Welcome to the Provider Insight® newsletter. This newsletter includes medical, and pharmacy information; as well as updates that pertain to our commercial and SelectHealth Advantage® (Medicare) plans. Please encourage each provider and member of your staff to review the newsletter for important information that affects those covered by a SelectHealth policy.

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Simplify Your Preauthorization Process

Like you, we are dedicated to promoting the use of evidence-based medicine and the appropriate utilization of services. Preauthorizations help confirm the right care is given at the right time and in the right setting—every time.

Discuss the following tips and reminders with your office staff to ensure your preauthorizations are submitted when required, and consequently processed in a timely manner.

Tips:

> View the list of procedures/services that require preauthorization. Bookmark this page and refer to it often. Be sure to view the list specific to the patient’s SelectHealth policy.

> Request access to CareAffiliate*, our electronic preauthorization tool, if you don’t currently have it. CareAffiliate enables providers to submit preauthorization requests and supporting documentation online rather than through fax or email. The online functionality improves the accuracy, security, and speed with which requests are reviewed.
  * To request access for CareAffiliate, complete and submit an Online Login Application, making sure to select the “Add: CareAffiliate” box for each user. A training video and additional instructions are provided on the secure CareAffiliate site after access is granted.

> Submit a Request for Preauthorization Form This form is required for all preauthorization requests for all SelectHealth members—unless the request is made through CareAffiliate. Forms are available for medical, substance-related, and psychiatric-related services.

> Always include the appropriate medical coding (e.g., ICD-10 or CPT) with your request.

Reminders:

> Documentation supporting the medical necessity of the procedure must be submitted with the request.

> Services will only be covered when required preauthorizations are obtained prior to the service being rendered. Claims from participating providers for services requiring preauthorization that are not preauthorized will be denied to the provider and facility.
  * Services will only be approved for procedures that meet clinical criteria.
  * Applicable payments will be made in accordance with the member’s plan materials.

> If you have questions about the preauthorization process, call:
  * Commercial plans: 800-538-5038
  * SelectHealth Advantage: 855-442-9900

COMING SOON

Our Provider Benefit Tool is being updated to offer increased functionality and a more intuitive user experience. This tool provides a convenient method to view secure member claims and remittance information online. We look forward to introducing the redesigned Provider Benefit Tool later this spring.
Revised Preventive Care Guidelines for Adolescents

Byline: Tamara Sheffield, MD, MPA, MPH

Our Preventive Care Guidelines for Adolescents ages 11-18 years have been revised for Utah and Idaho. The guidelines are revised and approved every two years. The Preventive Care Guidelines for children ages 0-10 years and adults ages 19 and older will be revised in 2018.

What is included in the guidelines?

The Adolescent Preventive Care Guidelines contains sections on screenings, health guidance, immunizations, and recommendations for sexually active adolescents; it also contains links to tools to assist in the delivery of preventive services. The guidelines are a synthesis of recommendations from the U.S. Preventive Services Task Force, primary care and specialty societies, and other expert groups. Immunization guidelines follow recommendations of the CDC’s Advisory Committee on Immunization Practices (ACIP).

What is new in the guidelines?

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

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

Where do I find the Adolescent Preventive Care guidelines?

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

Utah:

View preventive care guidelines at intermountainphysician.org/preventivecare

Idaho:

View preventive care guidelines at intermountainphysician.org/clinical/cpc/topics/preventivecare/idaho/Pages/home.aspx

Who do I talk to if I have questions about the guidelines?

