Welcome to the Provider Insight newsletter. This newsletter includes medical and pharmacy information and updates that pertain to our commercial, SelectHealth Advantage (Medicare), SelectHealth Community Care (Medicaid), Federal Employee Health Benefits, and SelectHealth 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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SelectHealth Commits to Providing Coverage for the ACA Population

One of the SelectHealth guiding principles is to provide high-quality healthcare at the lowest possible cost. This vision extends to our commitment to offer healthcare plans through the Patient Protection and Affordable Care Act of 2010 (ACA).

ACA plans are administered and regulated similarly to other government plans (i.e., Medicare and Medicaid). Overall, the health of members on Individual ACA plans roughly mimics the health of the aggregate Medicaid population, resulting in higher medical and pharmacy utilization. Rather than leaving the ACA market altogether, as many payers have opted to do, we are seeking opportunities to mitigate the impact of caring for the ACA population. These steps enable us to continue providing coverage for these members.

The changing healthcare climate requires SelectHealth, providers, and members to collaborate in a shared-accountability approach that provides balance and enables members/patients to receive the care they need. We want healthcare to be fair, predictable, and affordable for all parties in the communities we serve. These are the principles guiding our efforts toward community health and shared accountability.

Our mission is helping people live the healthiest lives possible—which includes ensuring members can obtain affordable healthcare coverage and quality healthcare services. In order to continue covering individual ACA members, we must work together to develop reasonable and fair solutions. We appreciate your dedication to partner with us to provide coverage and access to quality care.

Streamlining Communications

Could you wallpaper your office with all the mail you receive? We get it. And we’ve focused this year on streamlining our communications to get you the information you need, when you need it, and in the most appropriate method.

Here are some of our recent changes. Have you noticed a difference?

- Letters – Some letters must be mailed to every provider per their contracts, but whenever possible, notifications are emailed to providers and/or clinic managers
- Forms – Available online; many can be completed and submitted online
- Provider Insight newsletter – Available online each quarter with a postcard sent when new editions are published
- Flyers – Your Provider Relations representative is happy to email educational flyers to you, which you can print in the quantities you need or email to the rest of your team

Provider Website Redesign Project

We want our provider website to be your first stop when looking for SelectHealth information. In May, we introduced our redesigned secure website, which features more intuitive navigation, easy-to-find resources, easy-to-access online tools, and more. The site is available to providers or clinic staff with a secure-access username and password. Since the redesign, we’ve been programming similar changes to our public provider website. We’re hoping the redesigned public site will be ready to roll out early next year.

Stay Tuned

We continue to look for opportunities to improve our communication processes. To that end, we’ve created a short, 3-question survey to check our progress and provide a space for you to suggest other ways we can improve. We appreciate your collaboration to make SelectHealth communications your trusted source of information.
New Preauthorization Requirements for Selected Surgical Procedures

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

Like you, we are dedicated to promoting the use of evidence-based care and the appropriate utilization of services. After evaluating SelectHealth utilization data against national benchmarks, we learned use rates in Utah and Idaho for spine surgeries (lumbar and cervical), joint surgeries (hip and knee), tonsillectomies, adenoidectomies, and hysterectomies are among the highest in the country. Because every surgery carries inherent risk, SelectHealth is implementing changes to support appropriate utilization of services and adherence with evidence-based care process models developed through the Intermountain Healthcare Clinical Programs.

Payment for the procedures noted above, as well as the services that already require preauthorization, will be made only if they meet the clinical criteria established in collaboration between SelectHealth and Intermountain Healthcare Clinical Programs. Claims for services that are not preauthorized will be denied. Denials will apply to professional and facility claims. Providers are responsible for obtaining preauthorization; and members cannot be billed if the provider fails to obtain the required preauthorization or for procedures that do not meet clinical criteria. The preauthorization requirement will apply for the following product lines:

- SelectHealth commercial plans – Utah and Idaho
- SelectHealth Advantage® – Utah and Idaho
- SelectHealth Community Care® – Utah only
- Children’s Health Insurance Program (CHIP) – Utah only

The requirements will not apply to Federal Employees Health Benefits (FEHB) at this time.

Streamline Eligibility Verification with EDI

Are you looking to cut down the amount of time your office staff spends on the phone with insurance companies to verify eligibility and benefits? Use the Electronic Data Interchange (EDI) transaction 270 Eligibility and Benefit Inquiry to verify a member’s eligibility and benefit information. This transaction can be sent via real-time or batch, and when sent real-time, a response is typically received within 20 seconds. You can submit multiple member ID numbers—even from multiple payers—in the same 270 request.

