continued, "We all choose to work in the health insurance industry because we're passionate about creating positive health outcomes. There's a lot of promise on the horizon as far as medical development and technology and our goal is to stay ahead of this in a responsible and innovative way to help providers bring these developments to our members."

By continuing to work closely with our providers, Select Health can remain competitive in delivering exceptional healthcare at a reasonable cost, while growing the business.

Thank you for the service you provide for our members!

Compliance Matters

Compliance requirements center on ensuring:

- Accurate provider demographic information
- Equal access for those with disabilities
- Fraud, waste, and abuse training attestations

Contact your Provider Relations representative if you have questions or have **not** previously provided a preferred email address needed for the following required attestations.

1. **PROVIDER DEMOGRAPHIC INFORMATION ATTESTATION**

   Per **CMS and the Consolidated Appropriations Act**, practitioners are required quarterly to attest and update their demographic information.

   Select Health provides for these attestations via a quarterly Qualtrics survey sent to your email inbox.

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Effective **July 1, 2025**, if a provider offers telehealth services, it will be indicated in the provider directory. Learn more.

2. **EQUAL ACCESS FOR THOSE WITH DISABILITIES**

When you update your information in your quarterly demographic attestation, please update the specific ADA accommodations offered for those with disabilities along with your clinic location to specify whether your location is meeting the ADA standards.

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.

Learn more about these standards.

3. **FRAUD/WASTE/ABUSE (FWA) TRAINING ATTESTATIONS**

Per **CMS Medicare Managed Care Manual Ch. 21 (50.3.2)**, practitioners who work for an organization accepting funding from Medicare or any government agency are required to:

- Participate in FWA training
- Attest that compliant training has been completed in the first 90 days of contract/hire date and annually thereafter. Access the online attestation form.

NOTE: Using the previously required, CMS-issued content is no longer mandatory; however, this training is still available as an option.

PROVIDER SURVEY TIMELINES

June 2025: Annual Provider and Clinic Manager Experience Surveys

July 2025: Annual After Hours Survey

Quarterly: Provider Demographic Attestations

In addition, Select Health offers access to required and suggested training encouraged by regulatory bodies as follows:

1. **CULTURAL SENSITIVITY TRAINING**

Per **NCQA (QI, Element E, Factor 2)** and **CMS (42 CFR 438.10)**, practitioners are required to complete cultural competency/sensitivity training. Select Health offers a brief, online training that complies with this requirement in the education area of our website.

2. **QUALIFIED MEDICARE BENEFICIARIES (QMBs)**

This Centers for Medicare and Medicaid Services (CMS) program helps low-income Medicare beneficiaries by:

- Paying for their premiums, deductibles, copayments, and coinsurance
- Prohibiting billing for Medicare A/B deductibles and cost sharing
- Not discriminating against or refusing service because they are protected from paying cost sharing.

Learn more about CMS requirements for QMBs.

Questions about compliance?
Contact your Provider Relations representative at IDProviderRelations@selecthealth.org.

Get to Know Our Member Rights and Responsibilities

It is important that all caregivers understand the rights and responsibilities of Select Health members. Please become familiar with the following Select Health Member Rights and Responsibilities statement. This is meant as a general overview for all provider offices.

As a Member, you have the right to:

- Receive information about our services, providers, and members' rights and responsibilities.
- Receive considerate, courteous care and treatment with respect for personal privacy and dignity.
- Receive accurate information regarding your rights and responsibilities and benefits in member materials and through telephone contact.
- Be informed by your provider about your health so they may make thoughtful decisions before you receive treatment.
- Candidly discuss with your healthcare provider appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. We do not have policies that restrict dialogue between provider and patient, and we do not direct providers to restrict information regarding your treatment options.
- Have reasonable access to appropriate medical services regardless of race, religion, nationality, disability, sex, or sexual orientation; and 24-hour access to urgent and emergency care.
- Receive care provided by or be referred by your primary care provider.
- Have all medical records and other information kept confidential.
- Have all claims paid accurately and in a timely manner.
- Make recommendations regarding the organization's member rights and responsibilities policy.

