Welcome to our redesigned Provider Insight® newsletter. As a reminder, this format enables us to post the newsletter online and email it to participating medical and dental practices and facilities. We will no longer print and mail the newsletter in the tabloid format.

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

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ICD-10 is coming October 1, 2015

Readiness is critical to a smooth transition, especially with the implementation date within weeks.

SELECTHEALTH READINESS FOR ICD-10

We have been preparing for the past four years to ensure that we are able to seamlessly process ICD-10 codes with no delays. We have been testing with selected providers since early 2015 and are confident in our systems and processes. The most common mistakes we’ve found in claims received from providers include errors in the data, such as ICD-10 codes with an ICD-9 code set qualifier, and invalid revenue codes.

We’ve also conducted extensive parallel testing with claims coded in ICD-9 and ICD-10 to verify that we see no increase in denials or pends, and that claims are paying accurately based on medical policies and benefits.

Something to be aware of with the ICD-10 transition is that in some cases we are now able to more closely align payment to the existing medical policies, benefits, and Certificates of Coverage due to the increased specificity. This means that ICD-9 codes that covered a broad spectrum of disease and may have been fully denied could now have some related ICD-10 codes that will pay because we can differentiate the care provided.

For example, as illustrated in the table below, our Benefit Coverage states that ICD-9 635.70, legally induced abortion, unspecified with other specified complications, is not covered except when medically necessary or when pregnancy was caused by rape or incest. However, medical complications resulting from an abortion are covered. These complications can now be indicated using ICD-10 codes.

The converse may also happen—ICD-9 codes that were previously paid may now be mapped to a more specific ICD-10 code that may not be covered based on our medical policies or Certificates of Coverage. We recommend that you look closely at those high-volume or high-dollar claims your practice regularly generates, practice coding them in ICD-10, and verify the resulting codes against our medical policies and Certificates of Coverage or benefit coverage to understand any potential reimbursement effects.

View frequently asked questions and answers about the ICD-10 transition. If you have questions about the ICD-10 transition at SelectHealth, contact your Provider Relations representative.

Example of ICD-9 to ICD-10 Coverage Changes

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-9 Description</th>
<th>ICD-9 Coverage</th>
<th>ICD-10</th>
<th>ICD-10 Description</th>
<th>ICD-10 Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>635.70</td>
<td>Legally induced abortion, unspecified with other specified complications</td>
<td>Not covered</td>
<td>O04.85</td>
<td>Other various complications following (induced) termination of pregnancy</td>
<td>Covered – Complications resulting from abortion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>O04.86</td>
<td>Cardiac arrest following (induced) termination of pregnancy</td>
<td>Covered – Complications resulting from abortion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>O04.88</td>
<td>Urinary tract infection following (induced) termination of pregnancy</td>
<td>Covered – Complications resulting from abortion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>O04.89</td>
<td>(Induced) Termination of pregnancy with other complications</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
Care Process Models (CPMs) Updated

Care Process Models (CPMs) are created by the Intermountain Healthcare Primary Care Clinical Program committees. They summarize current medical literature and, where clear evidence is lacking, provide expert advice on diagnosing and treating chronic conditions. CPMs provide clinicians with treatment goals and interventions that are known or believed to favorably affect patient health outcomes.

Visit intermountainphysician.com to view CPMs.

- Select “Clinical Programs” from the “Tools & Resources” drop-down menu
- Select “Care Process Models (CPMs)”
- Click on the specific condition

You can request a hard copy of a CPM by calling Intermountain Patient and Provider Publications at 801-442-2963.

WE RECENTLY UPDATED INFORMATION FOR THE FOLLOWING CONDITIONS:

ADHD

- Updated Intermountain measures (Page 1)
- Updated diagnosis information based on the DSM-5 (Page 2)
- Updated substance use disorder screening, using the modified quick screen from the National Institute of Drug Abuse (NIDA) (Page 5)
- Updated medication information (Page 10)
- Added a tool to help parents, clinics, and schools collaborate to address children’s mental health problems using the Mental Health Inventory (MHI) (Page 14)

Depression

- Updated suicide risk assessment, using the Columbia-Suicide Severity Rating Scale (C-SSRS) and safety plan for at-risk patients (Page 6)
- Updated substance use disorder screening, using the modified quick screen from the National Institute of Drug Abuse (NIDA) (Page 8)
- Updated medication information (Pages 12-14)
- Updated information on screening and treatment in children (Pages 22-23)

Asthma

- Updated medication information (Page 13)
- Updated patient education (Page 16)
- Updated advice on key topics, including the following:
  - It is not necessary to avoid certain foods or delay their introduction to prevent asthma and allergic disease in young children
  - Especially for young children, prescribe the minimal corticosteroid dose required to achieve asthma control, but at the same time try to avoid the use of oral steroids
  - Monitor patient use of over-the-counter triamcinolone (nasal steroid spray)

