examiner

News for the WNY Provider Network January 2024

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News for the WNY Provider Network

examiner

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Let Us Know Your Thoughts

Univera Healthcare is committed to assuring that all participating physicians and providers are satisfied with daily operational plan functions such as network management and provider services relationships, resource management processes, quality improvement activities, and customer service. To that end, we invite your comments, concerns and questions. Your feedback will help us know how we're doing. Please contact Maria N. Valvo, Editor, at maria.valvo@univerahealthcare.com.

Univera Healthcare Mission:

To improve the health and quality of life of our members and the communities we serve.

SEASONAL PERSPECTIVES

January in Western New York is a good time to remind older patients about preventing falls on icy pavement and indoors.

More than one in four older adults (28%) in the U.S. report falling each year, according to Univera Healthcare's review of the most recent data available from the Centers for Disease Control and Prevention (CDC). That translates to about 36 million falls each year, of which 36,000 result in death. Many who survive and recover from a fall lose the ability to live independently on a short- or long-term basis, and those who require medical treatment may incur substantial out-of-pocket costs. According to the CDC, falls among older adults result in $50 billion in annual medical spending, including $12 billion out-of-pocket.

The simple Timed Up and Go test, or TUG test, is a risk assessment anyone can do it at home.

The TUG test requires a stopwatch or wristwatch with a second hand, a chair, and a friend to assist. Most cell phones have a stopwatch feature. Regular footwear should be worn, and any necessary walking aid should be used.

How to take the TUG test:

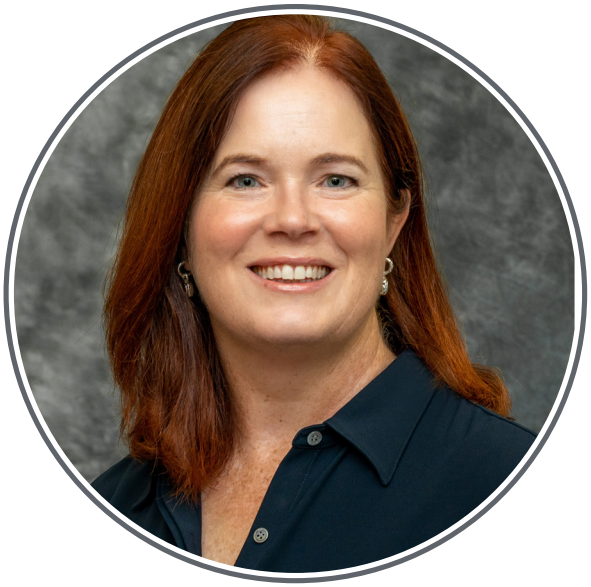
- Mark a line on the floor that's 10 feet away from the chair
- Sit in the chair
- When your friend with the stopwatch says "go," stand up from the chair
- Walk 10 feet to the line on the floor at your normal pace
- Turn and walk back to the chair at your normal pace and sit down

Start timing on the word "go" and stop timing after you sit back down (view a Univera Healthcare video demonstration of the TUG test online at https://youtu.be/jKjfH_JPc6Q).

If the patient takes 12 or more seconds to complete the TUG test, they may have a higher chance of falling and should be advised as to actions they can take to reduce the risk.

Please take a few moments to discuss the importance of preventing falls in the home and to take extra care in icy weather with your patients.

Helpful fall prevention resources and further information can be found at Older Adult Falls | Fall Prevention | Injury Center | CDC



Lorna Fitzpatrick, M.D.
Senior Medical Director

Authorization Tool Now includes Eligibility & Benefits Lookup Option

We remind you that an authorization lookup option is available on the Eligibility & Benefits landing page of our recently enhanced tool.

Features include:

- Streamlined eligibility search page
- Simplified instructions and search results view
- Ability to search for multiple members
- Detailed Member eligibility information
- Ability to View a Member ID Card

Member / Benefits Information

- Accordion display of Deductible and Out of Pocket information, Benefit details and more.
- Additional Benefit Details tab for member specific benefit information.

