Message from Brent and Susan

Dear Colleagues,

We are pleased to share December’s edition of Intermountain Med Staff News, a news brief with a goal of keeping Intermountain credentialed practitioners informed. This edition includes updates on various Intermountain initiatives including a look at how we’re doing with Zero Harm, SelectHealth preauthorization requirements for selected surgical procedures, and updates from various clinical programs.

This will be Brent’s last edition of Med Staff News as the Chief Medical Officer. Brent is retiring on January 12, 2018. Included in this edition is the announcement of his retirement and a summary of his career with Intermountain.

Click on any title in the list below and go directly to that article, or read the entire newsletter in PDF format on Intermountain’s Physician Portal. If you have questions, comments, or suggestions, please reach out to the contacts noted at the end of each article, or to either of us. If you have an article to submit or an idea for a story, please send it to us.

Thank you for all that you do in support of Intermountain Healthcare and the patients and communities we serve as we all help people live the healthiest lives possible.

Sincerely,

Brent Wallace, MD & Susan DuBois

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Brent Wallace, MD, Chief Medical Officer, is retiring from Intermountain

Among our recent organizational changes is the announcement that Brent Wallace, MD, Chief Medical Officer, will be retiring from Intermountain on January 12th, 2018. Brent has served as the system Chief Medical Officer since 2005.
In his role as Chief Medical Officer, Brent has been responsible for overseeing physician relations, medical affairs, post-graduate medical education, continuing medical education, research, contracting, and emergency preparedness including Life Flight. He's also provided physician leadership for the design of iCentra and served as the medical consultant for risk management. Over the years, he's visited hospitals and clinics to educate clinicians on major industry changes including ICD-10, MACRA, the Affordable Care Act, and Medicare National Coverage Decisions, and how they affect Intermountain.

In a co-leadership position with, most recently, Kim Henrichsen, Senior Vice President of Clinical Operations and Chief Nursing Executive, Brent has contributed to the Clinical Programs' growth and successes, championing important progress in quality improvement for the benefit of our patients. Under his direction, we prepared for the possible severe H1N1 influenza pandemic, and collaborated with the Utah Hospital Association and state leadership in defining how we will respond to potential community emergencies.

Brent’s other leadership roles included serving as the Medical Director for Intermountain Homecare, Chair of the Medical Group Board, and President of the Medical Staff and Chief of the Family Medicine Department at McKay-Dee Hospital. He completed his own residency at McKay-Dee Hospital before practicing family medicine for 26 years in Roy, Utah.

Brent says that one of the most enjoyable aspects of his career has been helping younger clinicians grow and develop in their own leadership skills. He's been thrilled to see them succeed.

Mark Briesacher, MD, Chief Physician Executive & President of the Intermountain Medical Group, says, “It's been truly an honor to learn from and collaborate with Brent over the years. His commitment to patients, physicians, and caregivers, thoughtful approach to complex problems, and collaborative leadership has been instrumental in our initiatives to enhance our Clinical Programs, clinical information systems, our hospital medical staffs, the Medical Group, and clinician engagement and satisfaction. He's been a clinician champion, acting as their voice to communicate frontline needs to system leadership. Brent is a trusted colleague and has had significant impact here at Intermountain.”
Dr. Marc Harrison and Dr. Stan Huff join White House discussion on electronic medical record sharing

Intermountain CEO Marc Harrison, MD, and Stan Huff, MD, chief medical informatics officer, were among approximately 35 people from a range of healthcare sectors invited to a special meeting at the White House last week. The meeting — led by Jared Kushner, White House advisor and director of the Office of American Innovation, and Centers for Medicare & Medicaid Services Administrator Seema Verma — featured a broad discussion on making health records and data more easily shared.

Dr. Huff says topics discussed included ways to get data into patients' hands, meaningful use, and improving electronic health records. He says the meeting was mostly a listening session, but helped lay the foundation for future work.

Marc tweeted from the event: “Privileged to represent @Intermountain in a patient-centered conversation about EHR interoperability at the @WhiteHouse hosted by @SeemaCMS and Jared Kushner.”

Read more about the meeting from FierceHealthcare, Politico, and Becker's.

Dr. Paul Krakovitz, MD, FACS, is now the Associate Chief Medical Officer for Specialty Based Care

Dr. Paul Krakovitz, MD, FACS, is now the Associate Chief Medical Officer for Specialty Based Care. This role reports to Dr. Mark Briesacher, Chief Physician Officer, and will work with Lisa Graydon and Steve Smoot to lead the Specialty-Based Care Group.
Dr. Krakovitz comes to Intermountain from Cleveland Clinic where he was the Section Head of Pediatric Otolaryngology, Vice-Chairman of Surgical Operations, and an elected member of their Board of Governors. At Cleveland Clinic, he was tasked with integrating and coordinating perioperative services across their health system's 300 operating rooms at 18 different locations.

Paul's experience in surgical operations brings new perspectives and thinking to our organization. He is uniquely suited to lead us through our development of One Intermountain, particularly in the specialty care area.

Since joining Intermountain earlier this year, Dr. Krakovitz has made significant contributions in the Healthy Future work to provide the highest quality care at the lowest appropriate cost. His leadership has helped our surgical and medical supply teams find efficiencies and reduce health care costs for our patients who are looking for the most affordable options for care. In his new role working with Lisa Graydon and Steve Smoot, he and his team will lead hospital medical directors and the specialty-care based medical directors of Clinical Program and Clinical Services to set clinical standards and advance our performance in each of Intermountain Healthcare's Fundamentals of Extraordinary Care – safety, quality, experience, access, and stewardship. He will also collaborate with population health leaders to determine appropriate utilization of hospital-based clinical services and advancement of centers of excellence.

Dr. Krakovitz's commitment to our mission, patients, and caregivers, and to the professional and personal development of our physicians is impressive.

Dr. Krakovitz and his wife, Laini, live in Park City with their two boys Monty and Miles. Dr. Krakovitz is an avid swimmer, runner, and aspiring snowboarder. He enjoys spending family time outdoors and travelling. He will continue practicing pediatric otolaryngology at Primary Children's.

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**Announcement from Mark Briesacher, MD**
Caregiver Leaders,

With One Intermountain team, our patients and families will experience extraordinary care whenever, wherever, and however they seek care at Intermountain. In support of this aspiration, I'd like to share an announcement with you:

On December 1, 2017, Dr. Shannon Connor Phillips became Intermountain's Chief Patient Experience Officer and is leading the new Office of Patient Experience. This office brings together safety, quality (clinical outcomes), and experience of care roles and teams, aligning critical functions that support all aspects of high reliability in safety, outcomes, and caring. This team will support Intermountain's caregivers to provide and continuously improve the extraordinary care we provide to our patients and families.