Tamara Sheffield, MD, MPH, Medical Director, Community Health and Prevention

Email: tamara.sheffield@imail.org
Phone: 801-442-3946
Opioid Epidemic

Tyler Hemsley, PharmD, Pharmacy Program Coordinator, St. Luke’s Health Partners

Rather than take a “shock and awe” approach to the topic of the opioid epidemic, today I’m relying on the premise that the audience of this article finds themselves in the proverbial choir—that you are acutely aware of the climbing morbidity and mortality associated with opioids and heroin\(^1\). I’m also operating under the premise that providers, first and foremost, seek to “do no harm” and although there have been astounding advances in medical innovations that continue to propel us toward decreasing disease burden and improving the quality of life for people everywhere, sometimes we need to recognize where we’ve made a wrong turn. Regardless of your practice, specialty, or perspective on the current epidemic, “syndemic,” or crisis facing us today, there is no question that our collective approach to pain control over the past 20 years has contributed to the complex problem that now requires our attention and action.

Unfortunately, there is no silver bullet, no “one-size-fits all” solution here. The CDC has provided some new guidelines for prescribing opioids in the setting of chronic pain\(^4\), and over the past few years we certainly have examples of meaningful interventions, demonstrating that it is possible to make progress in the right direction. Generally, successful models incorporate a variety of approaches involving patient and provider education, prescription drug monitoring programs, and coordination among prescribers, payers, and pharmacy outlets\(^5\). As an example of hard fought success: In Ohio, an innovative, multifaceted approach by the VA system has shown a nearly 25% reduction in opioid prescribing. As one of the earliest states most impacted by opioid-related deaths, this effort has been underway since 2010. Their progress significantly outpaces the performance in the rest of the region and the national average\(^6\).

Many providers in Idaho have already been actively addressing this topic within their own practices and sharing the message more broadly. Good work is being done; lessons learned should be shared so new best practices can be identified. We cannot afford to wait on a national solution to this problem. I hope we view this as an opportunity to work together in a meaningful way to transform the way we deliver care and bring value to the communities we serve.

Thank you for your attention to this important topic and for the care you provide.

1. [cdc.gov/mmwr/volumes/66/wr/mm6643e1.htm](http://cdc.gov/mmwr/volumes/66/wr/mm6643e1.htm)
2. [cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm](http://cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm)
3. [cdc.gov/mmwr/volumes/66/wr/mm6634a2.htm](http://cdc.gov/mmwr/volumes/66/wr/mm6634a2.htm)
4. [cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm](http://cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm)
5. [ncbi.nlm.nih.gov/pmc/articles/PMC4106581/](http://ncbi.nlm.nih.gov/pmc/articles/PMC4106581/)
YMCA Diabetes Prevention Program

The YMCA® offers a 16-week program for those at risk for developing diabetes. The program is available in the following communities: Treasure Valley, McCall, Mountain Home, Twin Falls, and Wood River Valley.

THE PROGRAM INCLUDES:

> Attending weekly sessions with a group of 12 to 15 participants
> Interacting with a lifestyle coach who can help with behavior change
> Participating in weekly discussions on healthy eating and physical activity, and hearing from guest speakers such as dietitians and personal trainers
> Receiving a four-month YMCA membership for the duration of the program. If participants would like to continue the membership after the program, the YMCA will waive the start-up fee and can offer financial assistance to those who qualify

CRITERIA TO PARTICIPATE

> Must be at least 18 years old AND
> Must have a BMI of ≥ 25. Asian individual(s) BMI > 22 and one of the blood values OR
> Must have a BMI of ≥ 25. Asian individual(s) BMI > 22 and score 9 or greater on the risk assessment

BLOOD VALUE/DIAGNOSIS QUALIFICATIONS

1. A1c test between 5.7 and 6.4 percent
2. Fasting plasma glucose between 100 to 125 mg/dL
3. Two-hour (75 gm glucola) plasma glucose between 140 to 199 mg/dL
4. Prediabetes determined by Gestational Diabetes Mellitus (GDM) clinical diagnosis during previous pregnancy

Cost: The full cost of the program will be covered by SelectHealth upon completion of the program. Participation of the program qualifies the member for the reimbursement of $240 per year under their wellness benefit.

The most effective outcomes involve a collaboration between members, providers, and the program sponsors. If you have a patient who may benefit from the YMCA Diabetes Prevention Program, please work with him or her to learn more at ymcatvidaho.org.