Adult Diabetes Mellitus (changes based on 2015 ADA Standards)

- New screening recommendations for Asian Americans (Page 5)
- New emphasis on limiting sedentary time (Page 9)
- New recommendations on diabetes in remission (Page 9)
- SGLT2 inhibitors as additional medication for glycemic control (Page 13)
- Statin treatment driven primarily by cardiovascular risk status, not by LDL level (Page 20)
- Diastolic BP goal at 90 mmHg (Page 22)

Choosing Wisely – Upper Endoscopy

Upper endoscopy is commonly used in the diagnosis and management of gastroesophageal reflux disease (GERD). Patients are frequently referred for procedures despite recent studies suggesting as many as 38 percent of these procedures are not medically necessary. In fact, 39.4 percent of procedures referred by primary care physicians and 33.3 percent initiated by gastroenterologists did not adhere to the 2012 recommendations of the American College of Physicians (ACP).
Evidence demonstrates that procedures are indicated only in certain situations, and inappropriate use generates unnecessary costs and exposes patients to harms without improving outcomes.

The Clinical Guidelines Committee of the American College of Physicians reviewed evidence regarding the indications for, and yield of, upper endoscopy in the setting of GERD, and to highlight how clinicians can increase the delivery of high-value healthcare.

**Best Practice Advice 1:** Upper endoscopy is indicated in men and women with heartburn and alarm symptoms (dysphagia, bleeding, anemia, weight loss, and recurrent vomiting).

**Best Practice Advice 2:** Upper endoscopy is indicated in men and women with:

- Typical GERD symptoms that persist despite a therapeutic trial of four-to-eight weeks of twice-daily proton-pump inhibitor therapy
- Severe erosive esophagitis after a two-month course of proton-pump inhibitor therapy to assess healing and rule out Barrett esophagus. Recurrent endoscopy after this follow-up examination is not indicated in the absence of Barrett esophagus
- History of esophageal stricture who have recurrent symptoms of dysphagia

**Best Practice Advice 3:** Upper endoscopy may be indicated:

- In men older than 50 years with chronic GERD symptoms (symptoms for more than five years) and additional risk factors (nocturnal reflux symptoms, hiatal hernia, elevated body mass index, tobacco use, and intra-abdominal distribution of fat) to detect esophageal adenocarcinoma and Barrett esophagus
- For surveillance evaluation in men and women with a history of Barrett esophagus. In men and women with Barrett esophagus and no dysplasia, surveillance examinations should occur at intervals no more frequently than three to five years. More frequent intervals are indicated in patients with Barrett esophagus and dysplasia

Because in many instances patients are referred specifically for endoscopic procedures, SelectHealth and Intermountain Healthcare encourage providers to be aware of current evidence-based recommendations and adhere to them. These practices are shown to optimize patients’ outcomes with less risk for patient harm.

**Reference:**

1. Nicholas J. Shaheen, MD, MPH; David S. Weinberg, MD, MSc; Thomas D. Denberg, MD, PhD; Roger Chou, MD; Amir Qaseem, MD, PhD, MHA; Paul Shekelle, MD, PhD, for the Clinical Guidelines Committee of the American College of Physicians. "Ann Intern Med. 2012;157(11):808-816. doi:10.7326/0003-4819-157-11-201212040-00008"

**Choosing Wisely – Testing for Thyroid Disease**

Thyroid disease is common. Prevalence is estimated to be up to 9 percent of the population. Many patients are suspected to have thyroid disease, and appropriate laboratory testing is key for accurate diagnosing and minimizing unnecessary laboratory expense.

Medical organizations disagree on the role of population screening, as shown in the table below.

**Recommendations of Six Organizations Regarding Screening of Asymptomatic Adults for Thyroid Dysfunction**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Screening Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Thyroid Association</td>
<td>Women and men older than 35 should be screened every five years</td>
</tr>
<tr>
<td>American Association of Clinical Endocrinologists</td>
<td>Older patients, especially women, should be screened</td>
</tr>
<tr>
<td>American Academy of Family Physicians</td>
<td>Patients ages 60 and older should be screened</td>
</tr>
<tr>
<td>American College of Physicians</td>
<td>Women ages 50 and older with an incidental finding suggestive of symptomatic thyroid disease should be evaluated</td>
</tr>
<tr>
<td>U.S. Preventive Services Task Force</td>
<td>Insufficient evidence for or against screening</td>
</tr>
<tr>
<td>Royal College of Physicians of London</td>
<td>Screening of the healthy adult population unjustified</td>
</tr>
</tbody>
</table>

