Welcome to the Provider Insight® newsletter. Here, you’ll find medical, dental, and pharmacy information, as well as updates to our commercial, SelectHealth Advantage® (Medicare), SelectHealth Community Care® (Medicaid), and Federal Employee Health Benefits plans. We encourage you to read the newsletter so you can stay up-to-date on policies affecting our members—and your patients!

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We’re Rebranding Our Networks and Products: Here’s What You Should Know

As many iconic brands will tell you, associating a product with the corporate name fuels familiarity and builds trust. Some examples of this are Microsoft Office®, Adobe® Acrobat®, Nike® Air, Jeep® Cherokee. Without the corporate name, the product—Office, Acrobat, Air, Cherokee—doesn’t carry the same recognition or trust.

Our members and providers know and trust the SelectHealth name. So, after many thoughtful discussions, we are changing the name of a few of our networks and products to build off the strength and familiarity of our corporate name. Over the next few months you will start seeing Select Care®, Select Choice®, Select Med®, and Select Value® renamed to SelectHealth Care℠, SelectHealth Choice℠, SelectHealth Med℠, and SelectHealth Value℠. These names are also consistent with our other networks and products, such as SelectHealth Advantage® and SelectHealth Community Care®.

The new product names will be noted on remittance advices immediately, but member ID cards will only be updated when the policy renews. Similarly, Participating Provider Service Agreements (PPSAs) will not be updated until recontracting is necessary.

Here is a sneak peek of our new card design. Watch for more information soon!

We anticipate that rebranding our networks and products will be seamless to you, but if you have any questions, please reach out to your Provider Relations representative or email Provider Development at provider.development@selecthealth.org.

When It Comes to Laboratories, It Pays to Stay In-Network

In a recent analysis of claims, we’ve identified a concerning pattern of providers or their office staff referring SelectHealth® members to labs that are not contracted with us. Using out-of-network laboratories subjects our members—your patients—to higher out-of-pocket costs in deductibles and coinsurance.

When the lab is not in the member’s network, services are often denied or benefits may be reduced for our members. This causes frustration for your patients and the referring provider. Additionally, out-of-network labs are not contractually obligated to abide by our quality standards. Using in-network providers for covered services improves member satisfaction, ensures quality results, and helps control costs.

Search for in-network labs on selecthealthphysician.org. Select “Provider & Facility Search,” and then “Facility Search.” Lists of pathology labs as well as draw centers are found in the category “Laboratory Draw Centers” under the drop-down arrow for “Type of Facility.”

If you regularly refer members or order lab work for which you believe there are not adequate in-network laboratory options, please contact your Provider Relations representative to request that these services be evaluated for access.

Thank you for helping your patients to obtain quality services at an affordable cost—without surprises.
We’re Reorganizing Health Services to Better Serve You

To better serve you and our members, the Health Services Commercial team is splitting into two:

1. Small Employer/Individual
2. Large Employer/Self-Funded/FEHB

Each team will provide care and disease management services, utilization review, and benefit determinations specific to the member’s plan type.

As a result of the split, some of our contact information has changed. When you call Health Services at 801-442-5305, please choose the appropriate option:

> Option 1: SelectHealth Medicare Advantage
> Option 2: SelectHealth Community Care (Medicaid)
> Option 3: SelectHealth Commercial Small Employer/Individual
> Option 4: SelectHealth Commercial Large Employer/Self-Funded/FEHB
> Option 5: Other concerns

Please use option 5 if you do not know the member’s plan. You will be directed to our Member Services department to look up the plan type and transfer you to the appropriate team.

Additionally, we’ve updated our preauthorization form to reflect new email and fax contact information for each commercial team. Using the email address or fax number corresponding with the member’s plan type ensures the request goes to the correct team and gives us the opportunity to process your request quickly. The revised form is available in the provider portal.

FluMist Approved for Coverage in 2018-2019

During the 2016-17 and 2017-18 influenza seasons, The Advisory Committee on Immunization Practices (ACIP) recommended that intranasal live-attenuated influenza quadrivalent vaccine (LAIV), such as FluMist®, not be used due to concerns over ineffectiveness against influenza A (H1N1)pdm09-like viruses circulating in the United States during the 2013-14 and 2015-16 seasons. SelectHealth did not cover FluMist® during those seasons.