If you have questions about these benefits, please call Member Services at 800-538-5038.

Increase Efficiency With Electronic Remits and Payments

SelectHealth offers the 835 Electronic Remittance Advice and Electronic Funds Transfer (EFT) transactions to providers. The 835 allows for auto posting of claim payments, reducing manual work and improving accuracy. The addition of EFT saves time spent going to the bank to make deposits and increases the security of payments. Please visit our secure website to request the 835 and EFT.

If you are already set up for the 835 or the 835 plus EFT with SelectHealth and continue to receive paper remittance advices or checks, please contact our EDI department at 800-538-5099.
Update to Outpatient Prospective Payment System and Ambulatory Surgical Center Policies

We revised Medical Policies #587 and #67 (see below) to allow certain procedures to be performed as either inpatient or outpatient.

During a comprehensive review of codes designated as inpatient-only procedures by CMS, a number of procedures were identified that can safely be performed in an outpatient setting.

Performance of the procedures listed below in an outpatient, office, or ambulatory surgical center setting is considered Investigational/Experimental because the safety and efficacy of performing the procedures in these settings is not established. Codes not listed in these policies will be covered on an outpatient basis as determined appropriate by the physicians performing the service. Please refer to Medical Policy #587 OPPS (Hospital Outpatient Prospective Payment System) and ASC (Ambulatory Surgical Center) Services Only Covered Inpatient or Coding and Reimbursement Policy #67 OPPS (Hospital Outpatient Prospective Payment System) And ASC (Ambulatory Surgical Center) Services Only Covered Inpatient for more details.

If you have any questions, call Provider Development at 800-538-5054.

SELECTHEALTH ADVANTAGE (MEDICARE)

Prohibition on Balance Billing Qualified Medicare Beneficiary Program Individuals

The Qualified Medicare Beneficiary (QMB) program is a Medicaid benefit that covers Medicare deductibles, coinsurance, and copayments. Medicare providers may not balance bill QMB beneficiaries for Medicare cost-sharing.

State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copays. However, federal law allows states to limit provider reimbursement for Medicare cost-sharing under certain circumstances.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services to a QMB beneficiary. Federal law bars Medicare providers from balance billing a QMB beneficiary under any circumstances. Medicare providers who violate these billing prohibitions may be subject to sanctions.

Be Aware of These QMB Balance-Billing Guidelines

It is imperative that you are aware of these policy clarifications to ensure compliance with QMB balance billing requirements.

> All original Medicare and Medicare Advantage providers—not only those that accept Medicaid—must abide by the balance-billing prohibitions.

> QMB individuals keep their protection from balance billing when they cross state lines to receive care. Providers cannot charge QMB beneficiaries, even if the patient’s QMB benefit is provided by a different state than the state in which the care is rendered.

> QMB beneficiaries cannot choose to waive their QMB status and pay Medicare cost-sharing.
What We Are Doing

> SelectHealth Member Services representatives will inform you of the QMB status if you call for benefits.

> “QMB” is displayed in the COB field in online eligibility inquiries, whether through the secure Provider Portal or through a 270/271 EDI transaction.

How You Can Help

By taking proactive steps to identify the QMB beneficiaries you serve and communicating with state Medicaid agencies (and Medicare Advantage plans if applicable), you can promote compliance with QMB balance-billing prohibitions.

> Determine effective means for identifying QMB beneficiaries among your patients. Find out what cards are issued to QMB beneficiaries so you can ask your patients if they have them. You can also contact Medicare Advantage plans to determine how to identify the plan’s QMB enrollees.

> Distinguish which billing processes apply in seeking reimbursement for Medicare cost-sharing from the states in which you operate.

> Ensure your billing software and administrative staff exempt QMB beneficiaries from Medicare cost-sharing billing and related collection efforts.