Dr. Phillips and the Office of Patient Experience is focused on three important fundamentals of extraordinary care:

- **Safety**: Zero Harm, infection prevention, clinical risk management and peer review
- **Quality (Clinical Outcomes)**: publicly reported quality measures for ambulatory and hospital care, with clinical partners, effective implementation of care process models, and clinical documentation improvement
- **Experience of Care**: patient and family advocacy, human connection, and advancing relationship-centered care

The office collaborates closely with nursing, physician, and operation leaders to further our Zero Harm high reliability journey.

Dr. Phillips will work in partnership with our Chief People Officer, Joe Fournier, to bring together people and teams from across Intermountain into this new office and to advance caregiver experience.

Dr. Phillips will also work closely with our Chief Consumer Officer, Kevan Mabbutt, to inform and align our patient experience with broader consumer needs and expectations and our end-to-end consumer experience and digital strategy.

This is an exciting and important time for Intermountain, our patients, and our community. Thank you for the care you provide every day for those who place their trust in us.

Thank you,

Mark Briesacher, MD

Chief Physician Executive

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**Dr. Brandon Webb is appointed to Stanford School of Medicine faculty as part of Intermountain’s Stanford partnership**

Congratulations to Intermountain Medical Center infectious disease specialist Brandon Webb, MD, who's received a faculty appointment at Stanford University as part of Intermountain's partnership with Stanford that includes collaboration on education, training, research, and clinical care.

In addition to Dr. Webb, six other Intermountain Healthcare physicians have been appointed to Stanford's faculty since the alliance began, including Brent James, MD, MSTAT, Jared Bunch, MD, Eddie Stenehjem, MD, Todd Allen, MD, Joey Bledsoe, MD, and Mark Ott, MD. “Brandon and all of the rest of us went through a full review by the appropriate Stanford School of Medicine departments before we were added to their faculty,” says Dr. Ott.

Dr. Webb will serve as a clinical assistant professor (affiliated) in the Department of Medicine and Division of Infectious Diseases at the Stanford University School of Medicine.

“We continue to seek these faculty appointments for appropriate Intermountain Healthcare clinicians as part of the Stanford/Intermountain collaboration that also includes joint efforts including research grants, implementation science, and educational opportunities,” Dr. Ott says. “Each of us is working with our colleagues there on various projects. The goal of our collaboration is to improve healthcare in our institutions and in healthcare at large. We believe Stanford and Intermountain have different strengths that complement each other and that our partnership has the potential to help us create profound changes in how clinical care can be delivered and improved. Dr. Webb is a terrific addition to this collaborative; he's a very skilled clinical leader who provides wonderful care for our patients and is a valuable resource for our caregivers.”
Dr. Webb is director of infectious diseases in Intermountain’s Transplant Program. He also serves in Intermountain Healthcare’s Division of Epidemiology and Infectious Diseases and the Intermountain Blood and Marrow Transplant Program. He graduated from University of Virginia School of Medicine, filled a fellowship in infectious diseases at the University of Utah, and is board-certified in internal medicine and infectious disease. He previously served as a hospitalist at the Phoenix Indian Medical Center in Arizona, at the Mayo Clinic Arizona Bone Marrow Transplant Unit, and in the Huntsman Cancer Hospital Hematology and BMT Unit.

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**INTERMOUNTAIN SYSTEMWIDE INITIATIVES**

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**Intermountain Partners with Press Ganey – Impact to the Clinician Experience Project**

Effective January 1, 2018 Intermountain will begin using Press Ganey as our vendor for patient experience surveys. Intermountain will utilize Press Ganey’s new reporting and analytics platform for enterprise insights and prioritized improvement opportunities to drive safety outcomes and achieve patient-centered care. Press Ganey’s survey will include the HCAPS In-Patient Survey and the CGCHAPS Outpatient Visit Survey used in our public transparency initiatives, including providing star-ratings and comments on our provider directories.

Many physicians and APCs took advantage of the Clinician Experience Project (the Project) provided to all credentialed practitioners as part of our contract with our former survey partner, National Research Corporation (NRC). Our move to Press Ganey means credentialed practitioners will no longer have access to the Project. This change will become effective on December 31, 2017.

Intermountain remains committed to caregiver resiliency and well-being. Earlier this year, Steve Swensen, MD, joined the Intermountain team as Medical Director of Professionalism and Peer Support. He is focused on supporting caregivers’ professional development in clinical excellence, leadership, and professional and personal well-being. As a trusted expert and nationally recognized caregiver advocate for reducing clinician burnout and improving employee engagement, he has led numerous research efforts exploring clinical leadership development and well-being. He is also a senior fellow at the Institute for Healthcare Improvement and has published in many areas, including a recent article in the New England Journal of Medicine (NEJM) Catalyst, “Leadership Survey: Why Physician Burnout is Endemic, and How Health Care Must Respond.”

Thank you for your participation in the Project. As we transition to Press Ganey, we are excited about the work Dr. Swensen will be leading to address caregiver well-being across the system and look forward to informing you of opportunities to build esprit de corps.

For questions of comments, please contact Susan DuBois, AVP, Physician Relations and Medical Affairs at 801-442-2840 or via email susan.dubois@imail.org.

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**How huddles help one clinic improve caregiver interactions and the patient experience**
How can internists and other caregivers in a busy clinic find a way to collaborate on patient care? In our new podcast series, Mark Briesacher, MD, Senior VP & Chief Physician Executive and President of Intermountain Medical Group sat down with Celia Garner, MD, an Internal Medicine physician at Intermountain's Avenues Specialty Clinic, to learn how she and her colleagues are working together to improve the experience patients have in their practice.

“The physicians in our clinic work really well together, but we are so busy, we rarely see each other during the day,” says Dr. Garner. “We also have a great care team who manages many things before and after the patient visits.” So how does the team stay connected? “Once a week we have a huddle with everyone in the office: the PSR pod, Medical Assistants, three or four available doctors, and the clinic management staff.”

**How does the huddle process work?**

The Internists use a huddle board based on the Fundamentals of Extraordinary Care, which they use to frame goals. Everyone has an opportunity to provide input about what is effective and where improvements can be made. The huddles are valuable to the whole care team – everyone finally understands how each role functions in patient care to make the patient experience as close to perfect as possible. “We recognize one caregiver after every huddle who has made a difference in a patient’s life that week,” says Dr. Garner. “It makes people feel appreciated and reminds us all of the importance of what we do every day. Care is improved and everyone is connected.

“These huddles make me a better doctor.”

Dr. Briesacher agrees. “People who go into healthcare are generally people who want to help others. This applies to all people on our teams – from Environmental Services to clinic managers to communications people. They have chosen these jobs to help people every day. Huddles help to connect the way each role provides care for people.”

Another improvement in the way care is delivered has been the addition of Advanced Practice Clinicians (APC) in the clinic setting. The Avenues Clinic recently added an APC, who has become a very valuable part of the treatment team. Dr. Garner says, “Everyone is seeing how effective these clinicians can be in terms of what they can help us do—one person can’t do it alone anymore. We are going to have to help each other take care of patients in order to provide the best care possible.”

