



## CONTENTS

ICD-10 Goes Live October 1, 2015 .....	1
2015 Medical Code Changes .....	2
ACA Plan Premium Grace Periods .....	2
New Preauthorization Form Available .....	3
SelectHealth Care Management and Disease Management Services.....	3
Breast and Colon Cancer Screening Programs .....	4
Coding and Coverage for Obesity Diagnoses.....	5
Accurate Documentation for Behavioral Health Diagnoses .....	5
SELECTHEALTH ADVANTAGE® .....	6
SelectHealth Advantage Achieves 4.5 Star Rating.....	6
Want to Know More About Star Ratings? .....	6
Documenting and Coding Chronic Conditions .....	6
CMS Enrollment Requirement for Medical and Dental Providers to Prescribe to Medicare Members.....	7
SELECTHEALTH FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) .....	8
FEHB ID Card Identifiers.....	8
FEHB PlanSmartChoice Plus Plan Award Recipient .....	9
FEHB Tier 4 Pharmacy Benefits .....	9
MEDICAL POLICY AND NEW TECHNOLOGY ASSESSMENT .....	10
Medical Policy Update Bulletin .....	10
Medical Policy Updates, Continued .....	11
Technology Assessment (M-Tech) News.....	12

simply click on the article title in the Contents bar. Please encourage each provider and member of your staff to review the newsletter for important information that affects your patients with SelectHealth insurance plans.

### ICD-10 Goes Live October 1, 2015

Every provider is required to bill ICD-10 codes for all claims with dates of service beginning October 1, 2015. This transition aligns the U.S. with health data reporting in most countries throughout the world. ICD-10 codes offer greater specificity for reporting diagnoses.

You will notice quite a few “many to one” ratios (especially in the orthopedics section). As an example, ICD-9 has four possible codes for a strained or sprained ankle, ICD-10 has 72 codes. This may seem intimidating, but the key to correct coding remains the same—provider documentation. It is essential for providers to add as much specificity as possible in documentation to ensure greater accuracy in coding. SelectHealth® will follow CMS guidance lead as to whether dual coding will be accepted. All claims with a date of service of October 1, 2015, and thereafter **must** be billed with ICD-10 codes. Any claims billed with ICD-9 codes will be denied.

To avoid interruption in billing and payment of claims, providers should start preparing now. System configuration and testing will be vital to a smooth transition. SelectHealth has been diligent in our efforts to make certain our systems are ready.

Welcome to the inaugural edition of Provider Insight newsletter for physicians, other healthcare professionals, and their staff who participate with SelectHealth in Idaho.

This newsletter includes information and updates that pertain to our commercial medical, SelectHealth Advantage (Medicare), and Federal Employee Health Benefits plans. For ease in navigating to the articles that apply to you,

### Did You Know?

- There are two different types of ICD-10 codes
  - > ICD-10-CM (Clinical Management)
  - > ICD-10-PCS (Hospital Procedure Codes)
- ICD-9 has 17,849 codes (CM= 14,025 & PCS= 3,824) compared to ICD-10 having 141,747 codes (CM= 69,823 & PCS= 71,924).
- ICD-10-CM codes consist of a three- to seven-character alphanumeric structure. The first character is always alpha (e.g., S12.030A). The letter "U" is not used.
- ICD-10-PCS codes are each seven characters in length and also have an alphanumeric structure (e.g., 3E033GO). The letters "I" and "O" are not used.

## 2015 Medical Code Changes

There are many CPT changes to be aware of in 2015. This includes changes to guidelines and modifiers. There are 264 new, 134 revised, and 143 deleted CPT codes. These changes took effect January 1. There is no grace period for using new codes and discontinuing the use of deleted codes.

Please make note of the following changes from SelectHealth:

- Commercial plans consider CPT **99140** (*anesthesia complicated by emergency conditions*) as a bundled (or Status B) code and will not reimburse it separately. Our other lines of business already consider this to be a bundled code.
- Commercial plans will reimburse separately for CPT 99050 and 99051 (*after hours services*).
- There are three new arthrocentesis, aspiration and/or injection codes that include Ultrasound Guidance: CPT **20604**, **20606**, and **20611**. With

the change in codes, ultrasound guidance will not be paid separately for these services (even on appeal). This policy applies for all lines of business.

Updates to medical codes may occur at any time, and may not be reflected in the most current coding manuals. Refer to the [AMA](#) and [CMS](#) websites for the most up-to-date information and corrections.

## ACA Plan Premium Grace Periods

Members who purchased health plans through the Federally-Facilitated Marketplace (FFM) and are enrolled with an Advance Premium Tax Credit have a 90-day grace period to pay delinquent premiums before coverage is terminated. This is mandated by the Affordable Care Act (ACA) and applies to every payer.