More Information

For more information about dual-eligible categories and benefits, please visit Medicare-Medicaid General Information. For more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please see the Medicare Learning Network® publication titled “Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs.”

CODING AND REIMBURSEMENT, AND MEDICAL POLICIES

Anesthesia Coding Updates

The following anesthesia codes terminated on December 31, 2017: CPT 00740 Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum and CPT 00810 Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum.

These codes are replaced, effective January 1, 2018, with CPT 00812 Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy, as well as the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>00731</td>
<td>Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified</td>
</tr>
<tr>
<td>00732</td>
<td>Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography</td>
</tr>
<tr>
<td>00811</td>
<td>Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified</td>
</tr>
<tr>
<td>00813</td>
<td>Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum</td>
</tr>
</tbody>
</table>

Medical Policy #51 Anesthesia (General & MAC) With Colonoscopies and Other Endoscopic Examinations was updated to reflect the coding changes. View this policy, along with all of our policies on our secure website. For more information about anesthesia codes and other coding updates, visit cms.gov—and be sure to refer to the 2018 version of your coding books.

PHARMACY

Pharmacy News

Please take a few minutes to read the latest Pharmacy & Therapeutics newsletter. The newsletter, updated quarterly, contains valuable information regarding pharmacy benefits and industry news.
# Coding and Reimbursement Policy Bulletin

A quarterly notice of recently approved and revised Coding and Reimbursement Policies is provided for your review. By accessing the Coding and Reimbursement Policy Update Bulletin, you may view new and revised Coding and Reimbursement policies in their entirety, along with an overview or summary of changes. The appearance of a policy in the Coding and Reimbursement Policy Update Bulletin indicates that SelectHealth has recently adopted or revised a Coding and Reimbursement Policy. The Coding and Reimbursement 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 Coding and Reimbursement 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>
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</thead>
<tbody>
<tr>
<td>06</td>
<td>Preventive Care and Screening Guidelines (Revised)</td>
<td>01/01/2018</td>
<td>SelectHealth Commercial&lt;br&gt;00812 - Anesthesia for a screening colonoscopy is covered once every 5 years effective 01/01/2018&lt;br&gt; SelectHealth Advantage&lt;br&gt;00812 - Anesthesia for a screening colonoscopy is covered once every 2 years effective 01/01/2018</td>
</tr>
<tr>
<td>07</td>
<td>IV Moderate Conscious Sedation (Revised)</td>
<td>01/01/2018</td>
<td>SelectHealth Commercial&lt;br&gt;We will no longer bundle moderate conscious sedation codes 99151, 99152, 99153, 99155, 99156, and 99157 with codes formerly listed in Appendix G of the Current Procedural Terminology (CPT) 2016 manual effective for dates of service 01/01/2018 or later. For dates of service prior to 01/01/2018, the reimbursement for conscious sedation will continue to bundle all codes listed in Appendix G of the Current Procedural Terminology (CPT) 2016 manual.</td>
</tr>
<tr>
<td>42</td>
<td>Preventive and Medical EM services (Revised)</td>
<td>01/01/2018</td>
<td>SelectHealth Commercial&lt;br&gt;Additional verbiage has been added to clarify that CPT 96127 will not be paid when billed in conjunction with a preventive exam, as this service should be included in a preventive exam.</td>
</tr>
<tr>
<td>51</td>
<td>Anesthesia with Colonoscopies and Other Endoscopic Exams (Revised)</td>
<td>01/01/2018</td>
<td>SelectHealth Commercial&lt;br&gt;New CPT 00812 with effective date 01/01/2018 has been added to the policy and will not require review to be paid. SelectHealth Advantage&lt;br&gt;New CPT 00812 with effective date 01/01/2018 has been added to the policy and will not require review to be paid.</td>
</tr>
<tr>
<td>67</td>
<td>Ambulatory Surgical Center Covered Services (Revised)</td>
<td>10/06/2017</td>
<td>SelectHealth Commercial&lt;br&gt;SelectHealth will allow some procedures that are designated as inpatient-only to be performed in an outpatient setting. Appendix A of Medical Administrative policy #587 lists the procedures that SelectHealth will cover only when performed as inpatient procedures.</td>
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</table>