The 271 response contains information such as eligibility dates, copay, and coinsurance; as well as accumulations such as how much has been met toward the deductible and out-of-pocket maximum, visit limits, and any applicable benefit limits. This transaction can be used for any provider type—medical, dental, or pharmacy. This transaction is HIPAA x12 compliant and follows those rules and standards. If you are not currently utilizing this transaction, contact your software vendor to see if they have the capability to submit it. Any vendor will need to be able to connect to UHIN to submit to SelectHealth.
Inside Look: SelectHealth Benefits Determination Team

Q: What is the Benefit Determination (Preauthorization) Department?
A: The Benefit Determination Department (also known as “the Ben Team”) is a group within the Health Services department that processes a wide variety of authorization request types, including requests for genetic testing, radiofrequency ablations, vein procedures, surgical procedures, enteral formula, and certain durable medical equipment (DME) items. Within the Ben Team, staff members are assigned to work on authorization requests for a specific line of business (e.g., commercial, SelectHealth Advantage, or SelectHealth Community Care).

Q: What kinds of requests are not handled by the Ben Team?
A: Skilled nursing facility/inpatient rehab admissions, home health services, inpatient hospital stays, organ transplant requests, as well as some DME items.

Q: Does the Ben Team create or change the medical policies?
A: No. The Ben Team is responsible for applying the criteria in the medical policies to authorization requests in a fair, accurate, and consistent manner. The Physician Services department is responsible for the creation and management of medical policies.

Care Management Services for Members With PTSD

Do you have patients who suffer from traumatic stress or post-traumatic stress disorder (PTSD)? SelectHealth is now offering care management services to assist members with PTSD.

We recognize that patients with behavioral health issues, such as PTSD, have less than optimal outcomes, especially coupled with chronic medical illness. There is a need to move beyond disease management into the realm of population health, and we do so through a new collaborative effort.

Brooks Keeshin, M.D. and Julie Bradshaw, LCSW, at the Primary Children’s Hospital Center for Safe and Healthy Families, were recently awarded a federal grant with which they are creating tools and clinical algorithms to aid providers in recognizing and treating traumatic stress and PTSD in children.

Care managers at SelectHealth worked closely with this team to build a new PTSD care management program for pediatric and adult patients. Our care plans prioritize access to evidence-based treatment and improvement in overall health.

To refer patients who suffer from PTSD, simply call **801-442-5305** and choose from the following lines of business:

- Medicare (SelectHealth Advantage): Option 1
- Medicaid (SelectHealth Community Care): Option 2
- All other SelectHealth plans: Option 4
Your Patients Need an Influenza Vaccine—Now, More than Ever

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

Late fall and early winter continue to be effective times to protect patients with influenza vaccines. The Centers for Disease Control and Prevention (CDC) recommend that “vaccinations should be offered as long as influenza viruses are circulating and unexpired vaccine is available.”1 For the elderly population, waning immunity has been shown to occur during the course of a single influenza season, with much higher vaccine effectiveness shown in the first 100 days after vaccination compared to persons vaccinated > 120 days prior to diagnosis. In 74 percent of the last 34 influenza seasons, the peak influenza activity occurred in the months of January through March. Continuing to strongly encourage vaccination throughout the influenza season should be a focus of all of our practices.

Besides protecting our elderly patients from hospitalization or death, the influenza vaccine also protects against loss of independence, which senior patients value highly. Influenza is one of the leading causes of catastrophic disability in older adults who lose up to 5% of their functional muscle strength each day they spend in bed, and when discharged after a hospital stay for influenza, as many as 14.6% have lost independence in caring for themselves1. This can be used as an additional incentive when discussing the benefits of immunization with patients.

This year, the CDC has produced two new documents to accompany its seasonal influenza vaccine recommendations: A four-page Summary of Recommendations on Seasonal Influenza Vaccine 2017-18 and a Background Document with all of the relevant research nicely organized. This new format allows greater and more efficient accessibility to the recommendations.

New products have been approved for this season by the FDA (Flucelvax Quadrivalent – IIV4 and Afluria Quadrivalent – IIV4) and new age indications have been approved (Afluria Trivalent – IIV3 and Afluria Quadrivalent – IIV4, both approved down to age 5 years, and FluLaval Quadrivalent – IIV4 approved down to age 6 months). Because there are now two products at different doses approved for ages 6 months through 35 months (Fluzone IIV4 at 0.25mL and FluLaval IIV4 at 0.5mL), influenza vaccine CPT coding has changed to a dose-based rather than an age-based code system.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Age Range</th>
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<tr>
<td>90685</td>
<td>0.25 mL syringe (6-35 mo)</td>
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<tr>
<td>90687</td>
<td>0.25 mL MDV (6-35 mo)</td>
<td></td>
</tr>
<tr>
<td>90686</td>
<td>0.5 mL syringe (ages 6 mo and older)</td>
<td></td>
</tr>
<tr>
<td>90688</td>
<td>0.5 mL MDV (ages 6 mo and older)</td>
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Staff who administer vaccines should also be educated about the new 0.5mL dose for infants ages 6 months through 35 months when using FluLaval to prevent dosing errors.