To comply with the ACA and to inform providers of members in a grace period, we are taking the following steps:

- **Claims Processing**
  - > First month of grace period - We will process claims for services received during the first month of the grace period and notify the rendering provider by mail that the member is in a grace period.
  - > Second and third months of grace period - We will pend claims for services received during the second and third months of the grace period until the premium is received. We will notify providers by mail of the pended status.
  - > At the end of the third month of premium nonpayment - The member's coverage will be terminated back to the end of the first month of the grace period. Any claims pended during the second or third month will be denied as ineligible, and the provider will be notified by mail. The member will be responsible for payment of claims for any services received during the second and third months of the grace period.

[Back to Table of Contents](#)

- **Member Services** – Representatives will alert providers calling in for eligibility status or benefits that a member is in a grace period for premium delinquency. Representatives can also update providers calling in about the status of a pended claim.
- **Care Management** – Representatives will alert providers calling in to preauthorize services that the member is in a premium grace period. When a provider faxes a preauthorization request, we will mail a letter (separate from the preauthorization outcome letter) to notify the service provider of the grace period status.
- **Electronic Transactions**
  - > Providers who submit a 270 Eligibility Benefit Inquiry through EDI will receive a 271 response with the following message: “Member is in a premium payment grace period.”
  - > Providers who submit a 276 Claim Status Request through EDI will receive a 277 pended claim response on claims pended during the premium grace period. The message will be: “766 – Services were performed during a Health Insurance Exchange (HIX) premium payment grace period.”
- **Provider Website** – The member’s file will be flagged on the “Patient Inquiry” screen in our secure “Provider Benefit Tools” with an asterisk next to his or her name, and the following message will be displayed: “There is currently a lapse in premium payment for this policy. To view more details regarding the patient’s eligibility, click the patient link above.”

If you have any questions about the premium payment grace period, please contact your Provider Relations representative or call **800-538-5054**.

### New Preauthorization Form Available

An updated preauthorization form is available on [selecthealthphysician.org](http://selecthealthphysician.org). Effective December 1, 2014, we no longer accept the previous version.

The form is required with each preauthorization request. Click on Provider Reference Manual, then on Preauthorization. Click on the appropriate links to download a Preauthorization Form or a list of procedures that require preauthorization. For questions about services requiring preauthorization or about a current request, contact Member Services at **800-538-5038**.

### SelectHealth Care Management and Disease Management Services

Whether it’s a new diagnosis or a major injury, specially trained care managers can help members navigate the healthcare system. Care managers act as a liaison between the member and providers to make sure immediate and ongoing needs are met and that the best possible care is received.

To help members take control of their chronic condition(s), our disease management team provides educational materials, access to online resources, newsletters, follow-up phone calls, and the expert support of a care manager.

Care management is available for these conditions and more:

- Depression
- Cancer
- High-risk pregnancy
- Hypertension
- Migraines
- Cancer
- Catastrophic health event

Our disease management quality programs focus on intervention and management of existing chronic health conditions such as asthma, COPD, diabetes, heart failure, and hepatitis C, among others. Disease management programs are designed to mitigate the effects of chronic conditions on the member and the community.

[Back to Table of Contents](#)

To learn more about our care management services, [view the Care Management chapter](#) of the Provider Reference Manual. To refer a member for care management, call **800-442-5305**.

## Breast and Colon Cancer Screening Programs

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed healthcare plans.

### Breast Cancer Screening

Breast cancer is one of the most common types of cancers, accounting for a quarter of all new cancer diagnoses for women in the U.S. It ranks as the second leading cause of cancer-related mortality in women and is estimated to cause almost 40,000 deaths in 2014.

The U.S. Preventive Services Task Force (USPSTF) cites evidence indicating that a large proportion of the benefit for a screening mammogram is maintained by biennial screening, reducing the harms of mammography screening by nearly half and lessening the costs of a yearly mammogram.

We collect data based on HEDIS specifications, and to support the American Cancer Society's recommendation for yearly mammograms beginning at age 40.

This measure calculates the percentage of women aged 50 to 74 who had a mammogram to screen for breast cancer in the last 27 months (two years plus a three-month grace period). The age parameter during this reporting period was changed to reflect the stance of the USPSTF. The previous reporting period's age parameters were 40 to 69 years of age. Because of this change, we do not have benchmark data for the new age

parameters, but historically our rates are considerably below national benchmark rates.

We'll send mammography reminder brochures to female members ages 40 to 74 who are due for their mammogram during the quarter of the members birth month; including a list of mammography centers.

