Welcome to the Provider Insight® newsletter. This newsletter includes information and updates that pertain to our commercial, SelectHealth Advantage® (Medicare), SelectHealth Community Care® (Medicaid), Federal Employee Health Benefits, and dental plans. Please encourage each provider and member of your staff to review the newsletter for important information that affects your patients covered by a SelectHealth policy.

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St. Luke’s Nurse Line

Now, a phone call could save your patients money—and an ER visit. Instead of relying on the Internet for self-diagnosis, patients can now pick up the phone and talk to a registered nurse at any time. This 24/7 service is available through St. Luke’s nurse line, which is staffed by registered nurses. Using nationally standardized protocols, these nurses offer home-based treatment options and make recommendations for when to seek care from a provider, urgent care clinic, or emergency room. The nurse line is free and can help patients make sense of their symptoms and determine how and where to get the best care. To reach the nurse line, patients can call **844-265-7648**.

Mid-level Credentialing

We believe physician assistants (PAs), nurse practitioners (NPs), and other mid-level providers play an important role in the care of our members. For this reason, since 2013 these providers have been eligible for individual credentialing consistent with their licensing requirements. Credentialing mid-level providers allows us to reimburse them directly for their services. Credentialing also allows provider-specific tracking for quality improvement purposes and may allow these providers to participate in quality improvement activities in the future.

If there are mid-level providers in your practice who are interested in becoming credentialed, or to learn more about credentialing, please contact your Provider Relations representative.

Flu Bugs Don’t Wait for Appointments

The flu season is in full swing, yet many people still have not received a flu vaccine. A few reminders to ensure all of your patients are protected:

> Verify every patient in your practice received their flu shot.
> Offer “walk-in” immunizations.
> Direct patients to the nearest participating pharmacy that offers walk-in immunizations if you can’t offer them in your practice.

We know prevention is the best treatment, and flu vaccines are key to prevention. Most medical plans pay for flu vaccines with no out-of-pocket cost for members. Let’s take every opportunity to keep our communities healthy this year.
2016 Medical Code Changes

Happy New Year! It’s official: We have transitioned to ICD-10. Make sure you use the new ICD-10 codes and have the documentation to support them.

Many CPT and HCPCS code changes became effective January 1, 2016. These changes include approximately 418 new, 178 revised, and 198 deleted codes. There is no grace period for using new codes and discontinuing the use of deleted codes.

Please refer to the latest edition of your coding reference books or software updates for information about these code changes. If you have purchased books, be aware that corrections may have already occurred. Refer to the American Medical Association (AMA) or Centers for Medicare & Medicaid Services (CMS) websites for the most up-to-date information and corrections.

Some other changes to be aware of:

> Effective January 1, our commercial plans will allow separate payment for CPT 99140 Anesthesia complicated by emergency conditions when billed with appropriate emergency diagnosis codes. Our other lines of business consider this to be a bundled code and will not pay it separately.

> HCPCS J7302 Levonorgestrel-releasing Intrauterine Contraceptive System, 52 Mg, has been replaced with the following two new HCPCS codes, specific to Liletta and Mirena, effective January 2:
  - HCPCS J7297 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3-year duration (Liletta)
  - HCPCS J7298 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5-year duration (Mirena)

> Effective January 1, we no longer cover any CPT codes for drug screening (80300–80377). To be reimbursed for these services, submit the appropriate Gxxxx codes that became effective January 1 for all lines of business.

Additional Information about Urine Drug Testing

In the November 2015 edition of Provider Insight, we notified you of our Medical Policy #569 – Urine Drug Testing in the Outpatient Setting. This article provides additional guidance to ensure you have the necessary information to bill Urine Drug Testing (UDT) appropriately.