For further guidance, see our Authorization Lookup Tools tip sheet.

Brainstorm with Us about this Newsletter!

What topics would you like see addressed in an upcoming issue of this newsletter?

We'd love to hear your thoughts. Use this one question survey to share your ideas and you may see your topic included in the next issue!

It's a New Year—Time to Update your Patient Records

We remind you that many of your patients change insurance coverage with the start of the new year. Please remember to check member cards at each visit and be sure to keep a copy of the current card in the patient's file.

It is also important to check eligibility and benefits at HealtheNet.com or our website prior to providing services.

Online Staff Training Materials Include D-SNP, Behavioral Health, More

We offer several online training resources for practitioners and office staff that you will likely find helpful as you conduct business with our Health Plan and deliver care to our members.

We have recently added training materials related to our Dual Eligible Special Needs Plan (D-SNP) to the Staff Training area of our website. These materials include a D-SNP Model of Care training video, as well as a Provider Training Guide, Model of Care Attestation and tip sheet.

We also offer monthly behavioral health webinar trainings on a variety of topics including: Cultural Competency, Basics of Substance Use Disorder, Poverty Competency, Working with LGBTQIA+ and many more.

Access the full monthly list here.

Thank You for Attending Our Fall Seminars!

Thank you to everyone who joined the Provider Relations team for its virtual fall seminars. We had 60 attendees! Many of you provided valuable feedback at the seminar that will help us to grow and improve to serve you better.

2023 Provider Manual Now Available!

The Univera Healthcare Participating Provider Manual has been updated and is now available on our website.

Please log in with your username and password to access the latest version of the manual, or call Customer Care at 1-866-265-5983 to request a paper copy.

Health Plan Launches Dual Special Needs Plan

We are excited to share that our new Dual Special Needs Plan (D-SNP), called Univera Medicare Dual is now available to individuals who are eligible for both Medicare and Medicaid.

It is a privilege for us to provide enhanced supplemental benefits and more comprehensive, individualized care coordination to our D-SNP members.

Please note that providers currently participating with our Medicare Advantage and Safety Net lines of business are considered in-network for D-SNP, and will be reimbursed based on current contracted rates.

For further details, please refer to the Staff Training section of our website that includes the D-SNP Provider Training Guide, D-SNP Model of Care Training, D-SNP Model of Care Attestation, and D-SNP Tip Sheet.

Health Plan Earns 85 Percent on Human Rights Corporate Equality Index

We're proud to share that Univera Healthcare has received a score of 85 percent out 100 on the Human Rights Campaign Foundation's 2023-2024 Corporate Equality Index (CEI), the nation's foremost benchmarking survey and report measuring corporate policies and practices related to LGBTQIA+ workplace equality.

Univera Healthcare joins the ranks of 1384 major U.S. businesses that were also ranked in the 2023-2024 CEI.

The CEI rates companies on detailed criteria falling under four central pillars:

- Non-discrimination policies across business entities;
- Equitable benefits for LGBTQIA+ workers and their families;
- Supporting an inclusive culture; and,
- Corporate social responsibility.

Read the full report at www.hrc.org/cei.

Member Rights and Responsibilities

The delivery of quality health care requires cooperation among patients, their providers and the Health Plan. One of the first steps to ensure quality is for patients and providers to understand their rights and responsibilities. We encourage you to review our Member Rights and Responsibilities and share this information with your patients.

This information is also included in the Univera Healthcare Participating Provider Manual.

Help Stop Fraud, Waste and Abuse

To report potential fraud, waste or abuse, please call our Fraud Hotline at 1-800-378-8024 or visit our website to complete and submit our Fraud Reporting form. All fraud, waste and abuse referrals are confidential and can be made anonymously. Those who report wrongdoing are protected from retaliation.

Help Us Boost Cardiac Rehabilitation Use

Did you know that cardiac rehabilitation is an underused member benefit? A review of claims data shows that only about 16 percent of members eligible for cardiac rehabilitation use the benefit. New York state ranks 49th in the nation for eligible Medicare members at 15.4 percent (Keteyian et. al., 2022). There are populations that are under-referred for cardiac rehabilitation, such as women, people of color, older people, and people with other medical conditions.