As a Member, you have the responsibility to:

- Treat all our providers and personnel at Select Health courteously.
- Read all plan materials carefully as soon as you enroll and ask questions when necessary.
- Ask questions and make certain you understand the explanation and instructions you are given.
- Understand the benefits of your plan and understand not all recommended medical treatment is eligible for coverage.
- Follow plans and instructions for care that have been agreed upon with the provider.
- Express constructively your opinions, concerns, and complaints to the appropriate people at Select Health.
- Follow the policies and procedures of your plan, and when appropriate, seek a referral from your primary care provider to Select Health providers or call Select Health for assistance.
- Communicate openly with your healthcare provider, develop a patient-provider relationship based on trust and cooperation, and participate in developing mutually agreed-upon treatment goals.
- Read and understand your plan benefits and limitations, and call us with any questions.
- Keep scheduled appointments or give adequate notice of cancellation.
- Obtain services consistently according to the policies and procedures of your plan.
- Provide all pertinent information needed by your provider to assess your condition and recommend treatment.
- Use our providers when applicable, carry your ID card, and pay copay/coinsurance amounts at the time of service.

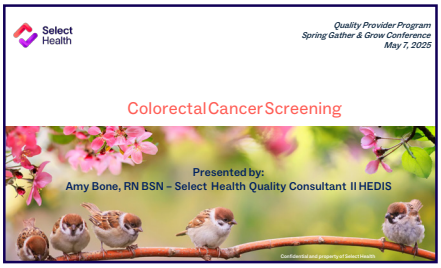
Access all member rights and responsibilities statements online.

Quality Improvement Programs

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

Held on **May 7, 2025**, the QPP spring conference featured sessions on program updates, colorectal cancer screening, controlling blood pressure, and social determinants of health (SDoH). These conferences provide an opportunity for us to review program updates, share best practice, and connect clinics to discuss common barriers and solutions.

Conference materials and presentations are available online in the **QPP Training area** or by clicking the linked images below. You can find the full video of the conference online as well.



Best Practices for Scheduling Well-Child Visits

Well-child visits offer an opportunity to monitor a child's overall health and development, ensure they receive vaccinations, detect and prevent health problems, and promote healthy habits. These visits are important for all children ages 0–21, including those with special needs or chronic physical or mental health conditions.

ENCOURAGING PARENTS TO SCHEDULE VISITS

Best practices you can implement to encourage parents to schedule their child's well exam include:

- Educating patients and families about the value of well visits. Make a strong recommendation for yearly exams when counseling parents. Some examples of what you could say include:
  - "Seeing you every year for your child's wellness check is important to me. Even if they are healthy and doing well, I want to ensure your family has the support they need at every different stage of life. Please make sure we schedule your next visit before you leave the office."
  - "We'd like to save you a spot on my schedule for next year's well-child exam. Please make sure to schedule now so we get you the appointment that works best for your schedule."
  - "Wellness visits are such important visits to us. Please be sure to schedule [patient's name] for their next wellness visit so that we have it planned for next year. If you ever need to reschedule, you are welcome to call the clinic to do so."[1]
- Discuss scheduling a well-care visit for unscheduled patients when they check-in for any appointment.[2]
- Use opt-out language when scheduling. For example, you could say, "Let's get your child scheduled for their well-care visit. Our next available appointment is_____," instead of, "Would you like to schedule your next well visit?"[3]
- Parents may try to schedule appointments during work breaks. Keep hold times and office wait times as short as possible.[2]
- Consider offering well-care appointments outside of standard business hours in the evenings or on weekends.[3]

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- Include a self-scheduling link or phone number to contact the scheduling desk when using text messaging or email.[2]
- Contact unestablished/inactive patients with a genuine interest in their well-being, and encourage them to set up an appointment for needed/overdue care.

Making it easy for parents to schedule appointments will help them access the care they need and improve their patient experience. Give them multiple opportunities to schedule their next annual exam before they leave the office. Guide them toward low-volume blocks in your appointment calendar for more booking options.[2]

Select Health's flexible policy on the timeframe between visits helps clinics and families with scheduling (i.e., 365 days is not required between well-child exams). **Figure 1** below details the allowed frequency associated with well-visit codes.