We'll also contact female members ages 40 to 74 who are due for a mammogram (via an educational interactive voice response phone call), offering assistance scheduling an appointment. The call also gives members the option of having a SelectHealth representative call them back to schedule a mammogram appointment over the phone.

### Colorectal Cancer Screening

Excluding skin cancers, colorectal cancer is the third most common cancer diagnosed in men and women in the United States. The American Cancer Society estimate the number of colorectal cancer cases in the United States for 2014 as follows:

- 96,830 new cases of colon cancer
- 40,000 new cases of rectal cancer

Overall, the lifetime risk of developing colorectal cancer is about 1 in 20 (5 percent). This risk is slightly lower in women than in men. A number of other factors can also affect a person's risk for developing colorectal cancer.

Colorectal cancer is the third leading cause of cancer-related deaths in the United States when men and women are considered separately, and the second leading cause when both sexes are combined. It is expected to cause about 50,310 deaths during 2014.<sup>4</sup>

The colorectal cancer screening measure calculates the percentage of adults ages 51 to 75 who have had appropriate screening for colorectal cancer. The screening criteria can be met with any one of four tests: a Fecal Occult

[Back to Table of Contents](#)

Blood Test (FOBT) during the measurement year, a flexible sigmoidoscopy within the last five years, or a colonoscopy within the last ten years.

If you would like more information on breast or colorectal cancer screening results, or if you are interested in learning more about other SelectHealth Quality Improvement programs, call **800-374-4949**, or email the [Quality Improvement Program](#).

References:

1. ["U.S. Breast Cancer Statistics." \*Breastcancer.org\*. 20 Sept. 2014. Web. 15 Oct. 2014.](#)
2. ["Cancer Facts & Figures 2011." \*Cancer.org\*. 2010. Web. 15 Oct. 2014.](#)
3. ["Screening for Breast Cancer: An Update for the U.S. Preventive Services Task Force." \*Screening for Breast Cancer: An Update for the U.S. Preventive Services Task Force\*. 17 Nov. 2009. Web. 15 Oct. 2014.](#)
4. ["What Are the Key Statistics about Colorectal Cancer?" \*What Are the Key Statistics about Colorectal Cancer?\* Web. 15 Oct. 2014.](#)

## Coding and Coverage for Obesity Diagnoses

Obesity and morbid obesity are common conditions seen in provider offices, but they are often not billed due to fear of nonpayment. It is recommended providers add obesity or morbid obesity as a diagnosis on a claim when appropriate. Adding these codes to other relevant codes will not affect payment when the services provided are covered services. Documentation should include a current BMI measurement and notation that the condition was monitored and addressed during the office visit. Documentation that confirms the condition was monitored and addressed include notation of the patient's current condition, diet plan, exercise plan, and/or referral to dietitian. Medical nutritional therapy visits may be limited according to the member's plan. Relevant ICD-9 codes include **278.00**, *obesity, unspecified* (BMI 30.0 – 39.9) and **278.01**, *morbid obesity*, (BMI 40.0 or greater).

## Accurate Documentation for Behavioral Health Diagnoses

Medical records provide behavioral health professionals with the information necessary to accurately diagnose and treat members. Accurate documentation facilitates coordination of care and appropriate reimbursement.

The behavioral health record should be a stand-alone document that fully reflects the level of care provided, including these elements at a minimum:

- Licensed healthcare provider's name and NPI
- Place of service
- Date of service
- Member's name and date of birth
- Member's current status
- Changes from previous visits
- The amount of time actually spent with the member
- The intensity of the evaluation and/or treatment, including thought processes and the complexity of medical decision making
- Treatment plan
- Medication list
- Telephone or verbal conversations concerning a patient's clinical care or medical advice, including date and time of the conversation
- Telephone orders should be authenticated (e.g., signature or initial) by the ordering clinician
- Any other information pertinent to the care the member received
- Documentation should be as complete as possible to support services billed

Some behavioral health services require preauthorization, including neuropsychiatric testing. Review a [list of services requiring preauthorization](#) or download a [Request for Medical Preauthorization form](#).

[Back to Table of Contents](#)

Some behavioral health benefits may or may not be covered, according to the member's plan. Medical nutritional therapy visits may be limited according to the member's plan. Call Member Services at **800-876-1989** prior to rendering services to ensure the member's coverage.

## SELECTHEALTH ADVANTAGE

### SelectHealth Advantage Achieves 4.5 Star Rating

Based on data gathered during the 2013 service period, SelectHealth Advantage earned an overall Star rating of 4.5 from the Centers for Medicare & Medicaid Services (CMS). This is a remarkable achievement for a new Medicare Advantage plan.