“I am passionate about our patient care being safe, high quality, and a great experience, but I’m also passionate about our caregivers,” says Dr. Briesacher. “They are so committed to taking care of their patients, but they also have to take care of themselves and those they love. Adding a partner to our practice can help improve patient care while also improving the lives of our caregivers.”

If you have any questions, please contact Kimberly Coudreaut at kimberly.coudreaut@imail.org.

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**Intermountain Medical Group’s Board Chair, Karyn Springer, MD, provides her insight on our governance restructure**
Our plans to restructure our Medical Group Board involve downsizing the Board to 13 members to facilitate decision-making, as well as creating new, expanded committees to encourage and diversify input among our physicians and APCs. These changes are in response to your request for more engagement in leadership and governance, and to align ourselves with how we care for patients and families.

To help you understand our new governance model, Mark Briesacher, MD, Chief Physician Executive & President of the Intermountain Medical Group interviewed Karyn Springer, MD, Family Medicine physician at North Orem Clinic and Chair of our Medical Group Board—to capture her take on these changes.

This recorded 14-minute discussion is available on Intermountain Podcasts.

In the podcast, Karyn talked about why this is the right time to do this work:

“The healthcare environment is very different from where [the Medical Group] first started back in 1994. Then—when I was just starting medical school—we had paper charts, private practices, and didn’t have the [electronic] medical record system or our alphabet soup of what exists today—MIPS, MACRA, ACO. Our Board was progressive then but we need to be progressive again in order to be successful. We were also recently listening to our physicians and APCs, who want greater involvement in how the Medical Group is run...and have a say. Our committee structure will allow a large group to give input and understand strategy. It’s where most of the work happens, [and those recommendations] get run through the Board. It also opens up a lot of opportunity for rising leaders to step into new roles and grow and develop.”

On aligning with our One Intermountain transition, Karyn said:

“These Medical Group changes align completely with that direction. We feel that a lot of the solutions will happen if we look at our workflows and how to best see patients. The frontline caregivers are the best to determine this.”

If you have any questions, please contact Ashley O’Brien at Ashley.OBrien@imail.org.

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Finding Joy in Medicine: Development of thoughtful physician leaders nurturing camaraderie and joy in work

A collegial work experience in medicine is becoming more and more difficult to create. Busy clinicians spend their days interacting with patients and seldom have opportunities to collaborate with colleagues. Interactions with patients, while essential and valuable, are brief and patient-centered. These exchanges might not always meet the needs we have as clinicians the same way bonds with our colleagues can.

A collegial work environment provides opportunities to share similar experiences, seek collaborative solutions to problems, and build trust among our peers. Being intentional about creating these kinds of work relationships can increase provider resiliency and decrease stress levels. Stephen Swensen, MD, Medical Director for Professionalism and Peer Support at Intermountain and Senior Fellow of the Institute for Healthcare Improvement sat down to chat with Mark Briesacher, MD, Senior VP & Chief Physician Executive and President, Intermountain Medical Group, about how leaders can help improve esprit de corps among providers.

Listen to Dr. Briesacher and Dr. Swensen talk about esprit de corps here.

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Click here to listen to the podcast.
“Esprit de corps begins with caring about each other first,” says Dr. Swensen. “Intermountain leaders must take care of our providers in order to maintain the high-quality healthcare our patients have come to expect.” So how do our leaders best do that? “The key ingredient of the secret sauce is leaders who care about their staff and look continuously to remove frustrations and inefficiencies in a patient-centered way. They care about their caregivers and take time to visit.”

“One of the things I like about Intermountain’s Continuous Improvement initiative is that it gives us an opportunity to understand what’s important to every frontline caregiver, where they find joy in their work, and what we might be able to do—or what they believe we can do—to make that work better,” says Dr. Briesacher. “And it seems like this fits right in with the idea of esprit de corps and building trust in each other.”

“Imagine if every point-of-care leader at Intermountain sat down with his or her colleagues and asked them what brings them joy in their work, or what saps that joy, or what makes for a good day,” says Steve. “Then, together—not for them or to them, but with them—we fix this. We figure out how to make our days more joyful or less frustrating, and we focus on providing the best patient care with the knowledge that we have the support of our leaders and teammates.”

The organizations that have the highest levels of social capital and trust among each other are safer and more efficient. They diffuse best practices and ideas faster, and they learn from adverse events faster than organizations that don’t have that trust or connectedness. Dr. Swensen says, “The more time we spend together to appreciate each other’s diversity and backgrounds, the better off we will be to provide the best for our patients.”

If you have any questions, please contact Kym Coudreaut at kimberly.coudreaut@imail.org.

What are the changes ahead for Family Medicine, and how can we stay competitive?

Changes and challenges in healthcare are being felt across specialties. Family medicine, for one, is facing new competitors in the market like urgent care, with providers vying for the same episodic care. Family medicine needs to balance that with managing a population of people and preventing chronic disease. Family medicine is also becoming internally competitive, seeing new sub-specializations and focused practices on certain segments of the population while generalists need to keep up with new requirements.

There’s a lot for family medicine clinicians to keep up with and keep together. Mark Briesacher, MD, Chief Physician Executive & President of the Intermountain Medical Group sat down with Karyn Springer, MD, Family Medicine physician at North Orem Clinic as well as Mark Milligan, Family Medicine physician at Layton Clinic—both leaders on our Medical Group Board and Committees—to discuss the state of and future of family medicine.

This recorded 23-minute discussion is available on Intermountain Podcasts. On how family medicine can respond to competition and incremental change, Mark Milligan said:
“Access is so important, [patients] seek care wherever they can find it. Access can improve the quality of care too because we're seeing patients when the care need happens. But we have to adapt to make ourselves available. At Layton we started allowing patients to schedule [appointments] online. Like buying movie tickets online and choosing a seat—patients are used to that and why can't they expect this in healthcare? Patients want good care and we want them to [access] good care.”

On how family medicine can balance the demands of keeping patients healthy and treating episodes of care, Karyn said:

“It's not just me managing them—it's absolutely a team. That's one of the biggest differences as medicine has evolved. It's not just a doctor or APC taking care of a patient, it's really a team that extends to my MA, to my care manager, my health advocate. I wouldn't be able to do it without all my support.”

Mark Milligan added:

“That's why it's not overwhelming. We're in an ocean of change...every step is daunting but we see the impact. When we see the next thing coming down the pike, we can get together as a big team, come up with how we can respond and be proactive, not stagnant, to continue to evolve and get better.”

Listen to the full podcast here.

If you have any questions, please contact Ashley O'Brien at Ashley.OBrien@imail.org.
Zero Harm – Where Are We?

Safety Metrics
We are seeing positive results of our high reliability safety culture with a consistent reduction in Serious Safety Events which are down 33% from our baseline assessment.