Figure 1. Well-Child Visit Frequency

HCPCS/CPT Codes	ICD-10 Diagnosis Codes	Frequency
Pediatric (0–21 years)		
Examination/Counseling		
99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395	Z00.00, Z00.01, Z00.121, Z00.129	No limit from birth to age 12; every 275 days from ages 12 to 21

*This table combines two sections, Pediatric (birth to age 18) and Adult (age 18 and older).[4]

REFERENCES

1. Intermountain Health. *WCC Scheduling Best Practices.* Internal document.]
2. Washington Department of Health; Washington State Medicaid MCOs' Collaborative PIP. *Tips to Increase Well-Care Visits for Children of All Ages.* DOH 141-072. December 2022. **https://doh.wa.gov/sites/default/files/2022-12/141-072-TipstoRaiseRateWellCareVisits.pdf**. Accessed May 2, 2025.
3. Partners for Kids. *Top 10 Best Practices to Improve Well-Care Visit Compliance by Patients and Families.* 2018. **https://partnersforkids.org/wp-content/uploads/2018/03/Top-10-Best-Practices-to-Improve-Well-Care.pdf**. Accessed May 2, 2025.
4. Select Health. *Coding and Reimbursement Policy: Preventive Care and Screening Guidelines.* 2025. **https://files.selecthealth.cloud/api/public/content/preventive_care_services_flyer.pdf**. Accessed May 7, 2025.

Pharmacy

Use Surescripts® and CoverMyMeds® to Reduce Preauthorization Headaches

Select Health and **Scripius** accept Electronic Prior Authorization (EPA) requests for prescription preauthorization via Surescripts® and CoverMyMeds®. EPA offers several benefits for healthcare providers and patients:

1. **Faster Processing:** You and your patients will experience reduced turnaround times (compared to manual faxes or phone calls). Immediate digital transmission improves medication access, compliance, and patient experience.
2. **Improved Accuracy:** Using automated form completion with a patient's (Electronic Health Record) EHR data reduces errors compared to manual entry. Standardized formats help to minimize miscommunication and rework and boost patient safety.
3. **Increased Efficiency:** EPA eliminates repetitive tasks and paperwork for prescribers, office staff, and pharmacy staff. This effectiveness frees up time for clinical care instead of administrative follow-up.
4. **Better Patient Outcomes:** Faster preauthorization means patients can start needed medications sooner and can reduce treatment abandonment due to preauthorization barriers.
5. **Enhanced Communication:** You and your office receive real-time updates on preauthorization status. Integrated EPA systems allow for easier tracking of approvals, denials, or requests for more information.
6. **Cost Savings:** Digital submissions reduce administrative burden, associated costs, and unnecessary prescriptions that don't meet formulary requirements.

For questions about online submissions via Surescripts or CoverMyMeds, contact your electronic medical record (EMR) provider.

Why Mental Health HEDIS Measures Matter to Your Practice

You know the challenge: Your calendar is full this week, but you have a regular client who has an urgent need for an appointment. Perhaps they have had a relapse following an inpatient stay or emergency department visit. Perhaps they have "dropped off the radar" following a mental health crisis. Whatever the reason, outcomes and your ability to deliver the most effective care can be compromised with added client needs. Is there a way to keep these patients out of crisis and avoid burnout for you and your colleagues?

Many behavioral health practices are not set up for participation in health plan quality measures programs such as the National Committee on Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Measures. Lack of implementation typically stems from a lack of available staff and time, reimbursement structures, integration with electronic healthcare records (EHR) systems, etc. However, learning about and using the tools these programs offer can significantly improve your clients' outcomes and help you more effectively manage your practice.

HEDIS results have the potential to:

- Inspire insurance companies to adjust provider networks based on HEDIS scores
- Influence patients to choose providers with high-performance scores
- Drive policymakers to guide and drive healthcare reforms and improvements using this data

Select Health gathers data from a variety of sources, such as medical records, claims, and patient surveys, for regulatory compliance reporting and to drive improvements in the behavioral health care plans for our members. Our **Quality Provider Program (QPP)** works with participating clinics to develop robust programs for improving quality measures and patient outcomes.

USING HEDIS MEASURES AS A PRACTICE MANAGEMENT TOOL

HEDIS data can be used to identify areas for improvement in care delivery and to track progress over time. For busy behavioral health providers, consistent measurement helps reveal patterns (whether a patient is worsening, stagnating or improving.) Most important, patients and clinicians work together to determine if a treatment approach is effective, or if it needs to be adjusted.