On February 21, 2018, the ACIP recommended that a reformulated version of FluMist be reinstated as an option when appropriate for the 2018-19 season. SelectHealth, in turn, will be covering FluMist on commercial plans under the preventive benefit for the 2018-2019 flu season.

The concern around FluMist had nothing to do with safety, only a lack of evidence of clinical effectiveness of the vaccine against the influenza A H1N1 strain. A systematic review of published literature regarding the effectiveness of LAIV3 and LAIV4 among children during the 2010-11 through 2016-17 seasons and pooled effectiveness data confirmed low to no significant effectiveness of LAIV against influenza A (H1N1)pdm09-like. However, studies found LAIV was generally effective against influenza B viruses, and similarly effective as inactivated influenza vaccine (IIV) against influenza A H3N2 viruses.
For the 2017-18 season, a new (H1N1)pdm09-like virus, A/Slovenia/2903/2015, was included in LAIV4, replacing A/Bolivia/559/2013. Shedding and immunogenicity data provided by the manufacturer suggest A/Slovenia/2903/2015 has improved replicative fitness over its predecessor. Providers should be aware that the effectiveness of the updated LAIV4 containing A/Slovenia/2903/2015 against currently circulating H1N1pdm09-like viruses is not yet known.

The American Academy of Pediatrics does not feel that there is enough evidence of effectiveness in the reformulated FluMist® product and recommends that LAIV FluMist® only be used when inactivated (IIV) is not available.

FluMist® is approved by the FDA for healthy individuals ages 2 to 49 years. There are two contraindications: Children ages 2 through 17 years who are receiving aspirin and those who have experienced severe allergic reactions to the vaccine or any of its components should not be given FluMist®. Others advised not to get FluMist® include pregnant women, immunosuppressed individuals, or children who are age 2 through 4 years with asthma or a wheezing episode in the last 12 months. These individuals should be given the injectable influenza vaccine. It is appropriate to give FluMist® to those with a history of egg allergy. The safety and efficacy of FluMist® has not been evaluated in people with chronic conditions such as asthma, pulmonary, cardiovascular, metabolic, and immune disorders.

**Don't Miss out on This Valuable Resource for Members**

Our care managers work with you and your SelectHealth patients to help manage their conditions and reach wellness goals. Our team is comprised of more than 40 registered nurses and LCSWs, including experts in certain diseases and behavioral health conditions.

**We help our members:**

- Understand their health conditions and medications
- Monitor and manage symptoms
- Address daily living concerns
- Coordinate care with you and other providers
- Communicate effectively with you
- Connect with online and community resources

We recently began sending notification letters to offices with patients enrolled in care management with us. Should you want to collaborate with our care managers to help your patients achieve their health goals, please contact us. We also invite you to refer any patients that might need care management services.

To contact us, you or your patient may call **801-442-5305**, and choose the appropriate option:

- Option 1 SelectHealth Advantage
- Option 2 SelectHealth Community Care
- Option 3 SelectHealth Commercial Small Employer/Individual
- Option 4 SelectHealth Commercial Large Employer/Self-Funded/FEHB
Use Our Electronic Data Interchange (EDI) Codes to Get Claim Statuses

SelectHealth offers an EDI 276 Healthcare Claim Status Request, and 277 Claim Status Response. Using the current X12 standards, this transaction facilitates the verification of the status of specific claims already submitted to SelectHealth. The 277 Claim Status Response will include the current status of the claim: received, pended, or finalized. A finalized claim status response will also include the amounts paid.

If you would like more information on the 276/277 transaction, please visit our Claims Status Request and Response (276 or 277) site for more information. Questions? Call us at 800-538-5099.

Here’s What You Should Know about iCentra This Quarter

Optimization continues on iCentra to best support caregivers, clinical and business strategies, and—most importantly—our patients. Due to the rigorous optimization schedule, you may see subtle changes in iCentra as you perform your daily tasks. Because we will continue to perform upgrades and optimizations, however, caregivers need to use iCentra as it currently exists in order to become proficient as these changes are made.