Patient Harm Index trend is down
The Patient Harm Index is an Intermountain developed composite of multiple measures that reflect harm to the patients (either temporary, permanent, or fatal) and that have active improvement activities. This data is calculated by a count of encounters (unique patient visits) with one or more events as a rate per 10,000 adjusted patient days.
Event reporting has increased 43% from 2014-2016. An increase in reporting is the direction we want, indicating increased safety awareness by caregivers and recognition that reporting events is key to finding and fixing problem causes before they result in a serious safety event. The chart on the right shows number of events actually reported. The chart below displays the types of events reported.

Zero Harm Website Updates

Safety Share Calendars: Southwest Region has developed a monthly safety calendar with a quick Zero Harm message for each day of the month. These can be used as Safety Stories at the beginning of meetings or huddles. This calendar is a great reminder and reference of Zero Harm Principles. These can be found on the ZH website under Documents and Job Aides.
**ShapeSafety Alerts and Safety Moments:** We have added a Safety Alerts and a Safety Moments tab to the Zero Harm website. The Safety Alert page houses all system Safety Alerts as well as instructions on how to submit one. The Safety Moment page will include a repository for system Safety Moments as well as include a link to the portal showing how to submit a Safety Moment.

**ShapeEmployee Injury Dashboard:** The Employee Injury Dashboard is now live. A link has been added on the ZH website homepage.

**Zero Harm Physician App Update**

With the launch of our new physician phone app, we have made it easy to access the Error Prevention techniques and other Zero Harm information.
Laboratory Services has established critical values thresholds for test results that may indicate a life-threatening situation, including thresholds for hematocrit (HCT) and hemoglobin (HGB). They have applied only the HCT thresholds to CBCs or other cases when HCT and HGB are reported together. Many physicians now look at HGB preferentially, and some have expressed concern about the lack of critical values notification when the HGB is critical but HCT is not. In response, Laboratory Services made a policy change.

As of November 15, 2017, critical value thresholds apply to both HCT and HGB, whether they are run individually or together.

**HGB and HCT Critical Values**

<table>
<thead>
<tr>
<th>Patient Age</th>
<th>HGB</th>
<th>HCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤7 days</td>
<td>≤12.0 g/dL or ≥22.0 g/dL</td>
<td>≤20.0% or ≥65.0%</td>
</tr>
<tr>
<td>All others</td>
<td>≤7.0 g/dL or ≥22.0 g/dL</td>
<td>≤35.0% or ≥65.0%</td>
</tr>
</tbody>
</table>

Please contact Sterling Bennett, MD, at sterling.bennett@imail2.org with questions or comments.
The Cardiovascular (CV) Clinical program continues to advance cardiovascular services throughout our system. We have excellent CV clinical and volumes reports which can be accessed on Intermountain.net under the reports portal. Open Internet Explorer and type CV into the address line. This will take you directly to the CV Clinical Program website. Click on reports on the left-hand navigation bar and then on the green Enterprise Report Center button in the middle of the page. Pick the Clinical Reports tab and then Cardiovascular. This will give you access to a wide variety of reports, most of which are updated on a daily basis.

Now that iCentra has been fully deployed, we are providing renewed attention on enhancing our CV power plans and care process models. All of you should have received some updates about clinical operation requirements based on patient safety and quality along with fulfilling regulatory requirements. In brief, future outpatient procedures such as ATM, stress tests, and Holter monitors need to be ordered by the clinician who will be responsible to review and act on the results. We also developed “smart” appropriate use ordering forms for echo, nuclear, pacemaker, and ICD’s that you will see as additional iCentra enhancements.

Please contact Colleen Roberts at Colleen.Roberts@imail.org with any questions.

Sepsis remains the most common inpatient diagnosis across all Intermountain hospitals. The early recognition and treatment of patients with sepsis has been a major healthcare strategy and a focus of the Intensive Medicine Clinical Program (IMCP) at Intermountain for over 12 years. Still, the prevalence and complexity of sepsis are likely to increase over the next several years due to multidrug resistant organisms, an aging population, and increases in chronic disease and immunosuppressive therapies. The IMCP is known worldwide for its important contributions to the science and processes of managing patients with sepsis, as described in their 2013 article in the American Journal of Respiratory and Critical Care Medicine. There, the IMCP set, for its hospitals with EDs and ICUs, a new ceiling for total sepsis bundle compliance at >73% (published rate) and a new floor for mortality in patients admitted from the ED to the ICU at <9%.

The IMCP remains committed to ensuring world class sepsis care to patients by embracing the CMS SEP-1 measure along with thoughtful consideration of the rapidly evolving science of sepsis. Large scale clinical trials have both changed the nature of the sepsis bundle and the very definition of sepsis. Our focus builds on more than a decade of caregiver engagement, resulting in unparalleled sepsis bundle compliance rates coupled with single digit mortality rates that persist to this day. Nonetheless, continued high performance has not been without its challenges. Over the last 2 years, sepsis care has been disrupted by the transition to iCentra and the CMS SEP-1 measure, both of which required important adjustments in clinical delivery, documentation, and reporting. However, Intermountain caregivers have responded to these perturbations with flexibility and a commitment to treating patients according to the best evidence available, as demonstrated by a sustained mortality rate of around 5% to date for patients diagnosed and coded with severe sepsis or septic shock using CMS SEP-1 sampling data. In a national comparison of APACHE IV hospitals, the observed to predicted ratio for hospital mortality at Intermountain Healthcare is 0.75 across the combined years of 2015-2017 (p < 0.01) when adjusted and controlled using APACHE IV severity scores. In spite of this success, the IMCP team recognizes that there is still room to improve and innovate to further identify and help our patients with this syndrome. As such, the IMCP is embarking on an aggressive plan that emphasizes 3 key strategies to establish a highly reliable system for sepsis care:

1. Improved accuracy of early sepsis identification, including both a clear identification of “time zero” and smart alerting of the clinical team to sepsis bundle milestones,
2. Integration of sepsis care delivery both across the continuum of care (i.e., pre-hospital through hospital environments and beyond) through development of a sepsis care iCentra workflow and across disciplines (i.e., collaborations aimed at improving coordination and care standards across care environments, including with CMS data abstractors),
3. Enhanced real-time and retrospective reporting through a standard dashboard to promote and support robust performance improvement and learning at the local level.

The opportunities to improve care for patients with complex medical conditions are greater than ever with a unified electronic platform and seamless transitions across episodes of care. The IMCP looks forward to improving its “best in class” reputation in the years ahead with sepsis care.

Please contact Marni Chandler at marni.chandler@imail.org with any questions.