Most guidelines including the U.S. Preventive Task Force recommend against screening unless there are overt findings of thyroid disease.
The American Association of Clinical Endocrinologists suggests following these recommendations:

> While there is no consensus about population screening for hypothyroidism there is compelling evidence to support case finding for hypothyroidism in:

- Those with autoimmune disease, such as type 1 diabetes (20,21)
- Those with pernicious anemia (109,110)
- Those with a first-degree relative with autoimmune thyroid disease (19)
- Those with a history of neck radiation to the thyroid gland, including radioactive iodine therapy for hyperthyroidism and external beam radiotherapy for head and neck malignancies (111-113)
- Those with a prior history of thyroid surgery or dysfunction
- Those with an abnormal thyroid examination
- Those with psychiatric disorders (114)
- Patients taking amiodarone (37) or lithium (32-34)
- Patients with ICD-9 diagnoses as presented in Table 9

### Table 9

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrenal insufficiency</td>
<td>E271</td>
</tr>
<tr>
<td>Addisonian crisis</td>
<td>E272</td>
</tr>
<tr>
<td>Drug-induced adrenocortical insufficiency</td>
<td>E273</td>
</tr>
<tr>
<td>Adrenocortical insufficiency, unspecified</td>
<td>E2740</td>
</tr>
<tr>
<td>Adrenocortical insufficiency, other</td>
<td>E2749</td>
</tr>
<tr>
<td>Postprocedural adrenocortical (-medullary) hypofunction</td>
<td>E896</td>
</tr>
<tr>
<td>Androgenic alopecia, unspecified</td>
<td>L649</td>
</tr>
<tr>
<td>Nutritional anemia, unspecified</td>
<td>D539</td>
</tr>
<tr>
<td>Nonscarring hair loss, unspecified</td>
<td>L659</td>
</tr>
<tr>
<td>Cardiac arrhythmia, unspecified</td>
<td>I499</td>
</tr>
<tr>
<td>Changes in skin texture</td>
<td>R234</td>
</tr>
<tr>
<td>Unspecified systolic (congestive) heart failure</td>
<td>I5020</td>
</tr>
<tr>
<td>Acute systolic (congestive) heart failure</td>
<td>I5021</td>
</tr>
<tr>
<td>Chronic systolic (congestive) heart failure</td>
<td>I5022</td>
</tr>
<tr>
<td>Acute on chronic systolic (congestive) heart failure</td>
<td>I5023</td>
</tr>
<tr>
<td>Unspecified diastolic (congestive) heart failure</td>
<td>I5030</td>
</tr>
<tr>
<td>Acute diastolic (congestive) heart failure</td>
<td>I5031</td>
</tr>
<tr>
<td>Chronic diastolic (congestive) heart failure</td>
<td>I5032</td>
</tr>
<tr>
<td>Acute on chronic diastolic (congestive) heart failure</td>
<td>I5033</td>
</tr>
<tr>
<td>Unspecified combined systolic (congestive) and diastolic (congestive) heart failure</td>
<td>I5040</td>
</tr>
<tr>
<td>Acute combined systolic (congestive) and diastolic (congestive) heart failure</td>
<td>I5041</td>
</tr>
<tr>
<td>Chronic combined systolic (congestive) and diastolic (congestive) heart failure</td>
<td>I5042</td>
</tr>
<tr>
<td>Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure</td>
<td>I5043</td>
</tr>
<tr>
<td>Heart failure, unspecified</td>
<td>I509</td>
</tr>
<tr>
<td>Constipation, unspecified</td>
<td>K5900</td>
</tr>
<tr>
<td>Dementia without behavioral disturbance, unspecified</td>
<td>FO390</td>
</tr>
<tr>
<td>Dementia with behavioral disturbance, unspecified</td>
<td>FO391</td>
</tr>
<tr>
<td>Diabetes mellitus without complications, type 1</td>
<td>E109</td>
</tr>
<tr>
<td>Dysmenorrhea, primary</td>
<td>N944</td>
</tr>
<tr>
<td>Dysmenorrhea, secondary</td>
<td>N945</td>
</tr>
<tr>
<td>Dysmenorrhea, unspecified</td>
<td>N946</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>E780</td>
</tr>
<tr>
<td>Hypertension, primary</td>
<td>I10</td>
</tr>
</tbody>
</table>

In almost all suspected cases of thyroid disease, the TSH level is the recommended initial screening test. This extremely sensitive assay changes exquisitely with minor alteration in free T4 levels.
The TSH assay should be used for diagnosis, evaluation of thyroid replacement in primary hypothyroidism, and for assessment of suppressive therapy in patients with thyroid cancer. If the TSH is abnormal or inappropriately normal in patients who are highly suggestive of having thyroid disease, a **free T4** is the preferred next diagnostic test used to confirm the clinical impression.