How can I suggest improvements or enhancements to iCentra?

The help desk Issues and Improvements Portal can be accessed in the PowerChart toolbar. When logged in, you may report an issue, report system slowness, or request an enhancement. Caregivers will receive email updates as a service record is changed or resolved.

The purpose of optimization is to solve problems and make improvements, reduce redundancies, make smart financial decisions, and support Intermountain Healthcare’s Fundamentals of Care. Suggestions for enhancements are prioritized based on whether the suggestion:

1. Aligns to strategic goals
2. Fosters transparency
3. Improves decision making
4. Supports the Fundamentals of Care

Service Excellence through Rounding

Care Transformation is pleased to introduce "Service Excellence Through Rounding," a proactive model to address and meet the needs of clinicians and caregivers. To address your request for more support and resources to mitigate issues, the program is designed to improve response time and reduce escalations. We appreciate your suggestions to improve our caregivers’ experiences.

How will this proactive rounding model work?

Beginning June 11, Care Transformation facilitators, who will lead teams responsible to different business areas, will assist in the resolution of escalated critical/safety issues, help triage and/or escalate issues that have not gained traction through regular support avenues, and advocate for our caregivers in geographical or Care Transformation meetings.

If you have questions, please contact any Care Transformation partner. Our commitment is to make our caregiver experience better than ever, and through our partnership, we expect to create a model that works for everyone.

Get to Know Our Member Rights and Responsibilities

It is important that all caregivers understand the rights and responsibilities of SelectHealth members. Please become familiar with the following SelectHealth Member Rights and Responsibilities statement. This is meant as a general overview for all provider offices.

SelectHealth Member Rights and Responsibilities Statement

As a Member, you have the right to:

- Receive information about our services, providers, and members’ rights and responsibilities.
- Receive considerate, courteous care and treatment with respect for personal privacy and dignity.
> Receive accurate information regarding your rights and responsibilities and benefits in member materials and through telephone contact.

> Be informed by your provider about your health so they may make thoughtful decisions before you receive treatment.

> Candidly discuss with your healthcare provider appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. We do not have policies that restrict dialogue between provider and patient, and we do not direct providers to restrict information regarding your treatment options.

> Have reasonable access to appropriate medical services regardless of their race, religion, nationality, disability, sex, or sexual preference; and 24-hour access to urgent and emergency care

> Receive care provided by or be referred by your primary care provider.

> Have all medical records and other information kept confidential.

> Have all claims paid accurately and in a timely manner.

**As a Member, You Have the Responsibility to:**

> Treat all our providers and personnel at SelectHealth courteously.

> Read all plan materials carefully as soon as you enroll and ask questions when necessary.

> Ask questions and make certain you understand the explanation and instructions you are given.

> Understand the benefits of your plan and understand not all recommended medical treatment is eligible for coverage.

> Follow plans and instructions for care that have been agreed upon with the provider.

> Express constructively your opinions, concerns, and complaints to the appropriate people at SelectHealth.

> Follow the policies and procedures of your plan, and when appropriate, seek a referral from your primary care provider to SelectHealth providers or call SelectHealth for assistance.

> Ask questions and understand the consequences of refusing medical treatment.

> Responsibility to understand your health problems, communicate openly with your Healthcare provider, develops a patient-provider relationship based on trust and cooperation, and participates in developing mutually agreed-upon treatment goals.

> Read and understand your plan benefits and limitations and call us with any questions.

> Keep scheduled appointments or give adequate notice of cancellation.

> Obtain services consistently according to the policies and procedures of your plan.

> Use our providers when applicable, carry your ID card and pay copay/coinsurance amounts at the time of service.

> Provide all pertinent information needed by your provider to assess your condition and recommend treatment.
SELECTHEALTH ADVANTAGE

Preservice Denials

SelectHealth will not automatically deny services to the patient when a GA Waiver of liability statement on file or GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit modifier is reported with a service. Providers must obtain a preservice denial prior to reporting a GA and/or GY modifier for services provided. If a claim is received with a GA and/or GY modifier but no preservice denial, the claim will be denied.