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### Lung Cancer Screening

By the time the last firework pops on New Year’s Eve, nearly 250,000 new cases of lung cancer will have been diagnosed in 2017. Individuals with a history of smoking make up the largest number of these cases. And while lung cancer leads all other cancers in the number of deaths, when caught early and treated effectively survival rates significantly increase. Consistent with our commitment to improving the health of our communities, Intermountain has launched a lung cancer screening initiative to improve lung cancer survival rates by finding the disease at an earlier, more treatable stage.

### 7 Facts about the lung cancer screening program

- The program uses a common diagnostic tool — a low-dose technique CT scan — to look for tumors before symptoms begin. Once symptoms begin to appear, it means the cancer has already advanced to a stage that is more difficult to treat.

- Previously offered at limited Intermountain facilities, the lung cancer screening program is now offered across the system from Cassia to Dixie.

- Patients must meet specific criteria to be eligible for the screening program.

- Those who fit the criteria for testing will have a lung cancer screening CT scan at one of the participating hospitals.

  **Ordering the lung cancer screening CT scan requires a specific order from the provider. A CPOE and attestation has been developed in the iCentra program. Both must be completed to order the scan.**

- Once the CT is ordered, a nurse coordinator will work with the patient to confirm eligibility and schedule their screening appointment.

  If a scan comes back with positive, high risk findings, the case is presented to the thoracic tumor board for review and next step/treatment recommendations from expert surgeons, oncologist and pulmonologist. If the scan comes back with low probability of cancer, the provider may recommend annual screenings.

**Who is eligible for screenings?**

- Current or former smoker between the ages of 55 and 77.

- Patients who have smoked the equivalent of one pack of cigarettes a day for at least 30 years. This could be one pack a day for 30 years, or two packs a day for 15 years, etc.

- If a former smoker has quit within the last 15 years but meets the 30-packs per year requirement, they are still eligible for screening.
No signs and symptoms of lung cancer.
Able to tolerate treatment (surgery, radiation, or chemotherapy).
Has received counseling and shared decision-making discussion for lung cancer screening.

For questions and more information call 801-507-3900 and choose the lung cancer screening option.

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**PRIMARY CARE**

**Chronic Kidney Disease (CKD)**

Members of the Primary Care Clinical Program / Chronic Kidney Development Team presented at the National Kidney Society meeting regarding our success at improving chronic kidney disease quality outcomes. While resources for CKD care are often clustered around late stage CKD with poor medical care in early stages leading to increased costs of care and avoidable morbidity and mortality in late stage CKD, primary care teams have been able to engage with patients who have CKD early on to improve clinical outcomes.

Patients with early stage CKD may overburden already stretched nephrology resources. The CKD team, under the leadership of Dr. Paula Haberman, has utilized a structured partnership between primary care teams, payers, and nephrologists through care process model adoption, leveraging the electronic medical record, and utilization of a multidisciplinary approach to improve CKD care.

If you have any questions, please contact Sharon Hamilton at Sharon.hamilton@imail.org.

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**Immunization Update and ACIP Highlights**

The Advisory Committee on Immunization Practices (ACIP) of the CDC met on October 25 -26 to provide guidance on vaccines. Below are the key highlights:

Shingrix® (HZ/su subunit adjuvanted Zoster vaccine, 2 doses separated by 8 weeks) is preferred over Zostavax® for the prevention of shingles and PHN and is recommended for all immunocompenent persons age 50 years and older. Persons who have previously been vaccinated with Zostavax® should be vaccinated with 2 doses of Shingrix® at least 8 weeks after Zostavax®. Shingrix® for immunosuppressed persons will be considered in future meetings, but it is not contraindicated in the FDA's approval guidance.

A third dose of mumps containing vaccine can be provided to patients determined by public health to be at increased risk during mumps outbreaks.

Adult and pediatric immunization schedules were approved and will be published in February 2018.

No recommendations were made, but information was reviewed concerning recent outbreaks of Hepatitis A, a recent study linking influenza vaccine to spontaneous abortion, and safety concerns of shoulder injury after vaccination, resulting from administration too high on the arm.
Future: the committee viewed evidence from a trial comparing HEPLISAV-B adjuvanted Hepatitis B vaccine to Engerix-B®. HEPLISAV-B is administered as a 2 dose series over one month and performs with higher seroprotection rates than Engerix-B® and a similar safety profile.

Harmonization of the male and female HPV vaccine recommendations will be presented at a future meeting.

If you have any questions regarding immunization, feel free to contact Tamara Sheffield, MD, MPA, MPH, Medical Director, Community Health and Prevention, Intermountain Healthcare, at (801) 442-3946.

Revised Preventive Care Guideline for Adolescents

Intermountain’s Preventive Care Guideline for Adolescents 11-18 years has been revised and was approved by the Intermountain Medical Group, the Primary Care Clinical Program Guidance Council, and SelectHealth. Guidelines are available for both Utah and Idaho. The guidelines are revised and approved every two years. The Preventive Care Guidelines for Children age 0-10 years and Adults age 19 and older will be revised in 2018.

What is included in the guideline?

The Adolescent Preventive Care Guideline contains topic sections on Screening, Health Guidance, Immunizations, and recommendations for sexually-active adolescents and also contains links to tools to assist in the delivery of preventive services. The guideline is a synthesis of recommendations from the US Preventive Services Task Force, primary care and specialty societies, and other expert groups. Immunization guidelines follow recommendations of the CDC’s Advisory Committee on Immunization Practices (ACIP).

What is new in the guideline?

Changes to the Adolescent Preventive Care Guideline include: a new section on screening for cervical cancer (promoting waiting to screen until age 21 years), introduction of the CRAFFT screening tool for substance use, instructions about using Naloxone for opioid overdose, and safety recommendations.

Immunization recommendation changes include a two-dose Human Papilloma Virus (HPV) vaccine series, updated influenza vaccine recommendations, the addition of HIV as a high-risk indication for MCV4, and a two dose Meningococcal B recommendation for one product.

Where do I find the guideline?

The guideline is accessible within Topics in the Primary Care Clinical Program website either inside the firewall at intermountain.net, or to all providers (including those without login access) through intermountainphysician.org. The advantage to accessing through intermountain.net is better formatting of the website for navigation.

Preventive Care Guidelines within the firewall can be found by typing “Preventivecare” as one word in the upper left-hand URL box after logging in to Intermountain.net.

A less formatted version can be accessed externally at: www.intermountainphysician.org/preventivecare

For questions about the guideline, talk to Tamara Sheffield, MD, MPH, Medical Director, Community Health and Prevention at tamara.sheffield@imail.org or 801-442-3946

New guidelines lower the definition of high blood pressure, encourage earlier intervention and lifestyle changes
The American College of Cardiology (ACC) and the American Heart Association (AHA) have updated their guidelines for high blood pressure (HBP), lowering the definition of HBP to account for complications that can occur at lower numbers and to encourage earlier intervention. The new definition will result in nearly half of the US adult population (46 percent) having high blood pressure, with the greatest impact expected among younger people.