Visit Our Redesigned selecthealth.org—Featuring an Improved Provider Search Tool

We’re excited to introduce our redesigned member website that reflects the growth and change SelectHealth has experienced during the last several years. We’ve accommodated new health laws, adapted to new technology, and hired new employees to meet increased membership needs. Our new website conveys important messages about who we are and what we sell. The new site:

➤ Describes who we are and what we do as a health plan
➤ Helps prospective members and employers understand available plans
➤ Conveys our mission of helping people live the healthiest lives possible
➤ Makes it easier for our customers—especially members—to get the answers they need, faster
➤ Empowers members with information to make the most of their health plan, including tools and programs to help them manage their care

You’ll notice more than just a new look: We’ve improved navigation and made the site responsive to mobile devices, so it works just as well on your phone as at your desk. Placing Utah and Idaho information on the same site makes it easy for members to find what they need regardless of where they live. Visit selecthealth.org to explore the new site, which will continue to grow as we do!

What should providers know about the new selecthealth.org?

We’ve completely re-engineered our provider search, which you can find at selecthealth.org/findadoctor or under “Find a Doctor” on the home page. Our comprehensive provider and facility quick-search options help users find care faster, and a drop-down menu (with an optional network lookup) makes it simple to search by network. Filters include smart search options that narrow depending on what’s typed into the search box. Search results display provider snapshots that include the provider’s name, photo, rating, location, phone number, and networks. Users can then view a full provider profile including languages spoken and hospital affiliations, as well as tabs that slide between locations (and in- vs. out-of-network status), a professional summary, and patient experience ratings.

We’ll continue to refine and improve the Provider Search, and we welcome your feedback as we make improvements. If you have questions or suggestions, please contact your Provider Development representative.
SELECTHEALTH ADVANTAGE

Health Services Realigns Support for SelectHealth Advantage

Our Health Services department is realigning staff to provide a single line of support for your SelectHealth Advantage patients. Beginning December 4, 2017, preauthorization, preservice benefits determinations, concurrent review, and Care Management program services are being coordinated by an integrated team dedicated to responding to the needs of SelectHealth Advantage members. This transition streamlines the submission process for clinical review requests, and promotes consistency in review practices and adherence to the Centers for Medicare & Medicaid Services (CMS) guidelines, while continuing to deliver the superior service you’ve appreciated from your Health Services partners. You’ll have one phone number, email address, and fax line by which to contact us:

> Phone: 800-442-5305, Option 1
> Email: medicareumintake@imail.org
> Fax: 801-442-0302

Stars Program Update – 4 Stars!

CMS performs an annual comprehensive review of all health plans contracted to offer Advantage plans to Medicare beneficiaries. SelectHealth participates in this program and offers the SelectHealth Advantage product in Utah and Idaho. SelectHealth Advantage includes both medical and pharmacy benefits and is evaluated on a total of 47 measures. Health plans scoring four stars or more are considered “high performing plans.”

CMS recently recognized SelectHealth Advantage with a four-star rating for 2018.

We sincerely appreciate the outstanding care you provide our SelectHealth Advantage members, and your commitment to quality improvement. Achieving this rating is the result of a combined effort between the health plan and the provider network.

We value your partnership in providing quality care to our members.

Diabetes Prevention Program

We are excited to announce recent CMS changes that allow for and encourage participation in a diabetes prevention program for selected patients. Diabetes affects 35 million people in the United States, and another 90 million have prediabetes. The costs of caring for diabetes currently exceeds $407 billion. The number of diabetics is expected to rise to 55 million by 2030. Studies show that programs focused on appropriate diet and exercise can decrease the onset of diabetes by 58%.

In addition to reducing the total cost of health care, most importantly, it improves the overall health of the population.
The coverage enhancements are tentatively scheduled to go into effect April 1, 2018. SelectHealth is reviewing options to be sure your patients have an appropriate program available. This applies to patients with a BMI of 25 and an A1C 5.7%-6.4%, (or a FBG 110-125) and no previous diagnosis of diabetes. The program will include 16 core sessions in the first six months and at least six sessions in the last six months. This program is likely to be available for up to an additional two years.

Within the SelectHealth Advantage population, based on a limited pilot program at Intermountain facilities, we could potentially avoid 45 cases of diabetes each year with this program. This is based on only 12% of eligible members participating. If 20% of eligible SelectHealth Advantage members participated, 78 cases could be prevented each year. And with 50% engagement, 195 cases could be avoided each year. Considering the morbidity and mortality associated with diabetes, this is a very promising approach.

View the final rule, “Medicare Diabetes Prevention Program Expansion,” for additional details. Watch future editions of Provider Insight for additional information about diabetes program opportunities for SelectHealth Advantage members.