TSH testing alone **is NOT appropriate** in certain thyroid conditions. These include:

- Suspected secondary hypothyroidism – Free T4 level is the preferred test
- Pregnancy – Serum total T4 is recommended due to alteration in serum protein in pregnancy
- Subclinical hypothyroidism – An additional Free T4 level will assist in determining those with overt thyroid disease if the TSH is 4.5-10
- Assessing recent anti-thyroid medication, surgical, or radioactive treatment for hyperthyroidism – Free T4 is the optimal test because TSH may remain low for many weeks to months

In addition, thyroid tests should be discouraged in hospitalized patients due to changes in both TSH and free T4 in critically ill patients. It is recommended to perform testing only in patients who have a high likelihood of thyroid disease.

Certain thyroid tests have no basis in screening or routine monitoring of most patients with thyroid disease. These include: total T3, free T3, and reverse T3. Patients taking desiccated thyroid extract such as “Armour Thyroid” should have treatment adjusted using the TSH result.

To assist in managing your thyroid patients, use the algorithm for thyroid testing developed by ARUP laboratory. It is a useful tool for appropriate and cost-effective laboratory testing for thyroid conditions.

**HEDIS Measurement: Human Papillomavirus (HPV) Vaccine for Female Adolescents**

The human papillomavirus (HPV) vaccine prevents certain cancers and other diseases caused by HPV. Typically, initial infection with HPV occurs in the teens or early twenties. Every year in the United States, approximately 17,600 women get cancer that is linked with HPV; cervical cancer is the most common form. A recent study by the CDC showed that the HPV vaccine is remarkably effective against the virus and helped to lower HPV infection rates in teen girls by half.

The HEDIS measure associated with HPV vaccine administration calculates the percentage of female adolescents who had three doses of the HPV vaccine by age 13.

**Utah Commercial Products – Percent of female adolescents who had 3 vaccine doses by age 13**

**Idaho Commercial Products – Percent of female adolescents who had 3 vaccine doses by age 13**

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References:
1. American Association of Clinical Endocrinologists
2. American Thyroid Association
3. U.S. Preventive Task Force
4. American Association for Clinical Pathology
5. ARUP Clinical Laboratory
We support the HEDIS measurement in the following ways:

- Implementing an interactive voice response telephone system to deliver education and encourage parents to immunize their adolescent turning 12 if adolescent vaccines have not been completed
- Publishing quarterly mailings to the 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
- Displaying clinic immunization results for adolescents on the reports page of the provider website
- Sending monthly reports to providers listing their SelectHealth members turning 12 who have not completed their adolescent vaccines

For more information on HPV results, or to learn more about other SelectHealth Quality Improvement programs, contact the Quality Improvement department at 800-374-4949, or via email at qualityimprovement@selecthealth.org.

Reference:
Human Papillomavirus Vaccine (HPV) for Female Adolescents

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

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

SelectHealth Mobile App

Members can access useful tools and data whenever—and wherever—they need it.

Members can:

- View, fax, or email SelectHealth ID Cards
- Search for participating doctors and facilities
- Access EOBs, determine amounts owed, and more
- Find out who is covered on their plans and view benefits
- Look at year-to-date medical and dental expenses
- See how medications are covered on their plan

Whether a member forgets his SelectHealth ID Card or needs to find out if a doctor is covered on her plan, the app makes it easy to get this information before leaving your office. And more informed, better prepared members can help your practice operate more efficiently.

The SelectHealth app is available on Apple App® and Google Play® stores.

Save Time with EDI Transactions

Electronic Data Interchange (EDI) transactions provide an efficient and secure way to send and receive information. EDI transactions are sent via a secure connection through the Utah Health Information Network (UHIN). Rather than sending claims through the U.S. Postal Service or taking the time to call Member Services, EDI real-time and certain batch transactions deliver results within seconds. Additionally, you can request batch information for most payers. This means, for payers that participate with UHIN, you can receive benefits and eligibility information on all of your next day’s scheduled appointments in one transaction.
Review the following transactions to see how EDI can make your practice more efficient.

> 837 – Claims Submission
> 999 – Claims Submission Acknowledgement
> 277CA – Individual Claim Acknowledgement
> 835 – Electronic Remittance Advice
> 270/271 – Eligibility and Benefit Inquiry/Response
> 276/277 – Claim Status Request and Response

To initiate participation on any EDI transaction with SelectHealth, call the SelectHealth EDI team at 800-538-5099. Find more information on the EDI section of our website. You’ll also find enrollment forms for ERA and EFT as well as companion guides for 270/271 and 276/277 transactions.