As a reminder, effective January 1, 2016, we no longer cover CPT 80300–80377 for UDT for our commercial and SelectHealth Advantage (Medicare) lines of business.* CMS created eight new HCPCS G-codes for UDT to include point-of-care testing and qualitative and quantitative panels.
Annual limitations apply as established in consultation with the Intermountain Healthcare Functional Restoration and Pain Team and local addiction specialists. For further clarification, review Medical Policy #569 – Urine Drug Testing in the Outpatient Setting, at selecthealthphysician.org.

The new covered codes for UDT, listed below, more appropriately reflect the correct type of testing.

**PRESCRIPTIVE DRUG TESTING**

- **G0477** – Drug tests, presumptive, any number of drug classes; any number of devices or procedures (e.g., immunoassay), capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), including sample validation when performed, per date of service

- **G0478** – Drug tests, presumptive, any number of drug classes; any number of devices or procedures (e.g., immunoassay), read by instrument-assisted direct optical observation (e.g., dipstick, cups, cards, cartridges), including sample validation when performed, per date of service

- **G0479 (covered for SelectHealth Advantage members only)** – Drug tests, presumptive, any number of devices or procedures by instrumented chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, MALDI, LDTR, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service

**DEFINITIVE DRUG TESTING**

- **G0480** – Drug tests, definitive, using drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources, including specimen validity testing, per day, 1–7 drug class(es), including metabolite(s) if performed

- **G0481** – Drug tests, definitive, using drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources, including specimen validity testing, per day, 8–14 drug class(es), including metabolite(s) if performed

- **G0482** – Drug tests, definitive, using drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources, including specimen validity testing, per day, 15–21 drug class(es), including metabolite(s) if performed

- **G0483** – Drug tests, definitive, using drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources, including specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed

To ensure optimal quality, highly complex testing (e.g., GC/MS or LC/MS/MS) will be covered as a preferred benefit when provided through one of the contracted vendors listed below or a participating network provider.
If you need order forms and appropriate sample containers, please call the vendors directly. You may also contact a vendor’s customer service representative.

> Aegis: 801-918-5450
> Dominion: 877-734-9600
> Intermountain Laboratory: 801-507-2110
> Millennium: 877-451-3534

A representative of the laboratory will instruct you on correct ordering and handling of the specimen.

HEDIS Measurement: Immunizations for Adolescents

HEDIS (Healthcare Effectiveness Data and Information Set) 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.

Adolescent immunizations help prevent serious illnesses, such as meningitis, tetanus, diphtheria, and pertussis. During 2010, outbreaks of pertussis sickened thousands and led to the deaths of several infants younger than three months. Because a baby can get sick from pertussis and because they are not fully protected until they have had several doses of Diphtheria, Tetanus, and acellular Pertussis (DTaP) vaccine, it is recommended that older children and adults around them be protected.¹ Vaccines are an easy, proven way to help a teen stay healthy and avoid the potentially harmful effects of adolescent diseases. Teens and adults can protect themselves and help reduce transmission of pertussis by getting the Tetanus, diphtheria, and acellular pertussis (Tdap) vaccine¹ or the Tetanus-diphtheria (Td) vaccine as recommended by their physician.

This HEDIS measure calculates the percentage of children and adolescents on our plans who have received one dose of meningococcal vaccine and one Tdap or one Td vaccine by age 13.

To support the HEDIS measure objectives, we are taking the following steps:

> An interactive voice response telephone system delivers education and encourages patients’ parents to immunize their adolescents.
> We send quarterly reminders to parents of adolescents ages nine to 14 who have received at least one dose of HPV vaccine in the last six months but have not completed the series.

If you would like more information, or if you are interested in learning more about other SelectHealth Quality Improvement programs, contact the Quality Improvement department at 801-442-7425 or qualityimprovement@selecthealth.org.

Reference:
Healthy Beginnings for Expectant Mothers

SelectHealth Healthy Beginnings® is a program for expectant mothers available at no cost to members. We work with you to help mothers have a safe and healthy pregnancy. To enroll, members can call 866-442-5052.