Risk Adjustment Supports Care for At-risk Patients

There’s no escape from hearing about risk adjustment. But why is it so important? As health plans expanded coverage to include the ACA population, there was concern that some plans may only take healthier patients while receiving the same or similar reimbursement. This would certainly cause a disequilibrium, and continue poor access to healthcare for sicker patients. To offset this possibility, a “risk adjustment” was created to adjust reimbursement from CMS, based on the chronic conditions present and the potential risk of increased cost of care for these patients. The only way to receive this additional reimbursement for a higher risk population is to accurately and completely document the chronic conditions of the members we serve. Because providers are already treating these patients and caring for their needs, regardless of the “risk adjustment,” our focus is on documentation of what is already being done.

You may wonder why this matters to you or your patient. Certainly, the primary focus needs to remain on caring for your patients—first and always. However, risk-adjusted reimbursements translate to funds for additional resources and services for these patients, and we want to make sure members can always have access to what is needed. With additional funds, we can provide enhanced care management and education for these members, which may prevent hospitalizations. Or if we are able to offer additional benefits, such as a gym membership, it may help manage hypertension and prevent the onset of diabetes.

As we head into the year end, we thank you for your care of these patients, and ask that you look at the documentation for any chronic conditions you’ve been addressing throughout the year to ensure it’s accurate and complete.

Preauthorizing Chiropractic Services Exceeding Ten Visits

For the Medicare Advantage line of business, preauthorization is required for services exceeding ten visits. Some chiropractic claims are submitted without having a preauthorization requested and reviewed. These claims are also submitted out of chronological order. Please call for benefits preservice to see if there are already chiropractic claims on file. Any chiropractic service that exceeds the ten allowed visits should be preauthorized. You should also send in a Preauthorization Request Form prior to rendering services to ensure approval. In the future, Care Affiliate will be available so you can submit a request for preauthorization electronically.
Jimmo v. Sebelius Ensures Coverage for Skilled Services

On January 24, 2013, the U.S. District Court for the District of Vermont approved a settlement agreement in the case of Jimmo v. Sebelius, involving skilled care benefits in inpatient rehabilitation and skilled nursing facilities (IRF and SNF), home health (HH), and outpatient physical therapy (OPT). The intent of the settlement agreement is to clarify Medicare’s longstanding policy regarding when skilled services are required to provide care that is reasonable and necessary to prevent or slow further deterioration. Coverage cannot be denied based on the absence of potential for improvement or restoration. As a result of the settlement agreement, CMS has revised the Medicare Benefit Policy Manual to provide clarifications to help ensure that claims are adjudicated in accordance with the existing policy.

The Jimmo Settlement required manual revisions to restate a “maintenance coverage standard” for skilled nursing and therapy under these benefits:

> Skilled nursing services would be covered when such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration, as long as the beneficiary requires skilled care for the services to be safely and effectively provided.

> Skilled therapy services are covered when an individual assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist (“skilled care”) are necessary for the performance of a safe and effective maintenance program. The maintenance program to maintain the patient’s current condition or to prevent or slow further deterioration is covered for as long as the beneficiary requires skilled care for the safe and effective performance of the program.

Please read the following information from CMS to ensure skilled services are provided in accordance with existing Medicare policy.

Clarified Summary of Questions and Responses from Call 5
Jimmo v. Sebelius Settlement Agreement Slideshow
Medicare Benefit Policy Transmittal 179
Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius
Jimmo v. Sebelius Settlement Agreement Fact Sheet
Jimmo v. Sebelius Settlement Agreement Program Manual Clarifications Fact Sheet
Idaho Service Area Reduction

Effective January 2018, the SelectHealth FEHB service area will no longer extend into the state of Idaho. SelectHealth FEHB membership will only be available to federal employees who live or work in the state of Utah, live in Utah and work in Idaho, or live in Idaho and work in Utah. All services must be received in Utah by a provider participating on the Select Med network. Services received in Idaho will only be covered if for urgent or emergent care.

To prevent any services received in 2018 from being denied, once your patient is enrolled with a new health plan, please verify whether you are participating on their new network. If you have long-standing patient relationships with Idaho FEHB members who will no longer have a SelectHealth plan, you may want to consult with these patients about continuing treatment.

We will send a letter to all affected Idaho FEHB members informing them that effective January 2018, SelectHealth will no longer be a plan option for them. The letter directs members to select replacement coverage since they will reside in a county that is outside of our service area. If they remain on the plan, they must access participating services from Select Med providers in the state of Utah; only urgent and emergency care will be covered outside of the SelectHealth service area.

Thank you for your continued participation in our network and the service you provide all of our members.

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.

Use PromptPA for Online Pharmacy Preauthorization Requests

SelectHealth is excited to offer you a new way to submit preauthorizations for medications. PromptPA™ is our new online preauthorization submission portal. No login credentials are required, so you and your staff can start using the portal right away. You can also easily upload any chart notes or supporting documentation with your request using PromptPA.