**Accessing Claims and Member Information Online via Secure Provider Benefit Tool**

We offer a secure online portal to view claims or member benefits and eligibility. Accessing this data online means your office staff can research information when it’s convenient for them, and they can be sure they are viewing private health information in a secure network.

To set up access to your patients’ claims and eligibility information online, visit selecthealthphysician.org and follow the instructions in the lower-left corner of the page. Complete and return the forms provided to receive your secure access.

Find more details on the “Click here to get started” page, where you can view information on accessing eligibility, benefits, and claims data.

**Coding Tips: Modifiers 59 and 25**

We often see appeals for claims on which modifiers are not being used appropriately. To prevent upfront denials and unnecessary backend work, please review claims to ensure they are coded appropriately the first time and the appropriate modifiers are appended based on supporting documentation. The most common appeals we see are for missing or misused Modifier 59 on integumentary codes (10000-19999) and Modifier 25 on Evaluation and Management procedures.

**MODIFIER 59 AND LESION REMOVALS AND BIOPSIES**

**Definition** – Distinct Procedures Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures or services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than Modifier 59. Only if a more descriptive modifier is not available, and the use of Modifier 59 best explains the circumstances, should Modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see Modifier 25.

Lesion removal includes obtaining a biopsy or debridement of the wound, as well as simple and intermediate-level repairs. Coding for the removal depends on the description of the CPT code. Typically, one removal code is reported per lesion, but some code definitions indicate multiple lesions, such as CPT 17110, destruction of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions. In addition, according to NCCI guidelines, if multiple lesions are removed in a single procedure (e.g., single excision of skin containing three nevi), only one code should be reported.
The physician can use different techniques, but if one method is converted to another method to complete the procedure, the provider should only report the code that describes the completed procedure.

If multiple lesions are removed separately, coders can often report multiple codes, depending on the CPT code and the type of procedure the provider performs. In these cases, coders should append the appropriate anatomical modifiers or Modifier 59 to indicate different sites or lesions. The medical record must document the appropriateness of reporting multiple HCPCS/CPT codes with these modifiers.

**MODIFIER 25**

**Definition** – Significant, separately identifiable Evaluation and Management (E/M) service by the same physician* on the day of a procedure.

*Same physician, as defined by CMS – “Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. Mid-levels will be considered the same specialty.”

All E/M services provided on the same day as a procedure are part of the procedure and will only be paid separately if an exception applies.

**Appropriate Usage**

- Modifier 25 indicates that on the day of a procedure, the patient’s condition required a significant, separately identifiable E/M service, above and beyond the usual pre- and post-operative care associated with the procedure or service performed.
- Use Modifier 25 with the appropriate level of E/M service.
- The procedure performed has a global period listed on the Medicare Fee Schedule Relative Value File. This global period could be 000, 010, or 090 days.
- An E/M service may occur on the same day as a procedure and within the post-operative period of a previous procedure. Medicare allows payment when the documentation supports Modifier 25 and Modifier 24 (unrelated E/M during a post-operative period).

- Use Modifier 25 in the rare circumstance of an E/M service the day before a major surgery that is not the decision for surgery and represents a significant, separately identifiable service.

**Inappropriate Usage**

- Reported by a physician other than the one performing the procedure.
- Documentation shows the amount of work performed is consistent with the work normally performed with the procedure.

The following statements are false for Modifier 25:

- I can always use this modifier when I did not plan the procedure.
- I can always use this modifier when the diagnoses are different.
- I can never use this modifier when the diagnoses are the same.

SELECTHEALTH ADVANTAGE

SelectHealth Requests for Confirmation of Diagnoses

Many primary care physicians will soon receive (or may have already received) a request from Cognisight to confirm that specific diagnoses for selected patients are complete and accurate. We have partnered with Cognisight to perform medical record reviews to capture diagnoses in patient records that were not submitted on claims. This effort is to satisfy a Centers for Medicare & Medicaid Services (CMS) requirement for health plans to compile and report complete diagnostic profiles annually for Medicare Advantage members. We ask that providers carefully review and determine which, if any, of the diagnoses listed on the form were recognized, considered, and/or treated during the referenced 2014 noted encounter. The form must be signed and dated within one year of the date noted at the top of the addendum form. If you have questions about this process, please contact Jason Brockett at 801-442-7977 or jason.brockett@selecthealth.org.

SelectHealth Advantage Members Receive Rewards for Healthy Behaviors

SELECTHEALTH ADVANTAGE REWARDS

We recently began a new program—SelectHealth Advantage Rewards—that rewards our members for visiting with their primary care provider and participating in healthy behaviors. Members can engage in a number of healthy activities and behaviors to earn points, which they can redeem for Visa gift cards. It’s that easy. The activities have different point values, with the most important activities given the highest point value. For example, members receive 50 points for going to their PCP for an Annual Wellness Visit, or 10 points for eating five fruits and vegetables a day for three weeks straight. For each activity members complete, they simply log in to the reward program portion of the website and tell us they have completed it.