The Health Plan offers:

- Cardiac rehabilitation with $0 copay for Medicare Advantage members.
- A transportation benefit for medical appointments, including cardiac rehabilitation (based on member benefits/eligibility).

In the first quarter of 2023, the Health Plan sent a survey to members who had a qualifying cardiac event. Most of the members who attended cardiac rehabilitation had a positive experience and feedback. A member said, "Please tell all potential patients it covers all issues – nutrition, drugs, exercise program." Another member stated, "Cardiac rehab teaches you how to monitor your exercise safely, the importance of both exercise and a heart healthy diet, and it starts the exercise process, which makes it easier to make it a part of your daily routine." Another member shared, "Doctors should bring this subject up with their patients."

The provider/patient relationship is vital to influencing use of the cardiac rehabilitation benefit. According to Million Hearts (2020), "the greatest predictor of participation is the strength of the physician's recommendation." Cardiac rehabilitation is a lifestyle change with evidence that shows reduced mortality rates, modification of risk factors, an enhanced quality of life (Bracewell et. al., 2022). It is also recommended by the American Heart Association and the American College of Cardiology.

The following Health Plan cardiac rehabilitation resources are available:

- Our case managers contact members across all lines of business who have had a qualifying cardiac event to help them understand and use their cardiac rehabilitation benefit. Case managers also engage with members to help them manage their health conditions. Call the Case Management team at 1-877-222-1240 for more information or to refer a patient.
- Cardiac rehabilitation facility location finder: https://www.cardiacrehabfinder.com/

Thank you in advance for referring our members to a cardiac rehabilitation program and for discussing the importance of cardiac rehabilitation as a crucial part of their recovery.

Sources:

Bracewell NJ, Plasschaert J, Conti CR, Keeley EC, Conti JB. Cardiac rehabilitation: Effective yet underutilized in patients with cardiovascular disease. Clin Cardiol. 2022 Nov;45(11):1128-1134. doi: 10.1002/clc.23911. Epub 2022 Sep 2. PMID: 36054282; PMCID: PMC9707561.

CDC. (2020, April 22). Cardiac Rehabilitation At A Glance. Centers for Disease Control and Prevention. https://millionhearts.hhs.gov/data-reports/factsheets/cardiac.html

Access & Availability Standards

We follow appointment availability standards established by the New York State Department of Health. These standards, which apply to all lines of business, are used to improve patient access to routine, urgent, preventive and specialty care. We also follow 24-hour access standards to measure after-hours access. Learn more by viewing our Access and Availability Standards tip sheet.

HEDIS® MY2023 - Ensuring a successful HEDIS Season

The Health Plan, in collaboration with our network providers, is committed to improving the quality of care for our members, your patients. One way we do this is by annual participation in the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data Information Set (HEDIS) data collection.

HEDIS consists of a set of nationally reported measures used to measure Health Plan performance on important dimensions of care and service. We gather this information by abstracting medical record documentation of services billed and performed to support the measure set criteria established by NCQA. Ensuring accurate coding for services provided is key.

We combine our HEDIS scores with our Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores and our NCQA Accreditation scores to receive a Health Plan Insurance Rating from NCQA. This rating can be viewed by consumers when selecting a health plan for the first time or if considering changing plans. Our audit of rate results is conducted by an NCQA-certified auditor. Results are used to evaluate where to focus quality improvement efforts.

A HEDIS representative will be contacting your office to discuss your preferred method to receive your patient list and to coordinate the best method for our Health Plan to retrieve the records. We realize that every practice is different, and we will work with each practice on your preferred method.

There are multiple options for submitting records. The preferred method is remote access to your Electronic Medical Record. Remote access is the most efficient way for medical record review as it requires less support from office staff and complete results. Other methods of access are faxing, encrypted email, secure file transfer of records, and mail in (paper, CDs). The use of a third-party vendor for record retrieval is available, but not preferred. Our Health Plan would like to remind offices that we do not incur any costs when a third-party vendor is used for record retrieval. The use of third-party vendors tends to slow retrieval and often produces a need to request additional information from records.