What you will need to use PromptPA:

> Patient’s SelectHealth member ID
> Patient’s name and date of birth as they appear on their SelectHealth insurance card
> Patient’s ZIP code
> Internet Explorer (using other browsers may cause display issues)
> Make sure to indicate you are a physician’s office submitting a new prior authorization by selecting “Prescribing Physician/Nurse” from the “Are you the...” drop-down.

Access the PromptPA portal at selecthealth.org/pa.
CODING AND REIMBURSEMENT, MEDICAL POLICIES, AND NEW TECHNOLOGY ASSESSMENT

Coding and Reimbursement Updates

There are many coding changes coming. Effective 10/01/17, there will be over 6,500 new, revised, and deleted ICD-10 CM/ICD-PCS codes, as well as 24 new and revised HCPCS/Procedure codes and one new modifier with effective dates ranging from 08/01/17 through 10/01/2017. To remain current and code accurately, please be sure to use the 2018 version of your coding books. For more information regarding these changes, visit cms.gov.

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.

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<tr>
<th>Policy Number</th>
<th>Policy Name</th>
<th>Policy Effective Date</th>
<th>Summary of Change</th>
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<tr>
<td>6</td>
<td>Preventive Care and Screening Guidelines (Revised)</td>
<td>09/06/2017</td>
<td>SelectHealth Commercial: Added CPT codes 99174 and 99177 to pay preventive when billed with eye exam diagnosis codes Z01.00 or Z01.01 for children ages 5 and younger Added HCPCS code S9443 to pay preventive when billed with a maternity diagnosis once per pregnancy SelectHealth Advantage: 92227 - Screening for diabetic retinopathy is covered annually, effective 01/01/2017</td>
</tr>
<tr>
<td>36</td>
<td>Lysis of Adhesions (Revised)</td>
<td>07/28/2017</td>
<td>SelectHealth Commercial: Language clarification of requirements</td>
</tr>
<tr>
<td>37</td>
<td>Fetal Non-Stress Test with or without Ultrasound (Revised)</td>
<td>08/14/2017</td>
<td>SelectHealth Commercial: Language clarification explaining the use of the 22 modifier</td>
</tr>
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## 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.