The program is designed not just to provide additional incentives to help members maintain healthy lifestyles and manage any health conditions they may have, but also to reward them for healthy activities they are already doing. Over time we will add new activities to the program and give members additional opportunities to earn rewards.

HOW MEMBERS PARTICIPATE

It is simple to participate and all SelectHealth Advantage members are eligible for this program. From selecthealthadvantage.org, members click on the button to the right that says “Already a Member,” and then click on the “Go” button in the My Health section of the page. Members will need to log in to My Health (the same tool they can use to view online Explanations of Benefits, claims, or messages from their doctor) and click on the “Member Rewards” tab.

If members need help signing up for My Health, logging in, or have questions about how the program works, please have them contact Member Services at 855-442-9900. For members without access to a computer, or who don’t feel comfortable completing the information online, they can contact Member Services to track activities over the phone.
Fraud, Waste, and Abuse Training and Attestation Now Available

The Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage plans provide general compliance information and Fraud, Waste, and Abuse (FWA) training and education for all contracted providers—referred to by CMS as First-Tier, Downstream, and Related entities (FDRs). **All FDRs are required to complete the training within 90 days of employment/contracting and annually thereafter.**

We have posted links to the approved training and to the attestation document on our [SelectHealth Advantage website](selecthealthadvantage.org). You may complete the training offered by CMS or other insurers that meet the CMS requirements.

If you are enrolled in Part A or B of the Medicare program as a provider, you have satisfied the FWA training requirement and you do not need to retake the FWA section of the training. However, you still need to review the compliance information and submit the attestation.

Visit [selecthealthadvantage.org](selecthealthadvantage.org) to review the compliance information, take the SelectHealth General Compliance and FWA Training, and submit the attestation. You can also access this site from [selecthealthphysician.org](selecthealthphysician.org). Click on “SelectHealth 2015 Fraud, Waste, and Abuse Training” in the “Education Opportunities” box.

As a reminder, CMS requires that you and each of your employees that support the SelectHealth Advantage program take the training annually. Employees can take the training individually or as a group of employees. Submit the attestation of completion via the same website.

Please note that FDRs are required to maintain training records for themselves and their employees for no fewer than ten years. SelectHealth and/or CMS may request evidence of completion from FDR organizations for these courses. Evidence may include training logs with dates and certificates of completion, sign-in sheets, attestations, or other methods to demonstrate fulfillment of the obligation.

If you have any questions about the FWA training or attestation, contact your Provider Relations representative at **800-538-5054** or [providerrelations@selecthealth.org](mailto:providerrelations@selecthealth.org).
## MEDICAL POLICY AND NEW TECHNOLOGY ASSESSMENT

### Medical Policy Update Bulletin

The following table provides quarterly notice of recently approved and/or reviewed medical policies. On this bulletin you may view new and/or revised medical policies in their entirety, along with an overview or summary of changes. The appearance of a policy in the Medical Policy Update Bulletin indicates that we have recently adopted or revised it. The bulletin does not indicate that we provide 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.