The Intermountain High Blood Pressure Development Team evaluated these guidelines, and endorsed adopting these standards for care of our HBP patients with a goal of <130/80 for the majority of patients. The team acknowledges it will take time to complete this transition and will begin work to update the care process model (CPM) to reflect these guidelines and transition data and reporting around these standards. Clinicians and care teams are encouraged to begin treating patients accordingly.

The highlights of the guidelines include:

Importance of using proper technique to take a blood pressure.

New definitions of high blood pressure:

- Normal: less than 120/80 mm Hg
- Elevated BP: Systolic between 120-129 and diastolic less than 80
- Stage 1 HBP: Systolic between 130-139 or diastolic 80-89
- Stage 2 HBP: Systolic at least 140 or diastolic at least 90 mm Hg

Emphasis on lifestyle: lifestyle change is the recommended first-line treatment for all instances where BP is not normal. It is the primary treatment for elevated BP.

Follow-up guidelines: patients being treated to goal with lifestyle should be reevaluated only every 3-6 months, whereas those on medication should be evaluated every 4 weeks until their BP is at goal.

Special populations: the majority of patients with comorbidities now have a goal of 130/80:

- atherosclerotic cardiovascular disease (ASCVD)
- chronic kidney disease (CKD)
- renal transplant
- congestive heart failure (CHF)
- peripheral arterial disease
- diabetes
- individuals over age 65 who are reasonably healthy and noninstitutionalized
- clinical CVD or 10-year ASCVD risk at least 10%

Utilization of ambulatory and home BP monitoring: now recommended to confirm the diagnosis of HBP, make adjustments of BP-lowering medication, and decrease the “white-coat effect” (elevated BP phenomenon experienced in clinical settings).

Utilization of team-based care, data registries, and telemedicine.

Questions about the new guidelines? Email Mark R. Greenwood, MD, Primary Care Clinical Program Medical Director, at MarkR.Greenwood@imail.org.
In 2009, as part of an ongoing eort to improve healthcare by transforming how primary care is organized and delivered, Dr. Linda Leckman asked Dr. Mark Briesacher to evaluate different Patient-Centered Medical Home models. After research and evaluation, the Medical Group determined that the National Committee for Quality Assurance’s (NCQA) model best aligned with Intermountain’s Mission, Vision, and Values. In 2010 we began our medical home journey in two clinics and then quickly rolled out the NCQA medical home model—referring to them as Intermountain’s “Personalized Primary Care” clinics—across the Medical Group.

As of December 2017, the NCQA has awarded all 83 Intermountain Medical Group primary care clinics its Patient-Centered Medical Home (PCMH) recognition. To earn recognition, which is valid for three years, each clinic demonstrated the ability to meet six key elements of care delivery:

1. **Patient-centered access:** Provides patients convenient, same-day access to appointments and clinical advice and helps ensure continuity of care.
2. **Team-based care:** Gives structure to a practice’s leadership team, defines care team responsibilities, and partners with patients, families, and caregivers.
3. **Population health management:** Proactively identifies populations of patients and reminds them of needed care based on patient information, clinical data, health assessments, and evidence-based guidelines.
4. **Care management:** Helps clinicians set up care management protocols and resources to identify and work with patients who need to be more closely managed and supported.
5. **Care coordination and care transitions:** Ensures that primary and specialty care clinicians are effectively sharing information, tracking patient referrals, and proactively managing transitions to minimize cost, confusion, and inappropriate care.
6. **Performance measurement and quality:** Develops ways to measure performance, set goals, and create activities that will enhance clinical quality, patient and family experience, and utilization.

About NCQA
NCQA is a private, non-profit organization dedicated to improving healthcare quality. NCQA accredits and recognizes a wide range of healthcare organizations, practices and clinicians. NCQA’s Healthcare Effectiveness Data and Information Set (HEDIS®) is the most widely used performance measurement tool in healthcare. NCQA’s website (ncqa.org) contains information to help consumers, employers, and others make more informed healthcare choices.
These PCMH standards were established by the NCQA in coordination with the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association.

Tim Johnson, MD, Senior Medical Director for the Medical Group states, “I am grateful for the leadership and hard work of Shauri Kagie, our Medical Group NCQA expert, and the regional and clinic care management teams. Their efforts have allowed us to successfully achieve NCQA recognition. I am also grateful for the foundational work put in by Mark Briesacher, MD, Susan Brown, Michele Lower, and many others. They put us in a position to provide safer care, realize better clinical outcomes, improve patient and caregiver experiences, and lower the cost of healthcare.”

“This great news comes from amazing teamwork. Thanks to our teams for their diligence, focus, and commitment to our patients and families,” says Mark Briesacher, MD, Chief Physician Executive & President of the Medical Group.

“Patient-Centered Medical Home recognition raises the bar in defining high-quality care by emphasizing access, health information technology, and coordinated care focused on patients,” says NCQA President Margaret E. O'Kane. “Recognition shows that Intermountain Medical Group has the tools, systems, and resources to provide its patients with the right care, at the right time.”

For more information and to find clinics with NCQA PCMH recognition, visit recognition.ncqa.org.

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New Preauthorization Requirements for Selected Surgical Procedures

Effective January 1, 2018, SelectHealth will require preauthorization for the following surgical procedures: Spine fusions (lumbar and cervical); joint replacements (hip and knee); tonsillectomy; adenoidectomy; and hysterectomy. These are in addition to procedures currently requiring preauthorization.

Payment for the procedures noted above, as well as the services that already require preauthorization, will be made only if they meet the clinical criteria established in collaboration between SelectHealth and Intermountain Healthcare’s Clinical Programs. **Claims for services that are not preauthorized will be denied.** Denials will apply to professional and facility claims. Providers are responsible for obtaining preauthorization; and **members cannot be billed** if the participating provider fails to obtain the required preauthorization or for procedures that do not meet clinical criteria.
Where are the preauthorization criteria for these procedures published?
Preauthorization criteria are available in the medical policy for each procedure. Medical policies are available on selecthealthphysician.org. Click on “Policies & Procedures,” then log in with your secure username and password. Enter the procedure name in the “Search” field and open the associated medical policy.

Does the preauthorization requirement apply to emergency surgeries?
Preauthorization is not required prior to emergency surgery. Documentation will be required to validate the emergent nature of the procedure. For members seen in the office and referred straight for emergency surgery, surgical admission through the Emergency Department (ED), or emergencies developing in the Operating Room (OR), please submit the completed Request for Preauthorization Form within three days of the procedure in one of the following methods:

- Email: shfaxben@imail.org
- Commercial/FEHB Fax: 801-442-0825
- SelectHealth Community Care (Medicaid)/CHIP Fax: 801-442-0625
- SelectHealth Advantage (Medicare Advantage) Fax: 801-442-0302
- CareAffiliate®

Authorization will only be approved if the clinical documentation meets the established criteria, but no penalty will be applied for lack of preauthorization prior to the procedure if medical records clearly demonstrate the emergent nature of the surgery.