Healthy Beginnings provides the following:

- Access to a perinatal nurse Care Manager
- Assistance in answering questions, offering emotional support, and providing referrals to community resources
- Educational materials
- A magnet with important information and phone numbers

If you have a patient who would benefit from Healthy Beginnings, please print our flyer, and encourage her to enroll.

Explore Opportunities for Care 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, our disease management team provides educational materials, access to online resources, newsletters, follow-up phone calls, and the expert support of a care manager.

A patient can be referred to a disease manager by provider recommendation or if the patient meets condition-specific criteria.

Learn more about our care and disease management services in the Care Management section of our Provider Reference Manual. To refer a member for care or disease management, call 800-442-5305.

Plan Coverage for Complementary, Alternative, and Integrative Medicine (CAM)

Increasingly many patients and providers are looking to complementary and alternative medicine (CAM) to treat conditions that have not adequately responded to traditional allopathic medicine practices. It is understandable that patients and providers may seek solutions to problems to alleviate pain or suffering from various conditions such as fibromyalgia and chronic fatigue etc. Although there may be a large body of information on many of these therapies, well-designed clinical trials have either not been performed or have not demonstrated effectiveness of these therapies.
Our plans exclude coverage of unproven or investigational therapies. Many complementary or alternative therapies fall into this category (e.g., long-term antibiotic therapy for Lyme disease), and they are excluded from coverage. Additionally, CAM is excluded from coverage in our Certificate of Coverage. This exclusion specifically identifies bio-identical hormone therapy as an exclusion. CAM services, if we identify them, will be denied coverage.

Incident to the exclusion for CAM therapy, lab or imaging services performed specifically to support CAM therapies (e.g., estrogen level testing in men, or testosterone levels in women as part of bio-identical hormone therapy) will also be denied. This places members at potential risk for significant costs, and providers should fully inform patients of this risk when doing labs for supporting CAM.

In addition, “integrative medicine” as it combines CAM with traditional medicine is excluded from coverage for the CAM components of therapy when identified.

Because contracts require providers to adhere to our policies, those who engage in CAM practices and incur significant costs to SelectHealth or our members risk being terminated from our networks.

**SELECTHEALTH ADVANTAGE**

**Taxonomy Codes Now Required**

Effective February 1, all providers are required to submit their taxonomy code on every claim for SelectHealth Advantage members.

**WHAT ARE TAXONOMY CODES?**

Taxonomy codes are unique, ten-character administrative codes that identify the provider type and area of specialization for healthcare providers. Verify your correct taxonomy code on the NPI website.

**WHY ARE WE REQUIRING TAXONOMY CODES?**

> Submitting taxonomy codes on claims ensures the most accurate pricing.

> Taxonomy codes help us select the correct provider ID to process a claim. A provider may have multiple IDs for any of the following reasons:

- Different fee schedules for different categories of service
- Multiple practice locations
- Different Tax IDs
- Different provider groups to which to send payment

> Faster and more accurate payment

> More accurate claim adjudication

Review the *Submitting Taxonomy* flyer for specific information about how to submit your taxonomy code. If you have questions, call your Provider Relations representative at 800-538-5054.
Coding Tips: Documenting Chronic Conditions

As we mentioned in the May 2015 edition of Provider Insight, CMS reimburses Medicare Advantage plans like SelectHealth Advantage based on the health and chronic medical conditions of members in the plan. To do this, CMS examines the chronic diagnoses reported for each member to determine the reimbursement for that member’s care.

We rely on you to fully report and document the chronic conditions of your patients. Over the next several editions of Provider Insight, we will share with you some common Hierarchical Condition Categories (HCCs) that affect reimbursement and the ICD-10 codes that apply to each category.