No other Medicare Advantage plans in Utah or Idaho received a higher rating.

#### What is a Star Rating?

Each year, CMS measures the quality and value of Medicare Part C- and Part D-certified health plans and assigns a Star rating similar to online shopping or travel sites. The scale ranges from one to five stars, with five stars representing the highest quality. Scores are based on more than 50 care and service quality measures across several categories. Some examples of the categories include:

- **Staying healthy** – How well the plan covers and helps its members receive recommended health screenings, vaccinations, and other check-ups and programs that encourage wellness and help members stay healthy.
- **Managing chronic conditions** – How often members with different chronic conditions receive certain tests and treatments that help them manage their condition.
- **Member experience** – How current members rate their satisfaction with plan benefits (e.g., coverage and copays) and customer service.

- **Member complaints and plan performance** – How often Medicare found problems with the plan and how often members had problems with the plan, including how well the plan handles member appeals and new enrollment requests.

#### Why Are Star Ratings Important?

Medicare uses information from member satisfaction, plan, and provider surveys to determine overall performance Star ratings. It also uses reviews of claims and other information that plans submit to Medicare, as well as results from Medicare's regular monitoring and auditing activities.

Medicare incentivizes plans to qualify for four and five Star ratings with a revenue bonus that the plan must reinvest in its programs in the form of better benefits and lower premiums and copayments for its members. Members and providers can review the Star ratings of certified plans in each service area at [medicare.gov](http://medicare.gov).

#### Want to Know More About Star Ratings?

Visit [selecthealthadvantage.org](http://selecthealthadvantage.org) to learn more about why SelectHealth Advantage has been recognized by CMS for quality and performance. You can also visit [cms.gov](http://cms.gov) or call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **877-486-2048**.

Plan performance summary Star ratings are assessed each year and may change from one year to the next.

Reference:

["Star Ratings" Medicare.gov. Web. 15 Oct 2014](#)

## Documenting and Coding Chronic Conditions

### SelectHealth Advantage Comprehensive Evaluation (Annual Wellness Visit + Preventive Exam)

For coverage of a Medicare Comprehensive Evaluation (Annual Wellness Visit + Preventive

[Back to Table of Contents](#)



Exam), complete documentation and coding of all chronic medical conditions must be included.

Follow these few simple tips to avoid missed opportunities:

- All chronic conditions should be documented with MEAT, meaning that the note should confirm that every chronic condition was Monitored, Evaluated, Assessed, and Treated. Make sure all chronic conditions documented in the problem list are carried over into the assessment and plan every time.
- Be specific and detailed. Include the severity of a condition when possible, such as Chronic Kidney Disease Stage 1, 2, 3, 4, 5 or end stage. If a condition has a cause-and-effect relationship with another condition, document that relationship. For example, diabetes and the numerous complications should be linked when applicable (e.g., diabetes with nephropathy, neuropathy, retinopathy). If a condition can be either acute or chronic, include that appropriate wording in the documentation.
- Remember to document stable, long-term chronic conditions such as amputations, stomas, and plegias in the exam and assessment.
- Always include a treatment plan or how the condition is being managed, even if the plan is to “continue current care.” If another provider is managing the condition, include this in the documentation, too.
- Avoid using “history of” when the condition is currently being treated or managed. For example, cancer should be documented as a current condition if there is a current treatment plan. It should be documented as “history of” only if the patient is currently in remission and not receiving treatment.

For more detailed coding information for the SelectHealth Advantage Comprehensive Evaluation, contact your Provider Relations representative. Helpful information about documenting and coding chronic conditions is

available in the Education Opportunities section of [selecthealthphysician.org](http://selecthealthphysician.org).

## CMS Enrollment Requirement for Medical and Dental Providers to Prescribe to Medicare Members

The Centers for Medicare & Medicaid Services (CMS) recently published a final rule regarding qualified prescribers who write prescriptions for Part D drugs. The requirement applies to physicians and other healthcare practitioners, including dentists, with valid medication prescription authority under state law.

Effective December 1, 2015, Medicare Prescription Drug Plans and Medicare Advantage plans that include prescription drug coverage, such as the SelectHealth Advantage plan, will be required to deny coverage for Part D drugs except in the following circumstances:

- The prescriber is enrolled in the Medicare program in an approved status, or
- Has a valid opt-out affidavit on file with an A/B Medicare Administrative Contractor

[Visit Medicare to enroll](#)

[Learn how to opt out](#)

CMS has indicated that prescribers of Part D drugs must submit their Medicare enrollment applications or opt-out affidavits to their Medicare Administrative Contractors (MACs) by June 1, 2015, or earlier, to ensure sufficient time to process the applications or opt out affidavits and avoid their patients' prescription drug claims from being denied by their Part D plans beginning December 1, 2015.