Using HEDIS follow-up measures as a practice management tool can be very important for:

- **Continuity of Care:** Those receiving behavioral health care in high-intensity settings, particularly for substance use disorder, are especially vulnerable to losing contact with the healthcare system after discharge.
- **Preventing Relapse:** Timely follow-up care is critical for preventing relapse and insuring ongoing treatment and management.
- **Improving Outcomes:** Lack of timely follow-up can result in negative outcomes such as continued substance use, relapse, high utilization of intensive care services, and even death.
- **Enhancing Communication and Engagement:** With concrete data, providers can more easily discuss why changing medications or intensifying support can improve a patient's mental health as well as treatment progress and goals.

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WHAT ARE THE BEHAVIORAL HEALTH HEDIS MEASURES THAT SELECT HEALTH TRACKS?

HEDIS measures we track focus on when a patient experiences an intensive level of care for a mental health and/or substance use diagnosis as a hospital inpatient or an emergency department (ER) visit. Appointments may be in person or using telehealth/telemental health/virtual visits. Criteria include:

- Seeing the patient within 1–7 days of **discharge** for mental health follow-up and ensuring that a patient has an appointment within 30 days of discharge **IF** a situation arises where a patient is unable to be seen within 7 days. **NOTE:** For those discharged from a facility with a primary substance use disorder diagnosis, the time is **0–7 days**.
- Including mental health or substance use disorder diagnosis codes on the claim, as appropriate
- Contacting patients to reschedule missed follow-up appointments
- **For those with a primary substance use disorder diagnosis,** referring patients for supportive therapy with a substance use provider

TOOLS TO HELP YOU INTEGRATE QUALITY FOLLOW-UP MEASURES INTO YOUR PRACTICE

We want to help you take the long view about preventing mental health crises relapse with broadening our requirements for telehealth visits and providing tools to support your practice. Even though the Select Health Mental Health QPP program is not currently offered outside of Utah, you can still use the program materials we provide online to help guide your own practice.

Access these guides and frequently asked questions (FAQs) below for more information:

- **2025 Mental Health Measures Booklet** and **Quick Guide**
- **Best Practice Guide**
- **Social Determinants of Health FAQs**
- **Follow-up After ED or Hospital Discharge FAQs**
- Select Health Medical Policy #241 (starting on page 29 of the **Behavioral Health Policies booklet**)

Practice Management Resources

Immunization Updates and ACIP Highlights

The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) met on **April 15–16, 2025**, for its triennial vaccine meeting, rescheduled from February 2025.

Figure 2 below and on the next page summarizes the votes, key guidance, evaluations, and discussions from these meetings related to meningococcal, respiratory syncytial virus (RSV), human papilloma virus (HPV), and other vaccines.

Learn more by accessing:

- **Related details** (vaccine evidence presented, committee discussion, and votes) for each recommendation summarized in **Figure 2** (and for previous updates) can be found on the **Select Health Provider Tools** area of our website under 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 2. Vaccines Guidance Summary

VOTES TO RECOMMEND AND APPROVE	
MENINGOCOCCAL VACCINES	Meningococcal ABCWY combination pentavalent vaccine Penmenvy® (GSK) may be used when Men ACWY and Men B are indicated at the same visit. This applies to persons ages: • 10 years and older at increased risk of meningococcal disease • 16–23 years when use of Men B vaccine has been chosen after shared clinical decision making Penmenvy® is FDA approved for ages 10–25 years.
RESPIRATORY SYNCYTIAL VIRUS (RSV) VACCINES ADULTS	ACIP expanded the age when adults at increased risk of severe RSV disease should receive a single lifetime dose of RSV vaccine from 60–74 years down to 50–74 years. Abrysvo® and Arexvy® are FDA approved in these ages with anticipated FDA approval of mResvia® for the newly recommended ages 50–59 years in **June 2025**.
CHIKUNGUNYA VACCINES	Recommendations for Bavarian Norda's virus-like particle (VLP) vaccine (VIMKUNYATM™) are for: • Laboratory workers with potential for exposure to chikungunya virus • Persons ages 12 years and older traveling to a location where there is a chikungunya outbreak • Consideration for those traveling or taking up residence for 6 months or longer in locations with elevated risk A precaution in persons ages 65 years and older has been added to the recommendation of Valneva's live-attenuated vaccine (IXCHIQ™) due to severe adverse events identified in post-marketing surveillance. IXCHIQ™ is approved for laboratory workers and travelers ages 18 and older.
VOTES PLANNED FOR JUNE 2025	
INFLUENZA VACCINES	Updates to the 2025–2026 ACIP Influenza vaccine statement.
COVID-19 VACCINES	Recommended use of the 2025–2026 COVID-19 vaccine formula, including the new Moderna mRNA – 1283 lower dose (10mcg/0.2mL) vaccine, for persons ages 12 and older and a potential risk-based rather than universal recommendation .