All SelectHealth medical policies can be viewed on selecthealthphysician.org. Select “Secure Content Login” and enter your log-in information, then select “Policies and Procedures.”
Medical Policy Bulletin

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

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<tbody>
<tr>
<td><strong>NEW POLICIES</strong></td>
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<tr>
<td>598</td>
<td>Total Knee Arthroplasty (New)</td>
<td>01/01/2018</td>
<td>Commercial Plan SelectHealth covers total knee arthroplasty (TKA) when the criteria outlined in Medical Policy #598 are met. SelectHealth does NOT cover robotic-assisted TKA (e.g., makoplasty or RIOS), as there is a lack of evidence to demonstrate clinically meaningful differences in outcomes for patients undergoing TKA using these technologies. Use of these technologies is considered investigational.</td>
</tr>
<tr>
<td>599</td>
<td>Total Hip Arthroplasty (New)</td>
<td>01/01/2018</td>
<td>Commercial Plan SelectHealth covers total hip arthroplasty (THA) when the criteria outlined in Medical Policy #599 are met. SelectHealth does NOT cover robotic-assisted THA (e.g., makoplasty or RIOS), as there is a lack of evidence to demonstrate clinically meaningful differences in outcomes for patients undergoing THA using these technologies. Use of these technologies is considered investigational.</td>
</tr>
<tr>
<td>612</td>
<td>Varicocele Repair (New)</td>
<td>10/03/2017</td>
<td>Commercial Plan SelectHealth covers microsurgical varicocelectomy as an acceptable alternative method of treating a varicocele when any of the criteria outlined in Medical Policy #612 are met. SelectHealth covers percutaneous embolization (by means of balloon or metallic coil) for the treatment of varicocele when any of the criteria outlined in Medical Policy #612 are met. SelectHealth does NOT cover surgical treatment (ligation, embolization) for subclinical varicocele as it is considered experimental and investigational because of insufficient evidence to support its effectiveness.</td>
</tr>
<tr>
<td>619</td>
<td>Colonic Manometry (New)</td>
<td>10/02/2017</td>
<td>Commercial Plan SelectHealth does NOT cover colonic manometry (colonic motility studies), as this testing is considered investigational/experimental since clinical utility has not been established.</td>
</tr>
<tr>
<td><strong>REVISED POLICIES</strong></td>
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<tr>
<td>101</td>
<td>Alcohol Ablation Septal Reduction (Transcoronary Ablation of Septal Hypertrophy and Percutaneous, Transluminal Septal Myocardial Ablation) (Revised)</td>
<td>10/19/2017</td>
<td>Commercial Plan We added Class II under the New York Heart Association (NYHA) classification to criterion #1.</td>
</tr>
<tr>
<td>125</td>
<td>Heart Transplant: Adult (Revised)</td>
<td>10/12/2017</td>
<td>Commercial Plan Morbid obesity and advanced hepatic disease have been separated to create distinct criteria.</td>
</tr>
<tr>
<td>168</td>
<td>Laser Treatment of Congenital Hemangiomas (Port Wine Stain) (Revised)</td>
<td>10/02/2017</td>
<td>Commercial Plan We added another area considered of functional importance by the plan “#3 Any port wine stain area to resolve a functional problem associated with pain, discomfort, or bleeding.”</td>
</tr>
<tr>
<td>169</td>
<td>Private Duty Nursing (Revised)</td>
<td>10/19/2017</td>
<td>Commercial Plan Under the exceptions to limitations, after acute hospitalization, we added “or temporary extensions to cover a short-term gap.”</td>
</tr>
<tr>
<td>Policy Number</td>
<td>Policy Name</td>
<td>Effective Date</td>
<td>Summary of Change</td>
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</table>
| 222          | Genetic Testing: Inheritable Colon Cancer (Revised)                         | 09/25/2017     | **Commercial Plan**  
Gardner Syndrome was added under the high-risk syndromes.                                                                                                                                                                                                                                                                                     |
| 233          | Computerized Microprocessor-Controlled Knee Prostheses (Ottobock-C Leg, Endolite Adaptive Prosthesis, Ossur Prosthesis) (Revised) | 08/21/2017     | **Commercial Plan**  