[Back to Table of Contents](#)

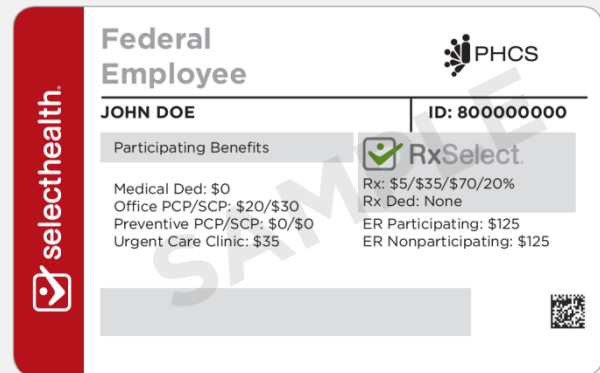
## SELECTHEALTH FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB)

### FEHB ID Card Identifiers

Do you have trouble navigating the pertinent information when looking at ID Cards? To ensure the quickest service for our members, please review these commonly used ID Card identifiers:

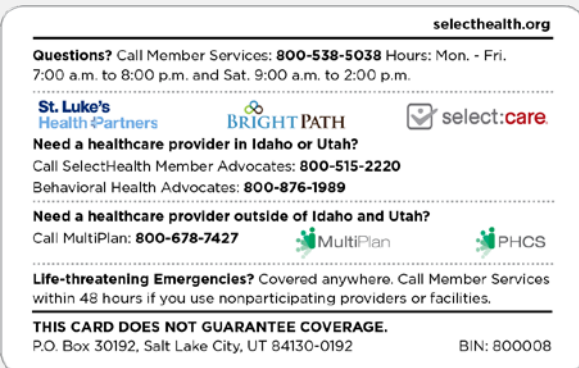
- Providers can identify a SelectHealth Federal Employee based on the “Federal Employee” identifier on the front of the member’s ID Card.
  - > This replaces the standard Select Care and Select Care + logo frequently seen on similar ID cards
- Benefits are found at the center of the card
- St Luke’s Health Partners, BrightPath, and SelectHealth networks are listed on the back of the Federal Employee’s ID Card.
  - > In Utah, Federal Employees may use the Select Care network
  - > In Idaho, Federal Employees may use the BrightPath or St. Luke’s network

### FRONT



### BACK

#### Idaho



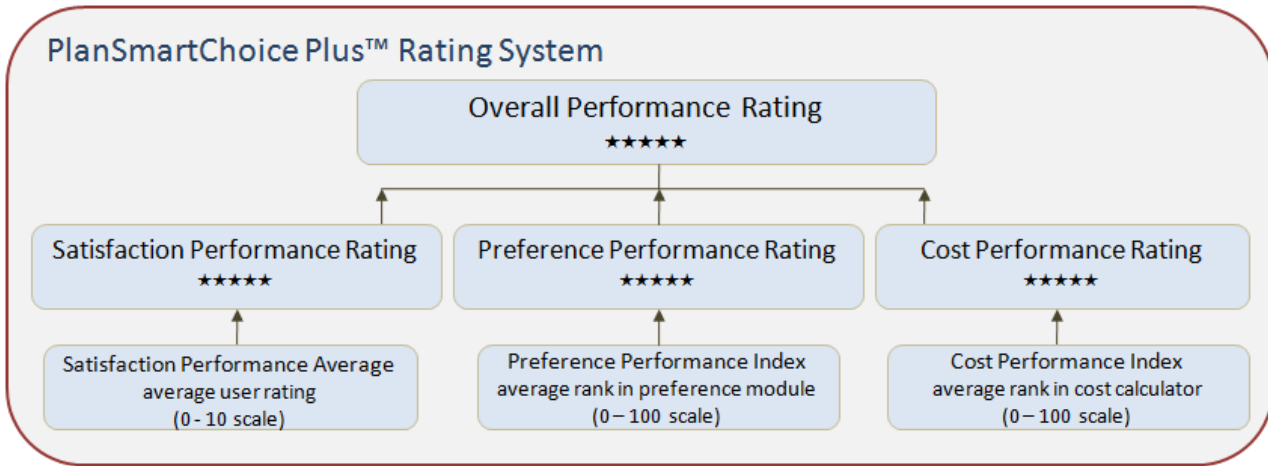
#### Utah



[Back to Table of Contents](#)