<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>563</td>
<td>Total Body MRI For Li-Fraumeni Syndrome (NEW)</td>
<td>04/21/15</td>
<td>New policy developed for total body MRI for patients diagnosed with Li-Fraumeni Syndrome. <strong>SelectHealth commercial plans</strong> cover total body MRI for cancer surveillance in patients diagnosed with Li-Fraumeni syndrome. <strong>SelectHealth Advantage</strong> covers MRI imaging consistent with Medical National Coverage Determination (NCD) 220.2. Because this NCD does not specifically address total body MRI for cancer surveillance in patients with Li-Fraumeni, commercial plan policy will apply specifically to this situation. <strong>SelectHealth Community Care</strong> covers total body MRI for cancer surveillance in patients with Li-Fraumeni syndrome. Because there are no Medicaid or InterQual guidelines that specifically address this service, commercial plan policy will apply. An exception to the usual Utah Medicaid noncovered status of CPT 76498 will be made in this situation.</td>
</tr>
<tr>
<td>565</td>
<td>Cryoablation for Desmoid Tumors (NEW)</td>
<td>06/02/15</td>
<td>New policy developed for cryoablation for the treatment of desmoid tumors. <strong>SelectHealth commercial plans</strong> do NOT cover cryoablation for the treatment of desmoid tumors as this procedure is considered unproven and not medically necessary. <strong>SelectHealth Advantage</strong> does NOT cover cryoablation for the treatment of desmoid tumors as there are no specific Medicare or InterQual guidelines for medical necessity that specifically address these services. SelectHealth commercial policy will apply. <strong>SelectHealth Community Care</strong> does NOT cover cryoablation for desmoid tumors as there are no Utah Medicaid or InterQual guidelines for medical necessity that specifically address these services. SelectHealth commercial policy will apply.</td>
</tr>
<tr>
<td><strong>REVISED POLICIES</strong></td>
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</tr>
<tr>
<td>444</td>
<td>Transcatheter Aortic Valve Implant (TAVI) Transcatheter Aortic Valve Replacement (TAVR) (REVISED)</td>
<td>04/03/15</td>
<td>Policy expanded to include coverage of transcatheter valve-in-valve aortic valve replacement when criteria are met.</td>
</tr>
<tr>
<td>453</td>
<td>Genetic Testing: Heritable Thoracic and Abdominal Aneurysm and Dissection (TAAD) Disorders (REVISED)</td>
<td>04/06/15</td>
<td>This policy replaces the policy on genetic testing for Marfan Syndrome and outlines criteria in which genetic testing is covered.</td>
</tr>
<tr>
<td>105</td>
<td>Human Stem Cell Transplantation (HSCT), Bone Marrow Transplantation (BMT) (REVISED)</td>
<td>03/19/15</td>
<td>Revision includes the following information from Federal Employee Health Benefits (FEHB): For FEHB plans only, the following are also covered: 1. Epithelial ovarian cancer 2. Childhood rhabdomyosarcoma 3. Advanced Ewing sarcoma 4. Aggressive non-Hodgkin’s lymphomas (mantle cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas, and aggressive dendritic cell neoplasms) 5. Advanced childhood kidney cancers 6. Mantle-cell (Non-Hodgkin’s) lymphoma</td>
</tr>
</tbody>
</table>
### REVISED POLICIES

<table>
<thead>
<tr>
<th>ID</th>
<th>Policy Description</th>
<th>Revision Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>227</td>
<td>Synthetic Skin Substitutes (REVISED)</td>
<td>04/21/15</td>
<td>• EpiFix Dehydrated Human Amnion/Chorion Member Allograft added as covered skin substitute.</td>
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<td>• Policy modified to list currently covered skin substitute products.</td>
</tr>
<tr>
<td>129</td>
<td>Hyperbaric Oxygen Therapy (REVISED)</td>
<td>06/02/15</td>
<td>Raynaud’s Phenomenon added as a noncovered indication.</td>
</tr>
<tr>
<td>150</td>
<td>Mohs Surgical Guidelines (REVISED)</td>
<td>05/25/15</td>
<td>Addition under <strong>Commercial Policy:</strong> Change criteria to clarify amount of tissue required to be removed and anatomical location to read:</td>
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<td>• In cosmetically sensitive areas where preservation of as much normal tissue as possible is important to maintain normal appearance and optimize the potential for cure, and to minimize the potential for recurrent surgery, <strong>if &gt;2 cm diameter tissue must be removed</strong></td>
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<td>• Skin cancers &gt;4.0 cm in diameter on any location</td>
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<tr>
<td>172</td>
<td>Reduction Mammoplasty (Breast Reduction) (REVISED)</td>
<td>05/08/15</td>
<td>Addition of “Documentation of signs and symptoms provided by a practitioner independent of the requesting surgeon’s practice” under criteria for coverage.</td>
</tr>
<tr>
<td>223</td>
<td>Continuous Glucose Monitoring (CGM) Systems with and without Real-Time Monitoring (REVISED)</td>
<td>05/04/15</td>
<td>Revision under “Replacements will only be allowed when all of the following criteria are met:</td>
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<td>• Documentation is provided demonstrating the member has used the device at least 50% of the time for a 30-day period within the past 90 days.</td>
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<td>• The member demonstrates stability or improvement in the A1C level.</td>
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<tr>
<td>492</td>
<td>Oral Appliances for Sleep Apnea (REVISED)</td>
<td>05/07/15</td>
<td>Under criteria for coverage:</td>
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<td></td>
<td>• #6- Addition of “Temporal Mandibular Joint Syndrome or other TMJ-related pathological processes insufficient dentition to support device stability.”</td>
</tr>
<tr>
<td>559</td>
<td>Sphenopalatine Ganglion (SPG) Injection in the Management of Headaches (REVISED)</td>
<td>05/15/15</td>
<td>Addition of new Medicare Local Coverage Determination (LCD) L34775 and L34779 under <strong>SelectHealth Advantage.</strong> Because these CMS LCDs do not list headaches as a covered diagnosis for these procedures, this procedure is not covered for this diagnosis.</td>
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<td><strong>SelectHealth Community Care</strong> language added:</td>
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<td>“SelectHealth Community Care does NOT cover sphenopalatine ganglion (SPG) block for acute and chronic headaches because SelectHealth has found this procedure to be not medically reasonable and necessary since current evidence is insufficient to determine the efficacy and safety. As there are no other Utah State Medicaid-specific guidelines or InterQual guidelines for sphenopalatine ganglion (SPG) block for acute and chronic headaches, commercial plan policy applies.</td>
</tr>
<tr>
<td>226</td>
<td>Radiofrequency Ablation (RFA) of the Dorsal Root Ganglion (DRG) of the Spine (REVISED)</td>
<td>05/15/15</td>
<td>Addition under <strong>SelectHealth Advantage:</strong> SelectHealth Advantage covers radiofrequency ablation of the dorsal root ganglion of the spine consistent with Medicare Local Coverage Determination (LCD) L34127, L33842, L34775, and L34779.</td>
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<td><strong>Addition under SelectHealth Community Care:</strong> SelectHealth Community Care covers non-pulsed radiofrequency rhizotomy of the cervical and lumbar spine. Since there are no Medicaid guidelines on these procedures, InterQual guidelines will apply.</td>
</tr>
<tr>
<td>265</td>
<td>Radiofrequency Ablation (RFA) for Back or Neck Pain (Radiofrequency Neurolysis, Facet Joint Rhizotomy) (REVISED)</td>
<td>05/15/15</td>
<td>Addition under <strong>SelectHealth Advantage:</strong> SelectHealth Advantage covers non-pulsed radiofrequency ablation (RFA) of the lumbar, thoracic, and cervical facet joints consistent with Medicare Local Coverage Determination (LCD) L34127, L33842, L34775, and L34779.</td>
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<td><strong>Addition under SelectHealth Community Care:</strong> SelectHealth Community Care covers non-pulsed radiofrequency rhizotomy of the cervical and lumbar spine when all of the medical necessity criteria are met according to the special note on Medicaid Coverage look-up tool, also available on the State of Utah Medicaid Program Medicaid Information Bulletin (January 2014, pages 14-34) and State of Utah Medicaid Provider Manual, (Section 2, page 35).</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 benefit coverage. Existing technologies are, at times, also examined through this process.