**BMI AND OBESITY**
- BMI – Z68.41–Z68.45
- Morbid obesity – E66.01

**DEPRESSION**
- Major depressive disorder, single episode – F32.0–F32.5
- Major depressive disorder, recurrent episode – F33.0–F33.9

**DIABETES**
- Type 2 diabetes mellitus without complications – E11.9
- Type 2 diabetes mellitus with kidney complications – E11.21–E11.29
- Type 2 diabetes mellitus with ophthalmic complications – E11.31–E11.39
- Type 2 diabetes mellitus with neurological complications – E11.40–E11.49
- Type 2 diabetes mellitus with circulatory complications – E11.51–E11.59

Remember to document every condition every year. Every record must include:
- Patient name
- Provider signature and credentials (MD, DO, NP)
- Date of service
- At least one element from the MEAT system for each diagnosis (parentheses indicate where to put each element in a SOAP note)
  - **Monitored** – Must indicate that you asked about the current status of the condition (Subjective HPI)
  - **Evaluated** – Exam or lab/imaging findings (Objective PE)
  - **Assessed** – Note the current medical status of the patient’s condition (Assessment)
  - **Treated** – Record the treatment plan (Plan); may state “continue current plan” if current plan is documented

We offer several training opportunities, including presentations and workshops, printed materials, and in-person training. Contact Provider Development at 800-538-5054 or via email to learn more.
Start Early to Schedule Annual Comprehensive Medical Exams

We recognize that one of the best ways to improve the health and wellness of the SelectHealth Advantage population is to encourage these members to receive an annual comprehensive medical exam. We cover an Annual Wellness Visit (AWV) and a preventive exam or Evaluation and Management (E&M) visit on the same date of service. The following code combinations help identify the services rendered for the comprehensive exam:

<table>
<thead>
<tr>
<th>Service</th>
<th>Coding Combination</th>
<th>Modifier Requirement</th>
<th>Member Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Visit plus a Preventive Exam, Initial Visit</td>
<td>G0438 Annual Wellness Visit, including a personalized prevention plan of service, initial visit AND 99387 Initial comprehensive preventive medicine evaluation and management, 65 years and older</td>
<td>No modifier needed</td>
<td>No copay applies</td>
</tr>
<tr>
<td>Annual Wellness Visit plus a Preventive Exam, Subsequent Visit</td>
<td>G0439 Annual wellness visit, including a personalized prevention plan of service, subsequent visit AND 99397 Periodic comprehensive preventive medicine reevaluation and management, 65 years and older</td>
<td>No modifier needed</td>
<td>No copay applies</td>
</tr>
<tr>
<td>Annual Wellness Visit plus an E&amp;M Initial Visit</td>
<td>G0438 Annual Wellness Visit, including a personalized prevention plan of service, initial visit AND 99201–99205 Office visit for evaluation and management of a new patient, minor – high severity</td>
<td>A modifier 25 must be added to 99201–99205 procedure codes</td>
<td>Member copay applies to E&amp;M service</td>
</tr>
<tr>
<td>Annual Wellness Visit plus an E&amp;M Subsequent Visit</td>
<td>G0439 Annual Wellness Visit, including a personalized prevention plan of service, subsequent visit AND 99211–99215 Office visit for evaluation and management of an established patient, minimal – high severity</td>
<td>A modifier 25 must be added to 99211–99215 procedure codes</td>
<td>Member copay applies to E&amp;M service</td>
</tr>
</tbody>
</table>

During the comprehensive exam, remember to fully document and code all chronic conditions. When billing a comprehensive exam, documentation must include the following elements:

> Documentation that supports both codes
> Evaluation and assessment of all chronic medical conditions
> Current treatment plan for each condition
> Medical conditions coded with accurate and specific ICD-10

Healthy Living Rewards for SelectHealth Advantage Members

To motivate SelectHealth Advantage members to live healthier, we offer rewards to members enrolled in our Healthy Living Wellness Activities program. We want our members to recognize the importance of living healthier lifestyles as they age because regular preventive care, exercise, healthy nutrition, flu shots, and tobacco avoidance may help delay or prevent many diseases and disabilities.