## FEHB PlanSmartChoice Plus Plan Award Recipient



SelectHealth has been recognized as 1 of 12 FEHB plans identified by Automatic Data Processing (ADP) as a PlanSmartChoice Plus Plan for 2014. This prestigious award is handed out annually to the top performing plans in FEHB programs across the country. These rankings are based on the combined overall performance in the following categories:

- **Preference Rating** - The preference performance rating signifies how well the plan performed on average in the PlanSmartChoice preference module. It measures how closely the plan matched users' stated preferences when selecting a plan.
- **Cost Rating** - The cost performance rating denotes how well the plan performed on average in the PlanSmartChoice medical cost calculator. It is a measure of the plan's cost effectiveness based on the expected healthcare use in the coming year.
- **Satisfaction Rating** - The satisfaction performance rating specifies how satisfied users are with their plan.

For more information on how plans are awarded and scored, please visit [plansmartchoice.com](http://plansmartchoice.com).

### FEHB Tier 4 Pharmacy Benefits

Effective January 1, the FEHB prescription drug benefit was changed to reflect four tiers (levels) of coverage. The tiers determine the amount members are responsible to pay. Copay and coinsurance amounts are shown in the FEHB Federal brochure and on ID Cards.

Federal Employees can [view the most current drug coverage and pharmacy benefit information](#). They can also find:

- Drug prices and potential lower-cost alternatives
- A drug lookup, searchable by drug name and dose
- Tier statuses of prescription drugs, including injectables

If you have questions, please call SelectHealth Pharmacy Services at **800-442-3129**.

[Back to Table of Contents](#)

## MEDICAL POLICY AND NEW TECHNOLOGY ASSESSMENT

### Medical Policy Update Bulletin

A quarterly notice of recently approved and/or revised Medical Policies is provided for your information. By accessing the Medical Policy Update Bulletin, you may view new and/or revised Medical Policies in their entirety, along with an overview or summary of changes for all commercial SelectHealth plans.

The appearance of a medical policy in the Medical Policy Update Bulletin indicates that SelectHealth has recently adopted or revised a Medical Policy for commercial health plans.

The Medical Policy Update Bulletin does not indicate that SelectHealth provides coverage for the procedures listed. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted Medical Policy, the provisions of the posted policy will prevail.

Policy Name	Date Reviewed	Summary of Changes
<b>Artificial Spinal Disc Replacement (REVISED)</b>	3/11/2014	The Mobi-C <sup>®</sup> Cervical Disc Prosthesis received initial FDA pre-market application (PMA) approval on August 7, 2013 for a <b>single level</b> disc replacement. On August 23, 2013, the FDA provided a second PMA approval for use of the Mobi-C implant at two levels. Added to the policy "SelectHealth covers Prestige <sup>®</sup> ST, BRYAN <sup>®</sup> , Mobi-C and ProDisc <sup>®</sup> -C artificial cervical discs for <b>single level disc</b> replacement in limited circumstances." All other conditions for use of this device or other artificial cervical spinal discs are considered investigational/experimental. Multilevel artificial disc implants are not covered. <b>See Policy #243</b>
<b>Genetic Testing: Coronary Artery Disease Expression (Corus<sup>®</sup> CAD) (REVISED)</b>	3/12/2014	As a laboratory test, Corus CAD is not FDA approved, but the laboratory performing the test, CardioDx <sup>®</sup> , is approved as a CLIA. It received Clinical Laboratory Improvement Amendments (CLIA) approval on 2/17/13. The approval is for two years. CardioDx is CLIA certified to receive samples from all 50 states, receiving New York state approval in December 2011 and College of American Pathology (CAP) Accreditation in 2013. <b>See Policy #442</b>
<b>Minimally Invasive Lumbar Decompression (mild) (REVISED)</b>	4/30/2014	Clarification was made under the <b>Commercial Plan Policy</b> section of the policy to show that SelectHealth does not cover the minimally invasive lumbar decompression (mild) procedure. In addition, clarification was made to show that SelectHealth does not cover any percutaneous lumbar decompression or laminectomy procedures, as these are specifically excluded in the plan Certificate of Coverage. SelectHealth covers other minimally invasive lumbar decompression procedures involving direct visualization of the spine, disc space, foramina, and spinal nerves including, but not limited to endoscopic minimally invasive spine surgery, as evidence has demonstrated these procedures to provide outcomes similar to standard lumbar decompression procedures. <b>See Policy #446</b>
<b>Physical Therapy (PT) Occupational Therapy (OT) (REVISED)</b>	4/16/2014	This policy has been revised to remove speech therapy guidelines. Speech therapy guidelines are now in policy #178. <b>See Policy #518</b>
<b>Speech Therapy Guidelines (REVISED)</b>	4/16/2014	Revision of this policy includes specific <b>Medicare and Medicaid</b> language for clarification of speech/language therapy. <b>See Policy #178</b>