Adhering to consistent criteria decreases potential variation in when and how services are provided, leading to more predictable outcomes. Additionally, substantiating the decision-making necessary to submit a preauthorization request ensures documentation is completed appropriately. Preauthorization helps us realize our vision of providing extraordinary care and superior service.

If you have any questions, please contact your Network Engagement representative (formerly known as Provider Relations representative), or email provider.development@selecthealth.org.

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SelectHealth Policies Update, December 2017

New Policies
To download a .pdf of the following policies, click on the policy name.

Colonic Manometry
Policy number 619, Effective 10/2/2017
Commercial Plan: SelectHealth does NOT cover colonic manometry (colonic motility studies) as this testing is considered investigational/experimental since clinical utility has not been established.

Varicocele Repair
Policy number 612, Effective 10/3/2017
Commercial Plan: Coverage Criteria for Surgery: (Any ONE must be met)

1. Adolescents with grade 2 or 3 varicoceles associated with ipsilateral testicular growth retardation (covered under the medical benefit)
2. Scrotal pain associated with varicoceles (covered under medical benefit)
3. Males with infertility problems who have decreased sperm motility and lower sperm concentrations (covered under fertility benefit)
SelectHealth covers percutaneous embolization (by means of balloon or metallic coil) as medically necessary for the treatment of varicocele when BOTH the following criteria are met:

1. Has one of the afore mentioned criteria for surgery
2. Post-surgical (ligation) recurrence of varicoceles

SelectHealth does NOT cover surgical treatment (ligation, embolization) for subclinical varicocele as it is considered experimental and investigational because of insufficient evidence to support its effectiveness.

SelectHealth does NOT cover endoluminal occlusion devices (e.g., the ArtVentive endoluminal occlusion system) as it is considered experimental and investigational for the treatment of varicoceles because their effectiveness has not been established.

**Total Knee Arthroplasty**

Policy number 598, Effective 1/1/2018

Commercial Plan: SelectHealth covers total knee arthroplasty as medically necessary when the following criteria are met:

Must meet criteria 1 or 2.

1. Advanced joint disease demonstrated by all of the following:
   a. Radiographic supported evidence or when conventional radiography is not adequate, magnetic resonance imaging (MRI) and/or computed tomography (CT) (in situations when MRI is non-diagnostic or not able to be performed) supported evidence (subchondral cysts, subchondral sclerosis, periarticular osteophytes, joint subluxation, joint space narrowing, avascular necrosis); and
   b. Pain or functional disability from injury due to trauma or arthritis of the joint; and
   c. Unsuccessful conservative therapy (non-surgical medical management) lasting at least 12 weeks that is clearly addressed in the pre-procedure medical record. Includes one or more of the following:
      i. Anti-inflammatory medications or analgesics, or
      ii. Flexibility and muscle strengthening exercises, or
      iii. Supervised physical therapy [Activities of daily living (ADLs) diminished despite completing a plan of care], or
      iv. Assistive device use, or
      v. Weight reduction as appropriate, or
      vi. Therapeutic injections into the knee as appropriate.
   d. If conservative therapy is not appropriate, the medical record must clearly document why such approach is not reasonable
   e. BMI is less than 45
   f. HgbA1c is less than 8
   g. Tobacco free for at least four weeks prior to knee arthroplasty.

2. The patient has severe deformity, pain or significant disability with interference in activities of daily living, and the surgeon determines that nonsurgical medical management would be ineffective or counterproductive due to:
   a. Failure of a previous osteotomy; or
   b. Distal femur fracture; or
   c. Malignancy of the distal femur, proximal tibia, knee joint or adjacent soft tissues; or
   d. Failure of previous unicompartmental knee replacement; or
   e. Avascular necrosis of the knee; or
   f. Proximal tibia fracture

SelectHealth will NOT cover total knee arthroplasty if any of the following contraindications or relative contraindications are present:

a. Active infection of the knee joint or active systemic bacteremia
b. Active urinary tract or dental infection
c. Active skin infection (exception recurrent cutaneous staph infections) or open wound within the planned surgical site of the knee
d. Rapidly progressive neurological disease
e. Insufficiency of extensor mechanism/quadriceps
f. Any process that is rapidly destroying bone
g. Neurotrophic arthritis

SelectHealth does NOT cover robotic-assisted total knee arthroplasty such as makoplasty or RIOS as there is a lack of evidence to demonstrate clinical meaningful differences in outcomes for patients undergoing TKA using these technologies. Use of these technologies is considered investigational.

SelectHealth will NOT reimburse additionally for custom knee components (see medical policy #511) as current evidence has not demonstrate clinically meaningful difference in outcomes for patients undergoing TKA compared to use of standard components. If the procedure otherwise meets criteria for TKA, the procedure will be covered but the components will only be reimbursed at the standard component reimbursement level.

**Total Hip Arthroplasty**

Policy number 599, Effective 1/1/2018

Commercial Plan: SelectHealth covers total hip arthroplasty as medically necessary when the following criteria are met:

Must meet criteria 1 or 2.

1. Advanced joint disease demonstrated by all of the following:
   a. Radiographic supported evidence or when conventional radiography is not adequate, magnetic resonance imaging (MRI) and/or computed tomography (CT) (in situations when MRI is nondiagnostic or not able to be performed) supported evidence (subchondral cysts, subchondral sclerosis, periarticular osteophytes, joint subluxation, severe joint space narrowing, avascular necrosis); and
   b. Pain or functional disability from injury due to trauma or arthritis of the joint; and
   c. Unsuccessful conservative therapy (nonsurgical medical management) lasting at least 12 weeks that is clearly addressed in the pre procedure medical record. Includes one or more of the following:
      i. Antiinflammatory medications or analgesics, or
      ii. Flexibility and muscle strengthening exercises, or
      iii. Supervised physical therapy [Activities of daily living (ADLs) diminished despite completing a plan of care], or
      iv. Assistive device use, or
      v. Weight reduction as appropriate, or
      vi. Therapeutic injections into the hip as appropriate
   d. If conservative therapy is not appropriate, the medical record must clearly document the rationale for why such approach is not reasonable.
   e. BMI is less than 45
   f. HgbA1c is less than 8
   g. Tobacco free for at least four weeks prior to hip arthroplasty.