### REVISED POLICIES

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<th>Policy Effective Date</th>
<th>Summary of Change</th>
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| 609           | Infusion Pumps (External or Implantable) (New) | 07/31/2017 | **Commercial Plan**  
Polices #130 Implantable Infusion Pumps For the Treatment of Chronic, Intractable Pain (Pain Pump) and #132 Infusion Pumps (External or Implantable) have been combined into 1 policy. No other changes made in coverage criteria. Please see the policy for coverage criteria. |
| 614           | Synthetic Cartilage Implant (Cartiva*) for Hallux Rigidus/ Limitus (New) | 08/01/2017 | **Commercial Plan**  
SelectHealth covers the Cartiva® Synthetic Cartilage Implants for use in the treatment of patients with painful degenerative or post-traumatic arthritis (hallux limitus or hallux rigidus) in the first metatarsophalangeal joint with or without the presence of mild hallux valgus. SelectHealth does NOT cover Cartiva® Synthetic Cartilage Implants for any other indication, as it is considered experimental/investigational. |
| 615           | Nucleic Acid Amplification Tests (NAAT) for Bacterial Vaginosis (BV) (New) | 06/20/2017 | **Commercial Plan**  
SelectHealth covers limited-spectrum NAAT when specific coverage criteria have been met, as evidence has demonstrated clinical utility in these situations.  
Coverage criteria for limited spectrum NAAT (must meet ALL):  
1. Patient with recurrent symptoms of bacterial vaginosis (BV)  
2. Microscopic assessment and culture inadequate to diagnose BV  
3. Patient has tried and failed at least one complete course of antibiotics appropriate to BV  
4. Other potential noninfectious etiologies of the patient’s symptoms have been excluded  
SelectHealth covers wide spectrum NAAT in limited circumstances when coverage criteria are met.  
Coverage Criteria for wide-spectrum NAAT (must meet ALL):  
1. Patient with recurrent symptoms of BV  
2. Microscopic assessment and culture inadequate to diagnose BV  
3. Limited-spectrum NAAT has been performed and has not provided adequate diagnosis  
4. Patient has tried and failed at least one complete course of antibiotics appropriate to BV  
5. Other potential noninfectious causes of vulvovaginitis, including noninfectious causes (e.g., desquamative inflammatory vaginitis, atrophy, lichen planus, lichen sclerosis, provoked and unprovoked vulvodynia) have been excluded (recommend use of algorithm at www.vulvovaginaldisorders.com/algorithms)  
Testing is being ordered or recommended by or in consultation with a vulvovaginal specialist. |
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<th>Policy Name</th>
<th>Policy Effective Date</th>
<th>Summary of Change</th>
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<tbody>
<tr>
<td>617</td>
<td>Noninvasive Fractional Flow Reserve Using CT Angiography (New)</td>
<td>08/01/2017</td>
<td>Commercial Plan SelectHealth does NOT cover noninvasive fractional flow reserve testing using computed tomography angiography (FFR-CT) preceding invasive coronary angiography in patients with suspected stable ischemic heart disease. It is considered investigational.</td>
</tr>
<tr>
<td>618</td>
<td>Vestibular Evoked Myogenic Potentials (VEMP) (New)</td>
<td>08/11/2017</td>
<td>Commercial Plan SelectHealth does NOT cover Vestibular Evoked Myogenic Potential (VEMP) testing, as it is considered investigational.</td>
</tr>
<tr>
<td>103</td>
<td>Benign Skin and Subcutaneous Lesion (Revised)</td>
<td>06/05/2017</td>
<td>Commercial Plan A paragraph was added to the description about lipomas and the coordinated billing codes. Paragraph states: A lipoma is a benign fatty tumor usually composed of mature fat cells, found in the dermis, epidermis, subcutaneous tissue, and rarely, found below the fascia (i.e., subfascial and submuscular). Most of these lesions are below the skin (dermis) but above the fascia.</td>
</tr>
<tr>
<td>123</td>
<td>Gene Therapy, Testing, and Counseling (Revised)</td>
<td>06/07/2017</td>
<td>Commercial Plan Identified that a statement previously present had been erroneously removed. This has been reinserted into the policy. Please see below: “SelectHealth covers genetic counseling when provided by certified and credentialed medical geneticists and genetic counselors.”</td>
</tr>
<tr>
<td>210</td>
<td>Genetic testing: Microsatellite Instability (Revised)</td>
<td>07/19/2017</td>
<td>Commercial Plan Coverage expanded to include microsatellite instability testing in patients with solid tumors, as recent evidence has demonstrated clinical utility of this testing as it relates to use of cancer immunotherapy.</td>
</tr>
<tr>
<td>237</td>
<td>Cryosurgical Ablation of Plantar Fasciitis, Morton’s Neuromas, and Other Conditions of the Feet (Revised)</td>
<td>07/19/2017</td>
<td>Commercial Plan The title of this policy was changed from Cryosurgical Ablation of Plantar Fasciitis, Morton’s Neuromas, and Other “Lesions” of the Feet to “Conditions” to better clarify that warts are not included in the policy.</td>
</tr>
<tr>
<td>243</td>
<td>Artificial Spinal Disc Replacement (Revised)</td>
<td>08/09/2017</td>
<td>Commercial Plan SelectHealth added coverage of the Prestige LP cervical disc to those artificial discs that are covered when criteria are met for two-level fusions.</td>
</tr>
<tr>
<td>265</td>
<td>Radiofrequency Ablation (RFA) for Back or Neck Pain (Radiofrequency Neurolysis, Facet Joint Rhizotomy) (Effective as of 8/1/17)</td>
<td>08/01/2017</td>
<td>Commercial Plan Two changes were made under Conditions for coverage of lumbar and cervical facet joint radiofrequency ablation (these changes will be effective as of 8/1/17*): 1. #4 The diagnosis of facet joint pain has been confirmed by a controlled, two-step diagnostic nerve block (using a short-acting anesthetic followed by a separate block using a long-acting anesthetic agent at least 1 week apart), performed under local anesthetic fluoroscopic guidance, and the patient has experienced at least an 80% reduction of pain on both. 2. #5 If the request is for a repeat (i.e., second) RF ablation procedure, the patient must have experienced at least 60% reduction in facet-related pain from the previous procedure and it has been at least 9 months since the previous procedure. Statement also added to clarify coverage of sacral nerve RFA. Statement says: SelectHealth does NOT cover radiofrequency ablation of sacral nerves. *In an effort to clarify the effective dates on this policy, we have uploaded the old version and put an effective date of “until 8/1/17” and on the new revised policy, we have put an effective date “as of 8/1/17” above the title in the policies.</td>
</tr>
<tr>
<td>Policy Number</td>
<td>Policy Name</td>
<td>Policy Effective Date</td>
<td>Summary of Change</td>
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<tr>
<td>---------------</td>
<td>------------------------------------------------------------------------------</td>
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<tr>
<td>336</td>
<td>Stereotactic Radiosurgery (SRS)/Stereotactic Radiotherapy (SRT)/Stereotactic Body Radiotherapy (SBRT) (Revised)</td>
<td>07/27/2017</td>
<td><strong>Commercial Plan</strong>&lt;br&gt;Additional criteria for coverage was added:&lt;br&gt;&lt;br&gt;• #13 For instances in which the first treatment has been standard external beam radiation, and the spine requires a second course of radiation&lt;br&gt;Additionally, clinical rationale supporting this change has been added to the summary.</td>
</tr>
<tr>
<td>471</td>
<td>Implanted Intraocular Devices for the Treatment of Glaucoma (Revised)</td>
<td>08/08/2017</td>
<td><strong>Commercial Plan</strong>&lt;br&gt;Coverage modified to cover the Xen® 45 Gel Stent (effective 09/15/2017) in patients who have maximally tolerated medical therapy as proven in the management of glaucoma.</td>
</tr>
<tr>
<td>570</td>
<td>Genetic Testing: Molecular Profiling for Determining Therapy of Malignant Tumors (Revised)</td>
<td>07/21/2017</td>
<td><strong>Commercial Plan</strong>&lt;br&gt;This policy was extensively revised from no coverage to allow for coverage of this testing in very specific circumstances. The specific policy language now states:&lt;br&gt;SelectHealth covers multimarker tumor panels using next generation sequencing in the diagnosis and treatment of cancer as a method to guide the selection of therapeutic agents for malignant tumors in <em>limited circumstances</em>.&lt;br&gt;Patients must meet ALL of the following to be eligible for next generation sequencing:&lt;br&gt;1. The member has <strong>one</strong> of the following clinic circumstances:&lt;br&gt;   a. Any advanced stage IV solid tumors;&lt;br   b. All lymphomas;&lt;br   c. Multiple myeloma.&lt;br&gt;2. Patient has demonstrated progression of disease despite at least 1 line of FDA-approved and NCCN-approved standard cancer therapy.&lt;br&gt;3. Member has performance level as evidence by documentation of ECOG performance status 0-2 or Karnofsky score &gt;70*&lt;br&gt;4. Advance care planning (ACP) has been completed and documented with a trained facilitator (e.g., nurse navigator, licensed clinical social worker or a palliative care provider, or the treating provider)&lt;br&gt;5. Submission by the treating physician of pathology, imaging, and treatment notes as well as ACP consultation notes&lt;br&gt;6. Service is requested from a contracted laboratory provider&lt;br&gt;7. Member must be eligible for MATCH, TAPUR, or other similar sponsored clinical trials intended to assess the effectiveness of targeted therapies based on tumor marker testing.&lt;br&gt;We also added the performance status guidelines table.</td>
</tr>
</tbody>
</table>
| 584           | Chiropractic Services for Children (Revised)                                 | 06/05/2017            | **Commercial Plan**<br>Language added clarifying coverage for Idaho ACA plans. (SelectHealth covers chiropractic care for children <7 years under limited circumstances, if criteria for coverage is met.)<br>Criteria for coverage:<br>• The child has a specific, chronic neuromusculoskeletal diagnosis causing significant and persistent disability<br>• Other conservative therapies have been tried and have failed to relieve the patient’s symptoms<br>• Improvement is documented with the initial two weeks of chiropractic care.
595  |  Minimally Invasive Fusion of the Sacroiliac (SI) Joint (Revised)  |  07/19/2017  |  