[Back to Table of Contents](#)

## Medical Policy Updates, Continued

Policy Name	Date Reviewed	Summary of Changes
Radiofrequency Ablation (RFA) for Back or Neck Pain (REVISED)	9/17/2014	Revision includes the following changes to the Commercial Plan Policy: SelectHealth does NOT cover a diagnostic median nerve branch block (MBB block) when performed as a precursor to thoracic RFA procedures as thoracic median nerve RFA procedures are not covered and thus medical necessity of diagnostic MBB not present. Clarification was also made under <b>SelectHealth Advantage</b> to include thoracic as a covered procedure. The <b>SelectHealth Community Care</b> section was updated to show coverage of the cervical and lumbar spine. <b>See Policy #265</b>
Robotic Assisted Surgery (REVISED)	9/29/2014	Revision of the policy includes the addition of Heller myotomy to the list of covered laparoscopic procedures using robotic assistance and some additional clarifying language. <b>See Policy #236</b>
Mechanical Insufflation-Exsufflation Therapy for the Clearance of Airway Secretions (CoughAssist Device) (REVISED)	9/29/2014	An extensive revision of this policy includes clarification of coverage under <b>Commercial Plan Policy</b> : SelectHealth covers mechanical insufflation-exsufflation devices as medically necessary for patients with neuromuscular disorders with significant impairment of chest wall and/or diaphragmatic movement resulting in difficulty clearing secretions, a demonstrated reduction in peak cough expiratory flow rate of <3L per second and for whom standard treatments (e.g., chest percussion and postural drainage) have not been successful in adequately mobilizing retained secretions. The medical literature has established that the use of these devices results in improved health outcomes for patients with ventilatory insufficiency and difficulty clearing secretions due to respiratory muscle weakness or chronic mechanical ventilation. Also included in the revision is the updated information for <b>Medicare and Medicaid</b> . <b>See Policy #246</b>
VWING Subcutaneous Vascular Needle Guide for Vascular Access in Dialysis (NEW)	4/29/2014	New policy was developed following an M-Tech review for VWING. SelectHealth does NOT cover VWING subcutaneous vascular needle guide for vascular access in dialysis as the device's current evidence is unproven. <b>See Policy #550</b>
Third Eye Retroscope for Colonoscopy Procedures (NEW)	4/29/2014	New policy was developed following an M-Tech review for Third Eye Retroscope for Colonoscopy Procedures. SelectHealth does NOT cover Third Eye Retroscope as an adjunct to colonoscopy procedures as it is investigational. <b>See Policy #551</b>
Sensory Integration Therapy for Non-Autistic Children (NEW)	5/13/2014	New policy was developed for Sensory Integration Therapy for Non-Autistic Children. SelectHealth does NOT cover sensory integration therapy for non-autistic children as this is considered investigational for the following conditions: learning disabilities, developmental delay, sensory integration disorder, stroke, speech disturbances, lack of coordination, and abnormality of gait. <b>See Policy #552</b>
Urolift System for the Treatment of Benign Prostatic Hyperplasia (NEW)	7/29/2014	New policy was developed for Urolift System for the Treatment of Benign Prostatic Hyperplasia following an M-Tech review for the procedure. SelectHealth does NOT cover the Urolift System procedure for the treatment of benign prostatic hyperplasia as it is considered investigational and not medically necessary. <b>See Policy #553</b>
Emergency Behavioral Health Services (NEW)	8/08/2014	New policy was developed for Emergency Behavioral Health Services. SelectHealth covers emergency behavioral health services when the following criteria are met: treatment evaluation is performed by a licensed provider who has been appropriately credentialed by SelectHealth to perform clinical evaluation, triage, and disposition planning. Services are provided in a hospital, urgent care, community or outpatient facility setting. Services are integrated into a system of care and must be designed to provide entry points into systems of care with the intent of avoiding crisis intervention that is disconnected from a patient's community and healthcare providers. <b>See Policy #554</b>

[Back to Table of Contents](#)