HEDIS Medical Record Chart Review Timeline

Time Frame	Office Communication
January	HEDIS reminder in Provider Newsletter
Mid-February	HEDIS reviewers begin contact with provider offices to set up preferred method of record collection
February through April	Record collection for HEDIS

Our HEDIS and Risk Adjustment teams have timelines that coincide, and they will reach out for medical records at the same time. However, the documentation that is needed for HEDIS purposes varies from the documentation needed for Risk Adjustment purposes. The Health Plan is working to increase efficiencies between HEDIS and Risk Adjustment to reduce the medical record collection duties of our provider offices.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 permits data collection and release of information as part of our Health Plan's Health Care Operations and includes quality assessment and improvement activities.

We appreciate your cooperation and participation in this time-sensitive review. If you or your staff have questions regarding HEDIS please contact the Quality Measurement department at 1-800-768-8177.

Tips for Claim Adjustment Submissions

Electronic claim adjustment requests using Frequency Code 7 or 8 are likely to receive a response within days as opposed to requests submitted on paper, which can take weeks before a response is issued.

The field locations for the frequency code differs for facility and professional claims.

<table>
<tr><th colspan="2">On a Facility Claim</th><th>On a Professional Claim</th></tr>
<tr><td colspan="2">The facility claim must indicate:</td><td rowspan="3">The professional claim will indicate a Frequency Code 7 in Box 22 on the claim image. This code will not appear on the screens in Facets
This information will display in the following places on the HIPAA Gateway:
The Frequency Code 7 will be in the CLM05-03 Section
The original claim number in the REF02 Section</td></tr>
<tr><td>On an Electronic Claim</td><td>On a Paper Claim</td></tr>
<tr><td>A Frequency Code 7 in the CLM05-03 Section
The original claim number in the REF02 Section</td><td>A Frequency Code 7 in Box 4
The original claim number in Box 64</td></tr>
</table>

If the request is submitted by paper, it is important to use the correct form to avoid delays in processing due to incorrect routing.

Examples:

If a claim has clinical editing denial and there is no change to any coding of claim when submitting records for review, use Clinical Editing Adjustment Form.

If claim has a clinical editing denial and there is a change to any coding, use Claim Adjustment Form or Frequency coding.

Are you adding/removing/changing a modifier, procedure code, units, dx codes, POS, or charges? We recommend that you skip the paper form and submit electronically with Frequency Code 7 and include the history claim number.

Formulary Updates Effective January 1, 2024

The list of medications covered by the Health Plan is reviewed regularly by an outside committee of physicians and pharmacists. Changes may be made to this list of covered drugs (formulary) to ensure that they meet the criteria for safety, effectiveness, and value.

Please review our recent bulletin for the summary of changes to the formulary effective January 1, 2024.

Keep Your Practice Information Current

Our online Practitioner Demographic Changes submission form makes it easier and faster to update the demographic information we have for your practice.

Visit the Update Practice Information section of our website. Log in with your username and password to use the online form. You still have the option to download a PDF version of this form if you choose.

We recommend that you verify demographic information every 90 days using our Find a Doctor/Provider tool.

Please also verify and update your demographic information on the NPI Registry. Log into your NPI record at https://nppes.cms.hhs.gov/#/.

If you need help using the new online form, please contact your Provider Relations representative. Thank you!

CODING CORNER

Benefits of Risk Adjustment

Have you ever wondered how Risk Adjustment (RA) benefits your patients and you? Documenting and reporting each health condition accurately not only impacts RA, but it also helps to improve the quality, access, and outcomes of patient care. The Health Plan uses information related to member health conditions to identify the need for health care services and/or care management. When the overall health conditions of patients are identified, we can positively impact the quality and affordability of the health care provided.