**Commercial Plan**

This policy has been significantly modified to reflect updated information related to optimal patient candidates. Several new criteria have been added. The policy now states:

SelectHealth covers minimally invasive fusion of the sacroiliac SI joint only using the iFuse Implant System® as a proven technology.

Criteria for coverage (ALL must be met).

Minimally invasive fusion of the SI joint utilizing the iFuse Implant System is considered to be medically necessary for the treatment of SI joint syndrome and SI joint mediated mechanical low back pain when ALL of the following criteria are met:

1. Patients aged 21-70 with confirmed diagnosis of SI joint mediated pain based on history and physical exam;
2. Physical examination documentation reflects SI joint pain confirmed with:
   a) The Fortin Finger Test;
   b) Neurological testing; and
   c) At least 3 of the 5 provocative maneuvers that stress the SI joint (e.g., distraction test, compression test, thigh thrust, FABER (Patrick’s) test, Gaenslen’s maneuver) causing the patient’s typical pain.
3. History documentation includes:
   a) Onset, location, character, duration, and modifiers of pain;
   b) Prior treatments and results;
   c) Medication use; and
   d) Prior surgical and nonsurgical procedures and results.
4. Advanced imaging studies of the joint such as CT, MRI, or alternating standing films to exclude other diagnoses (e.g., L5/S1 compression, hip osteoarthritis);
5. Persistent moderate to severe SI joint pain despite conservative therapy (baseline score of 30 or greater on the Oswestry Disability Index (ODI) and/or numeric pain score in the last week of 5 or higher on a 10 point VAS scale);
6. Failure to adequately respond* to at least six months of nonsurgical treatment (if not contraindicated) including ALL of the following:
   a) Nonsteroidal anti-inflammatory drugs and/or opioids;
   b) Course of physical therapy;
   c) Activity modification; and
   d) CT or Fluoroscopic-guided SI joint steroid injection.
7. Complete or near complete (>79%) relief of typical pain on CT-or fluoroscopic-confirmed injection;
8. MRI of the lumbar spine to rule out other possible sources of pain (unless complete pain relief with SI joint injection).