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Figure 2. Vaccines Guidance Summary, Continued

RSV MATERNAL/ PEDIATRIC	Clesrovimab RSV monoclonal for all infants younger than 8 months.
MENINGOCOCCAL ACWY	Expanded age for Menquadfi to infants 6 weeks to 2 years pending FDA anticipated approval in **May 2025**. When administered to this age, Menquadfi had a non-inferior immune response but more febrile/non-febrile seizures, serious adverse events, and deaths that were concerning to ACIP.
HUMAN PAPILLOMA-VIRUS (HPV) VACCINE	Routine recommendation for ages 9 through 12 years; recommendation of 1-dose schedule for age 9 through 14 years; still considering number of doses for those 15 and older.
PNEUMOCOCCAL VACCINES	Updated clinical guidance wording for use of pneumococcal vaccines in pregnant persons and haematopoietic stem cell transplantation (HSCT) patients.
MPOX VACCINE	Recommendation for 2 doses (1 month apart) of JYNNEOS Mpox vaccine in adolescents ages 12–17 years at risk during an outbreak—recommendation for this age during an outbreak has more committee support than for at-risk adolescents not during an outbreak because: • To substantially reduce the risk of outbreaks, 50% of the at-risk population needs to be vaccinated with at least 1 dose. • JYNNEOS is more immunogenic in adolescents compared to adults, but is a reactogenic vaccine with similar systemic and localized reactions to adults.

NO VOTE: EVALUATIONS AND DISCUSSIONS	
U.S. MEASLES UPDATE	The 2025 measles outbreak has been concentrated in Texas with related cases in nearby states, Canada, and Mexico. Cases have been identified in half of U.S. states, with 97% of cases being unvaccinated and 11% of cases hospitalized with some measles-related deaths. CDC has provided technical assistance to states, deployed additional vaccine doses to health departments, and provided laboratory support and health alert provider outreach.
INFLUENZA VACCINES	Strains have been chosen for the 2025–2026 influenza vaccine, which include a new Influenza A/H3N1 component. Influenza A predominated in the 2024–2025 season, with less than 3% of the specimens tested resulting Influenza B. Vaccine effectiveness (VE) results for the 2024–2025 influenza season from the US Flu VE, NVSN, and VISION networks were (range shows difference in VE between networks): • Pediatric Outpatient: 32–60% • Pediatric Inpatient: 63–78% • Adult Outpatient: 36–54% • Adult Inpatient: 41–55% Self/caregiver-administered FluMist will be available to commercially insured persons in the 2025–2026 season. It will be adjudicated and administered through a central online pharmacy. Patients will answer screening questions for eligibility determination. Vaccine will be shipped to patient's home for arrival at a date chosen by the patient. After delivery, storage of vaccine is limited to 12 hours out of refrigerator. Patients will report administration of vaccine by text to the online pharmacy, which will report administration to state vaccine registries.