Eight ways RA benefits patients and practitioners:

1. **Meets Centers for Medicare & Medicaid Services (CMS) requirements:** Accurate coding and documentation can help you meet CMS provider obligations, which include the use of diagnosis coding standards in medical record documentation in the event of a CMS Medicare Recovery Audit Contractor and Risk Adjustment Data Validation audits.
2. **Coordinates care and improves communication and practice patterns:** Accurate coding and documentation allows you to coordinate your patients' care collaboratively and can improve practice patterns and communication among your patients' team of health care providers.
3. **Reduces requests for medical records:** Appropriate diagnosis code reporting and complete clinical documentation can reduce the need for multiple medical record requests.
4. **Improves health care management:** Inclusion of chronic conditions considered in the medical decision making for evaluation and management allows for better health management.
5. **Engages patients in self-care and prevention:** Complete patient diagnosis coding can help your patients qualify for care and disease management programs offered by the Health Plan. These services reinforce self-care and prevention strategies. The sooner we know that a patient has a specific condition, the sooner we can engage them.
6. **Promotes preventive services:** Annual wellness visits or comprehensive physical exams are preventive services that can help capture your patients' current and active diagnoses annually.
7. **Avoids adverse drug and drug/disease interactions:** When you are aware of your patients' coexisting conditions, it can help you avoid prescribing drugs that can cause adverse drug or drug/disease interactions.
8. **Keeps insurance premiums affordable:** The reimbursement the Health Plan receives from CMS through risk adjustment helps to keep insurance premiums affordable for our members.

Important Reminders

- All diagnoses submitted on a claim should be supported by the **M**onitoring, **E**valuation, **A**ssessment and/or **T**reatment of the condition in the medical record documentation.
- "Unspecified" codes should only be reported when a more specific diagnosis cannot be determined.

For more information, contact Carole Clark, manager, risk adjustment training and practitioner education at 585-530-5542.

MEDICAL POLICY UPDATES

Univera Healthcare works to ensure that the development of corporate medical policies occurs through an open, collaborative process. We encourage participating providers to become actively involved in medical policy development. Each month, draft policies are available on our website for review and comment. To access the draft policies, click here. Providers may now attach supporting documentation related to their comments.

The following new and updated medical policies have been reviewed and were approved in **November 2023** by the Corporate Medical Policy Committee, including practitioner representatives from all our regions. A complete library of our medical policies can be found on our website.

Corporate Medical Policy Committee, including practitioner representatives from Western New York.

Current Policies – Significant Updates

- **(#2.01.28)** Sleep Studies defines various diagnostic methods used in the diagnosis of patients with disorders of sleep and daytime alertness and provides indications and coverage statements for polysomnography (PSG), EEG topography, multiple sleep latency test/maintenance of wakefulness test, nocturnal oximetry, PAP-Nap (Positive Airway Pressure Nap) and actigraphy. The policy includes criteria for facility-based polysomnography (PSG) in children and adults, facility-based CPAP titration, and split-night studies. A home/portable sleep study (HST) is an alternative to a facility-based PSG for patients who do not meet criteria in Policy Statement I A-C. Policy criteria for actigraphy has changed to consider an actigraphy study once per year medically appropriate in children aged four to 18 years, who have insomnia and/or circadian rhythm disorder associated with excessive daytime sleepiness, and a discrepancy between reported sleep history and described symptoms. *This off-cycle update includes a clarification for multiple sleep latency testing criteria, where all criteria must be met for the service to be considered medically appropriate. Criteria was also added to address repeat polysomnography after hypoglossal nerve stimulation implant for the titration of the device. The changes are aligned with The American Academy of Sleep Medicine recommended protocols. This policy update will require a 90-day provider notification.*

