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

We are pleased to announce the appointment of Russ Kuzel, MD, Vice President and Chief Medical Officer of SelectHealth. He succeeds Dr. Stephen Barlow, who transitioned to his new role as Population Health Medical Director for Intermountain Healthcare® last fall.

“I am very excited to be here at SelectHealth and to work within an integrated system,” Dr. Kuzel said. “There are increasing challenges and opportunities in the healthcare industry. I feel that Intermountain Healthcare and affiliated physicians working in alignment is the best model to address the needs of individuals, improve quality, and affect costs.”

Dr. Kuzel most recently served as the Senior Vice President and Chief Medical Officer of UCare, a large health plan located in Minneapolis, MN, where he led clinical strategy and services. UCare provided health insurance products and services designed for Medicare, Medicaid, and dual-eligible populations, as well as insurance exchange products for individuals and families.

Previous to UCare, Dr. Kuzel served as Chief Medical Officer of Marshfield Clinic’s Security Health Plan located in Marshfield, WI, where he was responsible for policy, planning, program development, and organizational strategies with providers and the health plan. In addition to his clinical leadership in not-for-profit health plans, Dr. Kuzel has significant clinical experience and has demonstrated success in large multi-specialty provider organizations, including the Dakota Clinic, where he led a group of 175 multi-specialty providers in his role as president and chair of the board of directors.

We are honored to have Dr. Kuzel bring his vast knowledge of clinical and health plan innovation to SelectHealth.

SelectHealth Share℠ Delivers Higher Quality for Lower Costs

A major story in The New York Times addresses the benefits of the new SelectHealth Share insurance plan—and Intermountain’s groundbreaking work to use population health to help people live the healthiest lives possible.

For decades, the big news story in healthcare has been increasing costs and premiums that consumers and employers struggle to pay. The New York Times wrote about SelectHealth and Intermountain Healthcare’s innovative approach to lowering costs while providing high-quality care. These aren’t just little savings, but savings to the tune of $2 billion over the next five years—savings that remain in the community in the form of lower premiums and other lower costs to consumers and businesses.

One way Intermountain looks to improve care while remaining affordable is through a new insurance plan called SelectHealth Share. “This is not a repackaging of the same old stuff,” Pat Richards, President and CEO, told the Times. “We’re fundamentally changing everything.”

By involving the patient, the providers (physicians and the healthcare system), and the payer (insurer) in the entire process from prevention to appropriate care, SelectHealth Share expects to keep costs and premium increases stable. SelectHealth Share is part of Intermountain’s effort to use population health, a highly effective healthcare model to cover the costs of maintaining the health, and providing care for, members of a defined group of people.

The benefits: Healthier patients, lower costs, and an increased ability for people to live the healthiest lives possible.
Patients and employers benefit because SelectHealth Share provides a guaranteed premium increase to the employer of only 4 percent in years two and three of the three-year arrangement. “We have not seen anything similar from other providers,” Lana Jensen, a personnel management manager with Utah County, told the Times. “This is worth a try.”

Brent James, MD, Executive Director for Intermountain’s Institute for Health Care Delivery Research, told the newspaper: “What we’ve decided to do is to give [cost savings] back to the community in terms of lower rates.”

*The New York Times* also quoted Dave Jackson, managing partner for FirstWest Benefit Solutions in Orem, Utah, saying Intermountain’s plan is “the first innovative thing we’ve seen in a long time. Share has got everybody at the table—everybody’s got accountability and got things to do.”

Intermountain knows the importance of providing extraordinary care and superior service at an affordable cost. Many innovation leaders—including readers of *The New York Times*—are following Intermountain’s efforts as a model health system that is indeed helping people live the healthiest lives possible.

Read the complete article.

**EDI Migrating to Edifecs**

On May 14, 2016, we are changing our Electronic Data Interchange (EDI) software to a new Trading Partner Management tool called Edifecs®. The new tool offers increased capabilities, and enables the EDI department to offer more efficient service.

We are testing diligently to make this migration seamless for your office, but as with any process change, you may notice a few differences such as:

> **Edits that we previously were not aware of are now applying to claims correctly.** You may see files reject for new reasons. We have been investigating those identified in testing and have not found any incorrect edits so far. If you see a rejection and have questions, please contact EDI Support and we will investigate the edit.

> **We no longer reject entire batches of claims.**

Previously, if there were front-end problems with one or two claims in the batch, we rejected the entire batch. Now we can reject only problematic claims and accept the rest. With the implementation of the new system, if you are notified that a claim rejected on the front end, make corrections and resubmit that claim only. If you resubmit the entire batch, resubmitted claims that were accepted on the previous batch will now reject as duplicates.

We anticipate the move to Edifecs will improve our EDI process. If you have questions, please call EDI Support at 800-538-5099.

**Protect Your Payments with Electronic Funds Transfer**

**Electronic Funds Transfer (EFT)** is a convenient way to ensure your claims payments are deposited directly into your bank account. With EFT, there’s no waiting for mail, no trips to the bank, and no manual handling of checks. Payments are deposited whether your office is open or not.