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Figure 2. Vaccines Guidance Summary, Continued

OTHER VACCINES: COVID-19	Review of VE for the 2024–2025 COVID-19 formula vaccine from COVID-NET (ED/Urgent Care: 33% in adults, 35% in persons 65+; Hospital Inpatient: 45–46% in all persons 65+, 40% in immunocompromised persons 65+) Noted that Pfizer's candidate COVID vaccine, mRNA-1283, elicits higher immune response compared to SPIKEVAX. Anticipated availability is fall of 2025. Listed current concerns about COVID-19 Workgroup's proposed risk-based recommendation, including: • One in five children and adolescents hospitalized for COVID-19 are admitted to the ICU with 41% of these having no underlying medical condition. • One in five adults hospitalized for COVID-19 were admitted to the ICU. Adults ages 65+ comprise 68% of adults hospitalized with COVID-19. • A 2023 survey estimated that 9.2 million adults have had long COVID. • Seventy-four percent of adults have at least one condition that puts them at higher risk for severe disease, which caused committee members to question why a risk-based recommendation would be necessary in a high incidence population.
OTHER VACCINES: RSV MATERNAL/ PEDIATRIC	Discussed a second long-acting monoclonal antibody to protect infants against RSV. Although Clesrovimab (Merck) is not yet approved by the FDA, it has a target action date of **June 10, 2025**, and: • **Recommendation** is only for infants <8 months of age and would not be indicated for second year administration to higher-risk infants. **NOTE:** Clesrovimab and nirsevimab recommendations would be the same with no preference expressed for infants ages <8 months. • **Dosage** is 105mg/0.7mL, intramuscular single injection with no difference in dose by infant weight. • **Storage requirements** are at refrigerator temperature with a maximum of 48 hours at room temperature. • **Efficacy** against RSV appears to be sustained although the half-life for Clesrovimab is shorter than for nirsevimab (42 vs. 71 days).
OTHER VACCINES: HUMAN PAPILLOMA-VIRUS (HPV)	There are 37,800 HPV-attributable cancers in the U.S. each year. In the 19 years since HPV vaccine licensure, we have seen high vaccine efficacy, high population impact, and strong herd immunity effect from the vaccine program. Quadrivalent HPV vaccine-type prevalence has declined 85% among 14- to 24-year-old, sexually experienced females from the pre-vaccine era to 2018. ACIP reviewed studies examining a 1-dose vaccine schedule. Review results included: • **Sixty-seven (67)** countries have adopted a 1-dose schedule for some ages. • The KEN SHE randomized control trial of young women ages 15–20 given 1 dose of HPV vaccine showed **98% VE** for HPV types 16/18 with 36-month duration of protection. • In the IARC-India trial of girls 10–18 who had received 1 dose, **VE was 92%** against HPV 16/18 with a median follow-up time of 12 years. • A Costa Rica study showed **99.4% seropositivity** 16 years after vaccination of women ages 18–24 years with 1 dose of HPV vaccine. Small decreases in antibody GMC were seen, but modeling of pooled studies estimates lifelong protection at best case and 25-year protection at worst case.

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Figure 2. Vaccines Guidance Summary, Continued

OTHER VACCINES: HUMAN PAPILLOMAVIRUS (HPV), CONTINUED	Models switching to 1-dose HPV vaccination project similar reductions in HPV and cervical cancer incidence when compared to continuing with 2 doses in the U.S. Outstanding questions informing a 1-dose schedule include protection against cancer of sites other than cervix as well as efficacy and immunogenicity in males, those who are immunocompromised, and older age groups. The ACIP does not plan to change the recommendation that immunocompromised persons receive a 3-dose series. Also, it will not change recommendation for shared clinical decision making for persons ages 27 through 45 years, although the recommended number of doses may change. Currently in the U.S., 5.7% of HPV vaccines are initiated at ages 9–10. Stakeholders have asked ACIP to modify its recommendation wording. Changing the wording of vaccine initiation age to a routine recommendation for ages 9–12 would allow information systems to more readily program clinician prompts to start the series at age 9 rather than age 11, which may increase series completion by age 13 years. A change in wording would align the ACIP's recommendations more closely to those of the AAP and American Cancer Society. Some adolescent stakeholders are concerned that starting the HPV vaccine earlier could weaken the adolescent visit platform, but since the meningococcal vaccine series initiation age may also change, that may not be an important factor. Votes for both recommendation changes are anticipated for the June 2025 meeting.
OTHER VACCINES: CYTOMEGALOVIRUS (CMV)	Congenital Cytomegalovirus (cCMV) infection occurs in 4.5 per 1,000 live births in the U.S. (16,000 births per year), resulting in 3,000 with cCMV disease. It is the most common cause of birth defects in the U.S. and causes 80 neonatal deaths per year. Most newborns with cCMV infection have no clinical signs at birth and are not diagnosed. Vertical maternal transmission occurs most commonly at birth with little sequelae to the infant. Maternal transmission is less common in the first trimester but causes the highest level of symptoms and abnormalities in those infants infected. Results from a phase 3 study of Moderna's mRNA-1647 CMV candidate vaccine (gB+pentameric Complex) in females ages 16–40 years are anticipated next year. Low CMV awareness and potential need for serologic screening may pose implementation challenges.
OTHER VACCINES: LYME DISEASE	A work group has been formed to evaluate 2 new vaccines currently in clinical trials.