A preservice denial can be obtained through the usual preauthorization process: Fax requests to 877-228-0825. For urgent requests, call 800-442-5305.

Risk Adjustment

Accurate documentation and coding is important because an inaccurate record leads to potential treatment errors. Additionally, the World Health Organization, Centers for Disease Control, and other agencies (including insurance companies) use that data to focus resources toward problem areas. But to code a condition, the condition must be stated and supported in the documentation for that visit. Here are some tips:

Official Coding Guidelines

Code all documented conditions that coexist at the time of the visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist.

M.E.A.T. – Only one part of M.E.A.T. needs to be documented with each condition. Has the condition been:

> Monitored
> Evaluated
> Assessed
> Treated

IMPORTANT: M.E.A.T. is not a substitute for the coding guidelines—it’s a brief reminder and tool to support documented conditions during the visit.

The coding guidelines always take precedence over any other way of determining if and how a condition should be coded.

Appropriate M.E.A.T. Examples

<table>
<thead>
<tr>
<th>Monitor:</th>
<th>Evaluate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient with hyperlipidemia – Lipid profile ordered</td>
<td>Stable on meds</td>
</tr>
<tr>
<td>Patient with osteoporosis – DEXA scan ordered</td>
<td>Condition improving/worsening</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assess:</th>
<th>Treat:</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD – listened to lungs, crackles present</td>
<td>COPD – start bronchodilator</td>
</tr>
<tr>
<td>Diabetic foot ulcer – assessed, improving</td>
<td>Diabetes – increase Metformin dose</td>
</tr>
</tbody>
</table>

Quick Tip: Use linking words such as “for” to clarify that a treatment or plan is for a specific condition. For example, Patient is to use his Albuterol inhaler as needed for Asthma.

Should you code conditions listed in:

Problem List? NO

Medication List? NO

> Problem and medication lists are often copied and pasted from one note to the next, which means:
  * Any errors are continually repeated
  * These lists may not be specific to what was addressed during the visit

> It cannot be assumed that certain medications are for specific conditions since many medications are used for multiple conditions

Provider or Patient?

Patient Health Information (PHI) is usually subjective information from the patient, so conditions can only be coded from PHI if it is clear the provider is speaking and not the patient.

Current vs. History

> If the patient currently has the condition, do not document as “history of”

> If the patient has a past condition now resolved, then document as “history of”
  * Cancer is one of the top deleted codes because it is often charted as current when it is resolved
CHIP

Medicaid and CHIP Providers Must Enroll with Utah Medicaid

Providers who participate in a plan managed by Medicaid and/or Children’s Health Insurance Program (CHIP) must enroll with their state’s provider enrollment system as required by the 21st Century Cures Act and 42 CFR Part 438. This requirement became effective January 1, 2018.

Several providers who serve SelectHealth Community Care® or CHIP members are either not currently enrolled or need to update their enrollment status with Utah Medicaid. We have notified these providers that the state will reject payment for services rendered to Medicaid or CHIP members for dates of service on or after April 1, 2018.

If you or a provider in your practice have not enrolled with the state and you wish to continue serving SelectHealth Community Care or CHIP members, you must enroll via PRISM immediately.

Please note that if you or a provider in your clinic wishes to become contracted on SelectHealth Community Care you must first enroll on the state’s Known Provider List via PRISM. Contracting cannot be finalized until this is complete. It is your responsibility to notify us when you or a provider in your clinic has enrolled with the state. We will not backdate the effective date of your SelectHealth Community Care Agreement, so you must ensure your state enrollment and your SelectHealth Agreement are in place prior to rendering services to SelectHealth Community Care members.

PRISM has been updated to allow providers the ability to complete enrollment as a Managed Care Network Provider Only, so if a provider does not want to become a Fee-for-Service provider, that option is available.

PHARMACY

Pharmacy News

Please take a few minutes to read the latest Pharmacy & Therapeutics newsletter, along with Formulary Updates. These contain information about recent formulary decisions, specific therapeutic class updates, and industry news.
CODING AND REIMBURSEMENT AND MEDICAL POLICIES

Note: Please review the new Category III and HCPCS codes, effective July 1, 2018.