The following is a list of recent technologies reviewed and M-Tech committee recommendations:

<table>
<thead>
<tr>
<th>Technology</th>
<th>Date Reviewed*</th>
<th>Committee Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cryoablation for Desmoid Tumors</td>
<td>06/02/15</td>
<td>Not covered as unproven and not medically necessary. Current evidence regarding the efficacy and safety of cryoablation of desmoid tumors is very limited and of weak methodology.</td>
</tr>
<tr>
<td>Hyperbaric Oxygen Therapy for the Treatment of Raynaud’s Phenomenon</td>
<td>06/02/15</td>
<td>Not covered as investigational. Current evidence is insufficient to reach conclusions regarding the safety and efficacy of hyperbaric oxygen therapy (HBOT) in the management of Raynaud’s disease.</td>
</tr>
</tbody>
</table>

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

The M-Tech committee is actively assessing other technologies. Those currently scheduled for review are listed below. As the reviews are completed, notices will be sent to stakeholders informing them of the coverage determinations:

- Anterior lateral ligament repair of knee
- Cologuard® for colorectal cancer screening
- ConfirmMDx® prostate cancer test
- Decipher® prostate cancer classifier
- Enterra® gastric pacemaker for gastroparesis
- Hemorrhoid RFA ablation
- Iluvien stent for ocular conditions
- iStent for Glaucoma
- Ligament-Sparing Knee Replacement Devices (e.g., Biomet Vanguard XP Knee)
- MAGEC®/VEPTR™ for juvenile spinal deformities
- Magnetic resonance-guided focused ultrasound (MRgFUS) for bone cancer
- Magnetic resonance-guided focused ultrasound (MRgFUS) for prostate cancer
- Magnetic resonance-guided focused ultrasound (MRgFUS) for uterine fibroids
- Oncotype DX® colon
- Prolaris® for prostate cancer
- Propel stent for chronic sinusitis
- Prosigna® breast cancer gene expression profile
- Psych med genetic testing
- RFA of low-grade dysplasia in Barrett’s esophagus
- SIRT for liver cancer
- SphenoCath SPG® block for migraine management
- Sublingual immunotherapy
- VBL® for weight loss
- Vermillion OVA1® for ovarian cancer

If you have questions regarding coverage of these or any other technologies or procedures, or if you would like us to consider coverage for an emerging technology, please email us at mtech@selecthealth.org or call 801-442-7585.

You can view all SelectHealth medical policies and technology assessments at selecthealthphysician.org. Click on “Policies and Procedures” to be directed to links for Medical Policies, Reimbursement and Coding Policies, and Medical Technology Reviews.