Healthy Living Wellness Activities is a wellness program for SelectHealth Advantage members, who can document healthy choices online to earn rewards. Examples include having their Annual Wellness Visit (AWV) and exercising regularly. Here’s how members participate:

> Choose two or more wellness activities, earning at least 60 rewards points.
> Record completion of the activities, using an online form, anytime from January 1 to December 14, 2016.
> Redeem their rewards points for a $15 Amazon or Visa gift card.
We’ve made it easy for members to earn rewards and stay motivated. Here are the activities they can choose from:

- **Annual Wellness Visit**: 50 points
- **Flu Shot**: 10 points
- **Tobacco Cessation/Non-smoker**: 10 points
- **Physical Activity** (150 minutes a week for 3 months): 10 points
- **Strength Training** (2 days a week for 3 months): 10 points
- **Nutrition** (5 servings fruits or vegetables a day for 3 months): 10 points

We urge you to support members in their progress toward healthier lives. Ask if they’re participating in the Healthy Living program. Encourage them to have their AWV and step up to the challenges for additional points. Let’s form a collaborative team to help our members—your patients—live the healthiest lives possible.

**FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB)**

**FEHB Patients Receive Incentives for Biometric Screenings**

We provide a wellness incentive to FEHB members who complete one or more selected biometric screenings per calendar year. By encouraging patients to schedule their annual preventive exam, you can help them capture important health information and receive a $25 cash incentive for learning about their Body Mass Index (BMI), blood pressure, total cholesterol, High-Density Lipoprotein (HDL), Low-Density Lipoprotein (LDL), triglycerides, and glucose. Simply provide your authorized signature, and FEHB members age 18 or older can submit an FEHB Wellness form to receive the $25 incentive.

**How to Identify FEHB Members**

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

- Identify a SelectHealth federal employee member based on the “Federal Employee” header on the front of the ID Card.
  - This replaces the standard Select Care® and Select Care Plus® logos frequently seen on similar SelectHealth ID Cards.
- Benefits appear at the center of the card.
- St. Luke’s Health Partners, BrightPath, and SelectHealth networks are listed on the back of the ID Card.
  - For services rendered in Utah, federal employees may use the Select Care network.
  - For services rendered in Idaho, federal employees may use the BrightPath or St. Luke’s Health Partners network.
The appearance of a medical policy in the Medical Policy Update Bulletin indicates that SelectHealth has recently adopted or revised a Medical Policy. 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.

Note: New medical policies will not include ICD-9 after January 1, 2016. All other medical policies will include ICD-9 and ICD-10 codes through 2016. In 2017, ICD-9 codes will be removed from all policies.