## Medical Policy Updates, Continued

<b>Total Ankle Arthroplasty (Total Ankle Replacement) (REVISED)</b>	3/04/2014	Revision of the policy includes clarification of criteria under <b>Commercial Plan Policy</b> to include that the patient has failed with at least six months of conservative treatment including all of the following: anti-inflammatory medications, physical therapy, splints or orthotic devices; and the patient has at least one of the following conditions: arthritis in adjacent joints (e.g., subtalar or midfoot) or arthrodesis of the contralateral ankle or severe arthritis of the contralateral ankle. <b>See Policy #358</b>
<b>Infliximab/Adalimumab Testing (REVISED)</b>	5/27/2014	Revision of the policy includes the addition of Adalimumab Testing. <b>See Policy #532</b>
<b>Acute Bronchiolitis Admission Criteria (REVISED)</b>	6/19/2014	Revision of the policy includes a new bronchiolitis risk of admission score table to replace the old table. Also, #1 Bronchiolitis score has been changed from a 4 to 3. <b>See Policy #109</b>
<b>Fetal Cell-Free DNA (CfDNA) Testing for Down Syndrome (Trisomy 21), Trisomy 13 &amp; 18 (REVISED)</b>	8/20/2014	Revision of the policy includes adding for clarification, "In cases where the pregnant woman has received a 'donor' egg and is acting as a surrogate, it is the age of the donor that is relevant to the decision process, not the age of the surrogate." <b>See Policy #509</b>
<b>Ozurdex Implant (REVISED)</b>	8/15/2014	Revision of the policy includes language that Ozurdex recently received FDA approval for 0.7 mg. dexamethasone intravitreal implant as a treatment option for pseudophakic and phakic diabetic macular edema (DME) patients. This revision was made under <b>Commercial Plan Policy</b> as now being covered. <b>See Policy #435</b>
<b>Varicose Vein Procedures (REVISED)</b>	8/05/2014	Revision of the policy to clarify wording of coverage under <b>Commercial Plan Policy</b> section from policy modification that occurred in September 2013 for clearer understanding. <b>See Policy #193</b>

## Technology Assessment (M-Tech) News

M-Tech is our formal process for reviewing emerging healthcare technologies (procedures, devices, tests and "biologics") to establish coverage benefits. Existing technologies are also examined through this process.

Other technologies currently under active assessment by the M-Tech Committee are scheduled and include the following. As the reviews are include the following. As the reviews are completed, notices will be sent to stakeholders accordingly to inform them of SelectHealth coverage determinations:

- Confirm MDx Test for Prostate Cancer
- Decipher Prostate Cancer Classifier
- EpiFix Bioengineered Skin
- iStent for Glaucoma
- Knee Resurfacing
- MRgFUS for Bone Metastases
- MRgFUS for Essential Tremor
- MRgFUS for Prostate Cancer
- MRgFUS for Uterine Fibroids

[Back to Table of Contents](#)

- MRgFUS for Prostate Cancer
- MRgFUS for Uterine Fibroids
- Negative Pressure Wound Therapy
- Noninvasive Skin Imaging
- Oncotype DX for Colon Cancer
- Prosigna Breast Genetic Test
- TENS for Migraines
- Total Body Photography
- VEMP Testing
- Vermillion OVA1 Test for Ovarian Cancer

If you have questions regarding coverage of these or any other technologies or procedures or if you would like SelectHealth to consider coverage for an emerging technology, please email [M-Tech](#) or call **801-442-7890**

[Log in to view](#) all SelectHealth medical policies and technology assessments. Click on “Policies and Procedures” to be directed to links for Medical Policies, Reimbursement and Coding Policies, and Medical Technology Reviews.

Technology	Date Reviewed	Committee Decision
Responsive Cortical Neurostimulation in the Treatment of Epilepsy (e.g., NeuroPace RNS)	9/19/14	<b>Cover in Limited Circumstances.</b> Current evidence demonstrates responsive cortical stimulation to be safe and efficacious in adults with partial-onset seizures refractory to at least two antiepileptic medications. <b>See Medical Policy #556</b>
Computerized Neuropsychological Testing in Concussion Management	10/28/14	<b>Cover as statistical validity established and clinical utility established in management of concussion.</b> Current evidence has demonstrated that neuropsychological testing is a validated tool for managing concussions. <b>NOT Covered for baseline testing.</b> Current evidence has not demonstrated that use of testing in this circumstance is validated for managing concussions. <b>See Medical Policy #334</b>
MRgFUS for Essential Tremor	12/16/14	<b>Deny as investigational.</b> Current evidence has yet to demonstrate the safety and efficacy of MRgFUS/HIFU for the treatment of essential tremor. <b>See Medical Policy #560</b>
Endovenous Ablation of the Small Saphenous Veins in the Treatment of Varicose Veins	12/16/14	<b>Cover.</b> Current evidence has demonstrated that endovascular ablation of the accessory and short saphenous veins is safe and effective in the treatment of varicose veins. <b>See Medical Policy #193</b>

\*Date Reviewed does not necessarily reflect the date of implementation of coverage policy.

[Back to Table of Contents](#)

©2015 SelectHealth. All rights reserved. 3859 2/15