- **(#2.02.49)** Molecular Markers in Fine Needle Aspirates of the Thyroid (New Policy Title: Molecular Marker Testing of the Thyroid) are approaches for improving the diagnostic accuracy of thyroid FNA for those patients with indeterminate results and include genomic sequencing, messenger RNA (mRNA) analysis, and/or microRNA (miRNA) expression analysis of cancer-associated genes of the thyroid. The tests are used to more accurately classify which patients need to proceed to surgery (and may include the extent of surgery necessary) and to identify patients who do not need surgery and can be safely followed. In addition to a title change, this year's annual update includes a change to medically necessary criteria for molecular marker tests or gene variant analysis in fine needle aspirates of thyroid nodules with strong findings suggestive of malignancy. The medically necessary tests are categorized by the 2017 Bethesda System for Reporting Thyroid Cytopathology. *The policy update includes the addition of RosettaGX Reveal, singe-gene TERT testing for thyroid and Thyroid GuidePX to the list of gene expression classifiers, genetic variant analysis and molecular marker testing which are considered investigational. Health Plan standard genetic testing language was added to the policy guidelines, as well as clarification that testing is only appropriate once per lifetime per thyroid nodule. This policy update will require a 90-day provider notification.*

- **(#4.01.03)** Prenatal Genetic Testing policy addresses the medically appropriate indications for preconception genetic testing, prenatal genetic testing, and preimplantation genetic diagnosis of embryos. Benefits for these testing modalities are based upon subscriber contract benefits and must be rendered in a setting with adequately trained health care professionals that provide the appropriate pre- and post-test counseling. Criteria related to coverage of prenatal carrier testing for fragile X syndrome and Spinal Muscular Atrophy (SMA) for NYS Managed Medicaid members is also included in the policy statements. Preconception or prenatal carrier screening of individuals of Eastern European Jewish (Ashkenazi) descent for Tay–Sachs disease (TSD), Canavan disease, cystic fibrosis, and familial dysautonomia is considered medically appropriate. Preconception or prenatal carrier screening for spinal muscular dystrophy (SMA) as a medically necessary part of routine care; and fragile X or fragile X-related testing is considered medically necessary in women with family history of fragile X-related disorders or intellectual disability suggestive of fragile X syndrome.

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MEDICAL POLICY UPDATES, continued from page 13

Current Policies – Significant Updates

These criteria are based on the recommendations of the American College of Obstetricians and Gynecologists and the American College of Medical Genetics. Genetic testing on products of conception is medically appropriate for evaluation of two (2) or more consecutive pregnancy losses (recurrent pregnancy loss). Non-targeted, multi-gene panel testing for preconception or prenatal carrier screening (e.g., Genesys Carrier Panel, Genesys Diagnostics; Horizon Advanced Carrier Screening, Natera; Myriad Foresight Screening, Myriad, SEMA4 Elements and Invitae carrier screening) is considered not medically necessary as it is not considered part of routine care. *This policy update includes the addition of policy criteria addressing preimplantation testing-monogenic (PGT-M) and a new requirement that testing must be supported by published peer-reviewed literature that demonstrations an improvement in health outcomes. Additionally, an investigational statement was added for preimplantation genetic testing for single-gene germline conditions (e.g., Spectrum PGT-M, Natera). This update will require a 90-day provider notification.*

- **(#6.01.07**) Positron Emission Tomography (PET) Non-Oncologic Applications is an imaging technology that can reveal both metabolic and anatomical information in various tissue sites. PET is considered medically appropriate as an imaging tool for various cancers as outlined in the policy. *With this policy update, criteria for the use of PET in the following scenarios have been added: Dementia, spine, peripheral vascular disease, peripheral nerve disease, pelvis, musculoskeletal, chest and abdomen. The updates are in alignment with the eviCore V1.2024 imaging guidelines and will require a 90-day provider notification.*