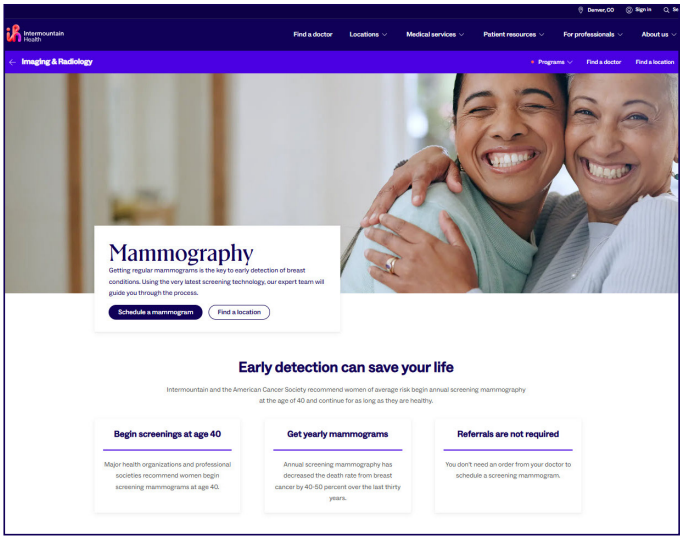
Questions about immunization? Contact Tamara Sheffield, MD, MPA, MPH, Medical Director, Immunization Programs, Intermountain Health Canyons Region, at **801-442-3946**.

Help Members Stay on Track with Breast Cancer Screenings

Getting regular mammograms is the key to early detection of breast conditions and now, it's easier than ever to schedule. Screening mammograms at an Intermountain Health facility do not require an order from a provider. Patients may self-schedule on the **Intermountain Health website**.

The American Cancer Society recommends women of average risk begin annual screening mammography at the age of 40 and continue for as long as they are healthy.

Intermountain Health uses advanced 3D mammography, or breast tomosynthesis, to get the most detailed and accurate information, enabling earlier detection of breast cancer. It also produces fewer false-positive results than traditional mammograms and lets providers identify small tumors that may be missed in traditional mammograms



Early detection can save a life.

Breast cancer is one of the most treatable forms of cancer if it's caught in its early stages. Annual screening mammography has decreased the death rate from breast cancer by 40–50 percent over the last 30 years.

Early Preventive Screening for Colorectal Cancer

Preventive vaccines, tests, and procedures look early signs of a disease or cancer to prevent the patient's condition from worsening. Vaccines prevent a disease or dramatically reduce its impact on the person's ability to recover.

HEALTH PLANS AND PREVENTIVE SCREENINGS

Regulations require that most commercial health plans cover certain services as preventive with no member payment responsibility. These mandated services (e.g., mammograms, vaccines, colorectal cancer screening) are usually based on recommendations from the U.S. Preventive Services Task Force (USPSTF) or Advisory Committee on Immunization Practices (ACIP).

Additionally, certain screening or preventive tests need to be covered as preventive at defined intervals as per published guidelines. For example, screening colonoscopies follow USPSTF recommendations and are required to be covered as preventive every 10 years. A plan can choose to be more liberal but not more restrictive.

COLORECTAL CANCER SCREENING AND RISK FACTORS

Key health guidelines recommend preventive screening for colorectal cancer (CRC) at age 45 years. There are circumstances that warrant earlier screening and could be covered under preventive benefits.