2. The patient has severe deformity, pain or significant disability with interference in activities of daily living, and the surgeon determines that nonsurgical medical management would be ineffective or counterproductive due to:
   a. Malignancy of the joint involving the bones or soft tissues of the pelvis or proximal femur; or
   b. Avascular necrosis (osteonecrosis of femoral head); or
   c. Fracture of the femoral neck; or
   d. Acetabular fracture; or
   e. e. Nonunion or failure of previous hip fracture surgery; or
   f. f. Malunion of acetabular or proximal femur fracture

SelectHealth will NOT cover total knee arthroplasty if any of the following contraindications or relative contraindications are present:

a. Active infection of the hip joint or active systemic bacteremia
b. Active urinary tract or dental infection
   c. Active skin infection (exception recurrent cutaneous staph infections) or open wound within the planned surgical site of the hip.
   d. Rapidly progressive neurological disease except in the clinical situation of a concomitant displaced femoral neck fracture
   e. Absence or relative insufficiency of abductor musculature
f. Any process that is rapidly destroying bone

g. Neurotrophic arthritis

SelectHealth does NOT cover total hip arthroplasty for any other indication as it is considered experimental/investigational.

SelectHealth does NOT cover robotic-assisted total hip arthroplasty such as makoplasty or RIOS as there is a lack of evidence to demonstrate clinical meaningful differences in outcomes for patients undergoing THA using these technologies. Use of these technologies is considered investigational.

**Revised Policies**

**Alcohol Ablation Septal Reduction (Transcoronary Ablation of Septal Hypertrophy and Percutaneous, Transluminal Septal Myocardial Ablation)**

Policy number 101, Effective 10/19/2017

Commercial Plan: We added Class II under the New York Heart Association (NYHA) classification to criterion #1.

**Heart Transplant: Adult**

Policy number 125, Effective 10/12/2017

Commercial Plan: Morbid obesity and Advanced Hepatic Disease have been separated to create distinct criteria.

**Laser Treatment of Congenital Hemangiomas (Port Wine Stain)**

Policy number 168, Effective 10/2/2017

Commercial Plan: We added another area considered of functional importance by the plan “#3 Any port wine stain area to resolve a functional problem associated with pain, discomfort or bleeding.”

**Private Duty Nursing**

Policy number 169, Effective 10/19/2017

Commercial Plan: Under the Exceptions to the limitations, after acute hospitalization, we added “or temporary extensions to cover a short term gap”.

**Genetic Testing: Inheritable Colon Cancer**

Policy number 222, Effective 9/25/2017

Commercial Plan: Gardner Syndrome was added under the high risk syndromes.

**Computerized Microprocessor-Controlled Knee Prostheses (Ottobock-C Leg, Endolite Adaptive Prosthesis, Ossur Prosthesis)**

Policy number 233, Effective 8/21/2017

Commercial Plan: We started covering microprocessor-controlled knee prostheses when the following criteria are met:

Criteria for Coverage of Microprocessor Knee Prosthetics: (Must Meet ALL)

1. Patient has one of the following: (must have 1 of 2)
   a. Demonstrated need for long distance ambulation at variable rates (use of the limb in the home or for basic community ambulation is not sufficient to justify provision of the computerized limb over standard limb applications).
   b. Demonstrated patient need for regular ambulation on uneven terrain or for regular use on stairs (use of the limb for limited stair climbing in the home or employment environment is not sufficient evidence for prescription of this device over standard prosthetic application).

2. Patient has documented physical ability, including adequate cardiovascular and pulmonary reserve, for ambulation at faster than normal walking speed.

3. Patient has documented adequate cognitive ability to master use and care requirements for the technology.

**Transcranial Magnetic Stimulation for Depression and Other Psychiatric Disorders**
Policy number 241, Effective 11/2/2017

Commercial Plan: TMS is now covered if the following criteria are met:

SelectHealth covers unilateral repetitive transcranial magnetic stimulation in patients with treatment resistant depression when specific criteria are met.

Criteria for Coverage (Must Meet ALL):

1. Patient age >18 year of age;
2. Diagnosis of major depression by a licensed mental health professional, (psychiatrist or Psychiatric Advanced Practice Registered Nurse) that meets the DSM-5 definition of major depressive disorder
3. Failure of Medication therapy defined by one of the following:
   a. Documented failure of at least 4 psychopharmacologic trials of adequate dose and duration (> 4 weeks) from two different agent classes in the current episode
   b. Written documentation of an inability to tolerate psychopharmacologic agents as evidenced by four or more lifetime trials of agents with distinct side effects
   c. Documented positive response (with appropriate standard rating scales and dates of service) to a previous TMS treatment

Is either not a candidate for electroconvulsive therapy (ECT), is intolerant to ECT, or has failed to adequately respond to a previous course of ECT completed in the previous 6 months.

SelectHealth does NOT cover unilateral repetitive transcranial magnetic stimulation for any other behavioral health indication as it is considered investigational.

SelectHealth does NOT cover bilateral repetitive transcranial magnetic stimulation for any behavioral health condition as it is unproven.

Radiofrequency Ablation (RFA) For Back or Neck Pain (Radiofrequency Neurolysis, Facet Joint Rhizotomy)

Policy number 265, Effective 9/26/2017

Commercial Plan: More up to date guidelines through the American College of Physicians/American Pain Society were added to the policy rather than using the Agency for Health Care Policy and Research (AHCPR).

Condition number 1 now states:

Patient has experienced moderate to severe lower back (lumbosacral) OR neck (cervical) pain limiting activities of daily living for at least 3 months in the current episode, unrelieved by more conservative medical management strategies recommended by the American College of Physicians/American Pain Society.

Bariatric Surgery Guidelines

Policy number 295, Effective 9/15/2017

Commercial Plan: SelectHealth now covers Biliopancreatic bypass with or without duodenal switch for those members that have a bariatric rider and meet criteria. Please see the policy for the list of criteria.

Gender Reassignment Surgery

Policy number 386, Effective 10/10/2017

Commercial Plan: For a better understanding we combined and reworded criteria 5 and 6 to state:

The patient has completed a minimum of 12 months of successful continuous full time real-life experience with no returning to their original gender. Examples which would demonstrate this criterion could include maintaining part- or full-time employment as the individual's self-identified gender, functioning as a student in an academic setting, functioning in a community-based volunteer activity, or seeking and obtaining legal gender change from the courts.

Oral appliances for sleep apnea

Policy number 492, Effective 10/5/2017
Commercial Plan: For clarification we specified whom the polysomnography test could be performed by in criterion number 1. “An American Board of Sleep Medicine (ABSM) board certified sleep specialist.”

**Urine Drug Testing In The Outpatient Setting**

Policy number 569, Effective 9/18/2017

Commercial Plan: We specified that the laboratory performing the services must be CAP (College of American Pathologists) and CLIA certified.

**Corneal Crosslinking for the Treatment of Keratoconus**

Policy number 580, Effective 11/10/2017

Commercial Plan: SelectHealth now covers epithelium-off corneal-crosslinking once per lifetime, per eye if the following criteria are met:

1. Patient has a diagnosis of keratoconus or corneal ectasia.
2. The medicine used is Photrex Visous/Photrex with the KXL device
3. The procedure is performed by a fellowship trained corneal provider

SelectHealth does NOT cover corneal crosslinking in conjunction with intrastromal ring segment placement as it is considered investigational.

**Archived**

None