- **(#7.01.99)** Drug-Eluting Sinus Stents and Nasal Implants (New Policy Title: Ablation, Implants and Stents for Nasal Conditions) Functional endoscopic sinus surgery (FESS), has become an important aspect for surgical management of chronic sinusitis. In patients with chronic rhinosinusitis the procedure restores patency and allows air and mucous transport through the natural ostium. Postoperative inflammation, polyposis, and adhesions, that often require subsequent medical and surgical intervention may occur after surgery. Sinus stents are devices used postoperatively following FESS. These devices maintain patency of the sinus openings in the postoperative period, and/or serve as a local drug delivery vehicle and potential reduce postoperative inflammation and maintain patency of the sinus to allow for optimal sinus drainage and improve recovery. Three sinus implants, Sinuva, Propel, and Latera have FDA approval. The Propel sinus implant may be placed as part of an outpatient procedure while the Sinuva and Latera sinus implants can be placed in a physician's office. Placement of these sinus implants is considered investigational due to the lack of long-term follow-up to show the benefit on health outcomes. *In addition to a new title, this off-cycle review adds investigational criteria for ablation of the posterior nasal nerve to treat chronic rhinitis (e.g., ClariFix and RhinAer) and radiofrequency ablation of nasal valve (e.g., VivAer) to treat nasal valve collapse with obstruction. This update will require a 90-day provider notification.*

- **(#11.01.01)** Medical/Non-Surgical Weight Management Programs This policy addresses commercial weight loss programs (e.g., Jenny Craig, Medifast, Nutrisystem, Noom), intensive/high intensity lifestyle counseling programs, and medical weight management programs. Commercial weight loss programs are generally excluded by contract and are, therefore ineligible for coverage. An intensive lifestyle counseling program or medical weight management program, provided by an appropriately licensed provider, to promote a healthful diet and physical activity in children/adults older than six (6) years of age, is medically appropriate when specific criteria are met as outlined in the medical policy. Intensive lifestyle counseling programs or medical weight management programs must be rendered by providers with the appropriate knowledge and training (e.g., physicians, registered professional nurses, nurse practitioners, clinical nurse specialists, certified dieticians, and certified nutritionists) who have an unrestricted New York State license and are credentialed by the Health Plan for services to be considered for coverage. Medical weight management programs are programs that do not include physical activity assessment, counseling, and exercises. These programs are considered medically appropriate as outlined in the medical policy. This annual update includes the addition of medically necessary criteria for

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MEDICAL POLICY UPDATES, continued from page 13

Current Policies - minor updates

The following policies have been updated by Health Plan medical directors to reflect minor changes, such as applicable references, criteria, or system pend, and are available on our website.

- **(#3.01.21)** Level of Care Criteria for Inpatient, Residential, Partial Hospital, and Intensive Outpatient Mental Health Services for Adults and Children
- **(#6.01.16)** Brachytherapy or Radioactive Seed Implant for Prostate Cancer
- **(#7.01.02)** Allogeneic Hematopoietic (STEM) Cell Transplantation
- **(#7.01.62)** Intervertebral Disc Decompression: Laser (Laser Discectomy) and Radiofrequency Coblation (Disc Nucleoplasty) Techniques
- **(#10.01.08)** Coverage for Dependents with Disabilities

Archived Policies

Policies are archived either because the criteria for evaluating the procedure/technology have not changed or because there has been little utilization or few requests. Archived policies are available on our website.

Newly Archived

- **(#8.01.12)** Physical Therapy

Previously Archived

- **(#1.01.15)** Airway Clearance Devices
- **(#2.01.03)** Ambulatory Event Monitor
- **(#2.01.39)** Auditory Processing Disorder Testing
- **(#2.02.07)** Genetic Testing for Germline Mutations of the RET Proto Oncogene in Medullary Carcinoma of the Thyroid
- **(#2.02.19)** Serum Antibodies for the Diagnosis of Inflammatory Bowel Disease
- **(#2.02.47)** Measurement of Serum Antibodies to Tumor Necrosis Factor Blockers
- **(#9.01.04)** Vision Therapy
- **(#11.01.17)** Temporomandibular Joint Disorders (TMJD)
- **(#12.01.06)** Private Rooms

Note: When policy criteria change, Univera Healthcare's requirements related to medical records may also change. Medical record requirements are available here. Failure to submit required records with the claim submission could delay claim processing and payment.

Although medical policies are effective, services may not be reviewed until our systems are updated.

Questions regarding medical policies should be directed to your Provider Relations representative.