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National guidelines, such as those published by the National Comprehensive Cancer Network (NCCN), recommend preventive screening at earlier ages than for average risk patients. These risks include:[1,2]

1. ≥1 first-degree relative with CRC at any age*
2. First-degree relative with confirmed advanced adenoma(s) (e.g., high-grade dysplasia, ≥1 cm, villous or tubulovillous histology, or advanced serrated polyps—1 cm, or any dysplasia) at any age*
3. Inflammatory bowel disease screening as per guidelines
4. Hereditary CRC disorders, such as Lynch syndrome screening, as per guidelines

Please note that having second- and third-degree relatives with CRC cancer history does not usually result in a recommendation for early preventive screening (e.g. maternal and paternal grandparents with CRC) unless there are ≥3 to 4 relatives on one side of the family noted with CRC.

Requesting preventive screening at age >10 years from patient family member with CRC will also not meet preventive screening guidelines (e.g., mother had CRC at age 45 and preventive screening is requested at age 29).

It is important that as a physician you do not lead a patient to believe a colonoscopy is covered as preventive if they do not meet the above criteria. Patients frequently misunderstand this verbiage, and it is frustrating in these situations as they have been told by their doctor that this is preventive.

Patients or physicians should request preventive colonoscopy coverage **prior** to it being performed if a patient is under 45 years of age. If a colonoscopy has already been performed without preauthorization, it can also be appealed for preventive benefits.

DIAGNOSTIC VS PREVENTIVE SCREENING

Because preventive screening generally means that the patients does not have signs or symptoms of a disease of the organ being screened at the time of the screening.

Charges for CRC would be covered as **diagnostic** and **NOT** be considered under the member's preventive benefit if the patient:[3]

- Visits a physician for symptoms, such as bloating, bleeding, or abdominal pain, that are outside of USPSTF screening recommendations for colonoscopy
- Returns for surveillance of abnormal asymptomatic polyp(s) when the screening interval doesn't follow NCCN guideline recommendations for repeat colonoscopy
- Has symptoms from abnormal asymptomatic polyp(s)

REFERENCES

1. U.S. Preventive Services Task Force (USPSTF). *A & B Recommendations*. USPSTF website. No date. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. Accessed May 20, 2025.
2. National Comprehensive Cancer Network (NCCN). *NCCN Guidelines: Colorectal Cancer Screening*. NCCN.org website. Version 1: 2024. https://www.nccn.org/guidelines/guidelines-detail?category=2&id=1429. Accessed May 20, 2025.
3. Select Health. Select Health Coding & Reimbursement Policy: Preventive Care and Screening Guidelines (06). Last Revised April 9, 2025. https://files.selecthealth.cloud/api/public/content/06_preventive.pdf?v=35fa3bfd. Accessed May 20, 2025.

* For this risk factor, screening should begin no later than age 40 years or 10 years earlier than a family member with CRC and repeat every 5 years or based on colonoscopy findings.

How Care Management Supports Your Practice

Select Health provides Care Management services for Select Health members. Case Managers work closely with the Intermountain Clinical Program work groups. Members are stratified using multiple tools and a member of the care management team contacts those found to be at risk.

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
- Assistance with insurance benefit questions

Care management 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

Treating a Select Health member where a care manager could help?

Contact our Care Management Department at **800-442-5305, option 2**.

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 determinants of health needs

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

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/publication-resources/tools
Request preauthorization?	https://selecthealth.org/providers/preauthorization
Appeal a claim?	https://files.selecthealth.cloud/api/public/content/provider_appeal_form.pdf
Find pharmacy resources?	https://selecthealth.org/providers/pharmacy
Access dental provider resources?	https://selecthealth.org/providers/dental
Access Select Health policies (medical, dental, coding/reimbursement)?	https://selecthealth.org/providers/policies
Learn about our secure provider tools (Provider Benefit Tool, CareAffiliate®)?	For the Provider Benefit Tool (check eligibility and claims status): https://selecthealth.org/providers/claims/provider-benefit-tool For CareAffiliate (submit and track online preauthorization requests): https://selecthealth.org/providers/preauthorization/careaffiliate/ca-training

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	The Provider Benefit Tool (see above) or 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.)
Resolve issues with provider setup or directory listing	Provider Development: **800-538-5054**; **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