*Failure to respond is defined as continued pain interfering in activities of daily living or resulting in functional disability.

**EXCLUSIONS:**

Minimally invasive SI joint fusion is NOT indicated for patients with the following:

- Fewer than six months of back pain;
- Inability to confirm pain arises from the SI joint;
- Failure to pursue conservative treatment of the SI joint (unless contraindicated);
- Pain not confirmed with a diagnostic SI joint block;
- SI joint pain due to chronic SI joint inflammatory disorders;
- Referred pain from other sources;
- Recent major trauma to the pelvis;
- Metabolic bone disease;
- Existence of other pathology that could explain the patient’s pain;
- Patients involved in litigation, on disability leave, or receiving workers compensation.

SelectHealth does NOT cover the use of minimally invasive fusion products other than iFuse Implant System for sacroiliac joint fusion, as current evidence related to alternative systems are inadequate to determine efficacy and safety of these products. Use of these technologies is considered experimental/ investigational or unproven.
Technology Assessment (“M-Tech”) News

M-Tech is our formal process for reviewing emerging healthcare technologies (e.g., procedures, devices, tests, and “biologics”) for the purpose of establishing coverage benefits. Existing technologies are also examined through this process.

Following is a list of recent technologies reviewed and committee recommendations:

<table>
<thead>
<tr>
<th>Technology</th>
<th>Date Reviewed*</th>
<th>Committee Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aqueous Shunts in the Management of Glaucoma (Xen)</td>
<td>August 8, 2017</td>
<td><strong>Covered in Limited Situations.</strong> Current evidence is fairly substantial, as this device has been used in Europe for some time and has demonstrated efficacy and safety in managing glaucoma. Published studies have not necessarily demonstrated durability, as the duration of the studies have been short term. However, given the current published evidence, we recommend coverage of the XEN aqueous shunt for the treatment of glaucoma for individuals who have failed maximal-tolerated medical therapy. <a href="#">See Medical Policy #471</a></td>
</tr>
<tr>
<td>Prestige LP Cervical Disc for Two-Level Replacement</td>
<td>August 8, 2017</td>
<td><strong>Coverage expanded to allow the Prestige LP artificial cervical disc for implantation at two levels, consistent with the FDA-approved indications.</strong> Given the quality of the evidence with outcomes demonstrating durability and effectiveness out of seven years and the FDA approval for use at two levels. <a href="#">See Medical Policy #243</a></td>
</tr>
<tr>
<td>Biliopancreatic Duodenal Switch Bariatric Surgery</td>
<td>August 8, 2016</td>
<td><strong>Covered for members who have the bariatric benefit.</strong> The biliopancreatic duodenal switch procedure has been available for decades. The evidence related to its efficacy and safety is mature and robust, though much of this literature lacks significant evidence related to long-term efficacy, durability, risks, and complications except for a small number of studies. Cost effectiveness studies, especially long-term cost effectiveness studies taking into account the costs of managing the side effects and revisions, are also lacking. However, these limitations also occur for other bariatric procedures. <a href="#">See Medical Policy #295</a></td>
</tr>
</tbody>
</table>

*Date Reviewed does not necessarily reflect the date of implementation of coverage policy.
Other technologies currently under active assessment by the M-Tech Committee include the following. As the reviews are completed, notices will be sent to stakeholders accordingly to inform them of SelectHealth coverage determinations:

- Anser® ADA
- Anser® iFX
- iStent® for Glaucoma
- Balloon Dilation of the Eustachian Tube for Eustachian Tube Dysfunction
- ConfirmMDx® Prostate Cancer Test
- Corneal Crosslinking for Keratoconus
- Decipher® Prostate Cancer Classifier
- First MTP Arthroplasty
- Functional Electrical Stimulation (FES) Neuromuscular Electrical Stimulation (NMES)
- 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
- Osteochondral Allografts
- Pharmacogenomic for Psychiatric Medications
- Prolaris® for Prostate Cancer
- SphenoCath® SPG Block for Migraine Management
- Sublingual Immunotherapy
- Surgical Guidance Systems for Breast Tumor Localization
- Transcranial Magnetic Stimulation

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

All SelectHealth medical policies and technology assessments can be viewed on selecthealthphysician.org. Select “Secure Content Login” and enter your login information, then select “Policies and Procedures.”

SelectHealth refers to many of the drugs [in this list] by their respective trademarks, but SelectHealth does not own those trademarks; the manufacturer or supplier of each drug owns the drug’s trademark. By listing these drugs, SelectHealth does not endorse or sponsor any drug, manufacturer, or supplier. And these manufacturers and suppliers do not endorse or sponsor any SelectHealth service or plan and are not affiliated with SelectHealth.