SelectHealth covers microprocessor-controlled knee prostheses when criteria outlined in Medical Policy #233 are met.                                                                                                                                                                                                                       |
| 241          | Transcranial Magnetic Stimulation for Depression and Other Psychiatric Disorders (Revised) | 11/02/2017     | **Commercial Plan**  
TMS is now covered if the following criteria are met:  
SelectHealth covers unilateral repetitive transcranial magnetic stimulation (TMS) for depression and other psychiatric disorders if ALL criteria outlined in Medical Policy #241 are met.  
SelectHealth does NOT cover unilateral repetitive TMS for behavioral health indications not specified in the Medical Policy, as it is considered investigational.  
SelectHealth does NOT cover bilateral repetitive TMS for ANY behavioral health condition as it is unproven.                                                                                                                                                               |
| 265          | Radiofrequency Ablation (RFA) for Back or Neck Pain (Radiofrequency Neurolysis, Facet Joint Rhizotomy) (Revised) | 09/26/2017     | **Commercial Plan**  
More up-to-date guidelines through the American College of Physicians/American Pain Society were added to the policy rather than using the Agency for Health Care Policy and Research (AHCPR).  
Condition #1 now states:  
"Patient has experienced moderate to severe lower back (lumbosacral) OR neck (cervical) pain limiting activities of daily living for at least 3 months in the current episode, and is unrelieved by more conservative medical management strategies recommended by the American College of Physicians/American Pain Society."  |
| 295          | Bariatric Surgery Guidelines (Revised)                                       | 09/15/2017     | **Commercial Plan**  
SelectHealth now covers biliopancreatic bypass with or without duodenal switch for members who have a bariatric rider and meet criteria. Please see the policy for the list of criteria.                                                                                                                                                                                                 |
| 386          | Gender Reassignment Surgery (Revised)                                       | 10/10/2017     | **Commercial Plan**  
For a better understanding, we combined and reworded criteria #5 and #6 to state:  
"The patient has completed a minimum of 12 months of successful, continuous full-time real-life experience with no returning to their original gender. Examples that would demonstrate this criterion could include maintaining part- or full-time employment as the individual’s self-identified gender, functioning as a student in an academic setting, functioning in a community-based volunteer activity, or seeking and obtaining legal gender change from the courts."  |
| 492          | Oral Appliances for Sleep Apnea (Revised)                                   | 10/05/2017     | **Commercial Plan**  
For clarification, we specified whom the polysomnography test could be performed by in criterion #1. "An American Board of Sleep Medicine (ABSM) board-certified sleep specialist.”  |
| 569          | Urine Drug Testing in the Outpatient Setting (Revised)                      | 09/18/2017     | **Commercial Plan**  
We specified that the laboratory performing the services must be CAP- (College of American Pathologists) and CLIA-certified.                                                                                                                                                                                                                     |
| 580          | Corneal Crosslinking for the Treatment of Keratoconus (Revised)             | 11/10/2017     | **Commercial Plan**  
SelectHealth now covers epithelium-off corneal-crosslinking once per lifetime, per eye if the following criteria are met:  
1. Patient has a diagnosis of keratoconus or corneal ectasia.  
2. The medicine used is Photorexa® Viscous/Photorexa® with the KXL device.  
3. The procedure is performed by a fellowship-trained corneal provider.  
SelectHealth does NOT cover corneal crosslinking in conjunction with intrastromal ring segment placement, as it is considered investigational.                                                                                                                                 |

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