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Name</th>
<th>Policy Effective Date</th>
<th>Summary of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEW POLICIES</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>574</td>
<td>In Vivo Detection of Mucosal Lesions with Endoscopy (NEW)</td>
<td>10/15/2015</td>
<td>New policy created. SelectHealth Commercial does not cover in vivo techniques in the assessment of mucosal changes in endoscopic procedures. The impact of these technologies has not been proven to alter health outcomes. This meets the plan’s definition of experimental/investigational.</td>
</tr>
<tr>
<td><strong>REVISED POLICIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>243</td>
<td>Artificial Spinal Disc Replacement (Revised)</td>
<td>10/7/2015</td>
<td>Clarification of language for SelectHealth Commercial: Symptomatic cervical Degenerative Disc Disease (DDD) at 1 level (or 2 contiguous levels for a 2-level repair) from C3-C7</td>
</tr>
<tr>
<td>322</td>
<td>Endoscopic Ablation Therapies in the Treatment of Barrett’s Esophagus (Revised)</td>
<td>9/8/2015</td>
<td>Following an M-Tech review, the policy has changed: SelectHealth Commercial now covers low-grade dysplasia in patients with Barrett’s esophagus when all of the following criteria are met: 1. Disease found to be persistently present based on at least two sets of biopsies obtained at least six months apart 2. Documentation demonstrates patient to have had adequate conservative therapy for at least six months 3. Presence of LGD confirmed by two GI specialist pathologists 4. Patient shown to have multifocal or long-segment disease</td>
</tr>
<tr>
<td>133</td>
<td>Insulin Pumps (Revised)</td>
<td>10/7/2015</td>
<td>Language added for SelectHealth Commercial: Exclusions for replacement insulin pumps regardless of warranty status 1. Upgrade or replacement of the device when existing equipment is still functional 2. Damage due to patient neglect and abuse</td>
</tr>
<tr>
<td>436</td>
<td>Total Artificial Heart (Revised)</td>
<td>10/19/2015</td>
<td>Changed CardioWest™ to SynCardia throughout the document to represent the company’s new name.</td>
</tr>
<tr>
<td>101</td>
<td>Alcohol Ablation Septal Reduction (Transcoronary Ablation of Septal Hypertrophy and Percutaneous Transluminal Septal Myocardial Ablation) (Revised)</td>
<td>10/15/2015</td>
<td>Modified criteria to allow for alternative methods for provocation beyond exercise. Language change for SelectHealth Commercial Criteria for Coverage: 4. Left ventricular outflow tract gradient 30 mmHg at rest, or ≥50 mmHg with provocation with exercise, Valsalva, pharmacologic agent or post PVC</td>
</tr>
</tbody>
</table>
## 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, at times, also examined through this process. There are no technology updates to report in this edition. Any technologies currently being reviewed will be reported in the May edition of Provider Insight.

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<tr>
<td><strong>REVISED POLICIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>548</td>
<td>Closed-loop Insulin Delivery System (Revised)</td>
<td>10/07/2015</td>
<td>Language added for <strong>SelectHealth Commercial</strong>: Exclusions for replacement Closed-loop regardless of warranty status: 1. Upgrade or replacement of the device(s) when existing equipment is still functional 2. Damage due to patient neglect and abuse</td>
</tr>
<tr>
<td>434</td>
<td>Genetic Testing: BRAF Mutation Testing (Revised)</td>
<td>11/11/2015</td>
<td>Modified language for <strong>SelectHealth Commercial</strong>: SelectHealth covers BRAF V600E and BRAF V600K when used to determine the use of medication used in the treatment of metastatic melanoma.</td>
</tr>
</tbody>
</table>
| 567 | Blepharoplasty, Brow Ptosis Repair and Reconstructive Eyelid Surgery (Revised) | 12/7/2015 | Changes made for **Commercial Plan Policy**:  
*except for ectropion, entropion, anophthalmic socket, and trichiasis repairs where visual fields are not necessary* has been relocated to:  
A. Results of complete (taped and untaped) bilateral visual field examinations including visual points seen and not seen (except for ectropion, entropion, anophthalmic socket and trichiasis repairs where visual fields are not necessary).  
Under Coverage Criteria:  
1. Blepharoptosis replaced levator resection in several areas  
2. Under brow ptosis repair the word “BOTH” was removed and replaced with “at least one”  
3. Section on trichiasis, ectropion or entropion re-written for clarification  
4. Criteria for eyelid surgery in patients with an anophthalmic socket replaced with new language:  
III. Eyelid surgery in patients with an anophthalmic socket (has no eyeball) is considered reconstructive and medically necessary when BOTH of the following criteria are present:  
A. Patient has an anophthalmic condition  
B. Patient is experiencing difficulties fitting or wearing an ocular prosthesis |
| 308 | Selective Internal Radiation Therapy (SIRT, Radioembolization) (Revised) | 12/7/2015 | Language changes made under **Commercial Plan Policy**:  
Added coverage for:  
Hepatic metastases from neuroendocrine tumors with diffuse and symptomatic disease when systemic therapy has failed to control symptoms |