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.

Q0091 Not Reimbursed Separately

To bring our reimbursement policy into alignment with nationally accepted coding standards, effective September 1, 2018, HCPCS Q0091 Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory will not be reimbursed separately when billed with Evaluation and Management (E&M) codes CPT 99201 through 99215, or Preventive Medicine Visits, CPT 99381 through 99397.

Payment for Pap smear is included in the scheduled fee for the office visit codes.

<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>6</td>
<td>Preventive Care and Screening Guidelines (New)</td>
<td>06/06/2018</td>
<td>SelectHealth Commercial: CPTs 92227 (effective 04/20/18) and 92250 (effective 01/01/17) are covered for Diabetic Retinopathy Screening when billed with a diabetic diagnosis once every 24 months for adults. SelectHealth Advantage: CPT 92250 was added and was effective 01/01/17 for Diabetic Retinopathy Screening when billed with a diabetic diagnosis once every 12 months for adults. CPT code 81528 for colon cancer screening has been changed from covered once every 12 months to covered once every 3 years.</td>
</tr>
<tr>
<td>57</td>
<td>Grafts During Spinal Surgery (New)</td>
<td>04/18/2018</td>
<td>SelectHealth Commercial, SelectHealth Advantage and SelectHealth Community Care: Updated verbiage for better clarification. CPT codes 20930 and 20936 will not be reimbursed as they are considered B status codes and CPT codes 20931, 20937, 20938 and/or 20939 may be reimbursed; however, only one unit of each code can be allowed per operative session, regardless of the number of vertebral levels fused.</td>
</tr>
</tbody>
</table>

Changes to Services Requiring Preauthorization

Radiofrequency Ablation and Medial Branch Block now require a preauthorization for commercial plans, effective June 1, 2018.

The following services will require a preauthorization for commercial plans, effective September 1, 2018.

> Kyphoplasty  
> Vertebroplasty  
> Total Ankle  
> Total Shoulder  
> Artificial Disc  
> Wound Vac
Using Gender Edits in Coding

Many codes are specific to gender. This supports accurate coding by catching common errors caused by things such as transposed numbers, typing errors, or an incorrect patient name. Here are two examples:

- A claim reporting a single live birth on a male member
- A claim reporting testicular cancer on a female member

These types of claims will edit for invalid gender/code combination, allowing you to correct any errors and resubmit the claim or appeal with documentation. In general, gender edits made by SelectHealth occur due to incorrect coding.

However, there are times when coding is correct and an edit would be erroneous. A transgender member born as one gender but now living as another is an example of a claim that may apply a gender edit when the coding is correct.

We recognize how frustrating it can be if we make an edit that you must call about or appeal. Avoid unnecessary gender edits by submitting one of the following diagnoses on your claim when applicable:

- F64.0 - Transsexualism
- F64.1 - Dual role transvestism
- F64.2 - Gender identity disorder of childhood
- F64.8 - Other gender identity disorders
- F64.9 - Gender identity disorder, unspecified
- Z87.890 - Personal history of sex reassignment

Read the Latest Medical Policies

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 we have 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.

<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>114</td>
<td>Corneal Epithelial or Limbal Stem Cell Transplant</td>
<td>05/15/2018</td>
<td>Conditions that can cause damage to the corneal surface were added in the description of the policy.</td>
</tr>
<tr>
<td>302</td>
<td>Cochlear Implantation</td>
<td>05/15/2018</td>
<td>Clarification on adult criteria #2: Member has bilateral severe-to-profound sensorineural hearing loss determined by a pure tone average of at least 70 dB of the combined frequencies 500 Hz, 1000 Hz, and 2000 Hz.</td>
</tr>
<tr>
<td>508</td>
<td>Corneal Crosslinking for Treatment of Keratoconus</td>
<td>05/15/2018</td>
<td>Removed criteria requiring procedure to be performed by a fellowship-trained corneal provider.</td>
</tr>
</tbody>
</table>