EFT is more secure because there is no printed check to get misplaced or mishandled. Payments are transmitted twice a week for medical claims and once a week for dental. And most accounts receivable software can be set up to automatically post EFT payments to your patients’ accounts.

To get set up for EFT, fill out and submit the **Electronic Remittance** form. Make sure to select EFT in the “Choose the form type” drop-down option.

For more information about EFT, contact our EDI department via email or at 800-538-5099.
Corrective Action Plans

The Participating Provider Services Agreement (PPSA) is a contract that ensures SelectHealth and participating providers are acting under an agreed-upon set of guidelines for the protection of both parties as well as our members. Though infrequent, we will occasionally receive a report – either from a member or from an audit finding – of a provider not living up to the standards of the PPSA or applicable laws. The following table outlines corrective actions that we may take to ensure that providers are practicing in accordance with their PPSA and Medicare and Medicaid regulations.

DEFINITIONS:

The following definitions are not exhaustive. Other actions or omissions may also fall within the scope of these definitions.

**Major:** Significant beneficiary harm, reportable to CMS, at fault CTM, recurrence (after documented training), fraud, deceptiveness, false report against another party, retaliation for report of non-compliance, failure to complete required training, misrepresentation of plan.

**Minor:** Self-reported, unknowingly committed, misinformed, failure to comply with new regulations for current contract year, limited or no beneficiary harm, beneficiary harm prevented as a result of self-report.

**Unfounded:** Inconclusive in nature, self-reported as precaution.

We reserve the right to exercise all of our rights under the PPSA with regards to providers who do not comply with applicable laws and regulations, including those related to fraud, waste, and abuse. This may include termination of a provider’s PPSA. All issues will be investigated and reviewed in their entirety. If there are discrepancies between anything in this article and a provider’s PPSA, the terms or provisions in the PPSA will take precedence.

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**Contracted Provider Corrective Action Decision Grid**

<table>
<thead>
<tr>
<th>INCIDENT #1</th>
<th>INCIDENT #2</th>
<th>INCIDENT #3</th>
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<tbody>
<tr>
<td><strong>MAJOR Violation</strong></td>
<td>Corrective Actions as necessary (issue appropriate) Reportable to CMS (non compliance) Documented Follow-up 1:1 Coaching with Provider Relations representative Actions up to termination of provider contract (with AVP or VP of Provider Development feedback)</td>
<td>Corrective Actions as necessary (issue appropriate) Reportable to CMS (non compliance) Documented Follow-up 1:1 Coaching with Provider Relations Representative Actions up to termination of provider contract (with AVP or VP of Provider Development feedback)</td>
</tr>
<tr>
<td><strong>MINOR Violation</strong></td>
<td>Verbal Coaching Documented Follow-up Other Corrective Action</td>
<td>Verbal Coaching Documented Follow-up Other Corrective Action Reportable to CMS May be classified as MAJOR Violation (incident #1) as determined by decision makers</td>
</tr>
<tr>
<td><strong>UNFOUNDED Violation</strong></td>
<td>Verbal Coaching Documented Follow-up</td>
<td>Verbal Coaching Documented Follow-up May be classified as MINOR violation as determined by decision makers</td>
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</tbody>
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Preventive Care Guidelines Updated

SelectHealth and Intermountain Healthcare have worked with physicians and public health experts to update the Adolescent Preventive Care and Screening Guidelines. These recommendations help providers improve preventive care services through local standardization of national recommendations. View Preventive Care Guidelines.*

*These guidelines are not guaranteed to be covered under preventive care benefits

Review SelectHealth Reimbursement and Coding Policies for Accurate Billing and Payment

Reimbursement policies vary from payer to payer. This can be confusing for providers and their office staff. A number of reimbursement and coding policies are available on our provider website to help providers avoid coding and billing errors and facilitate more timely claims payment. The following are examples of our policies:

> Modifiers
> Preventive and Problem-Oriented Evaluation and Management Services
> Cerumen Removal
> After Hours and Urgent Care Charges

Reviewing coding and reimbursement policies helps your practice understand when it's appropriate to appeal for additional payment or send a corrected claim. Policies also outline the criteria and documentation requirements used for reviewing claims and appeals. These policies are available on selecthealthphysician.org. Your secure login, with the same User ID and password used to access other Intermountain Healthcare websites, is required to view the policies.

If you need help accessing the policies, contact your Provider Relations representative.

Documentation Requirements for Preauthorization Requests

As with most health plans, SelectHealth requires some services to be preauthorized prior to treatment to ensure appropriate utilization. The requesting office can facilitate timely, accurate reviews by providing supporting documentation and the appropriate clinical records with the preauthorization request.

Our clinical reviewers often do not have access to all clinical records. In addition, it is more appropriate for provider offices to determine which records are relevant to the requested review. Failure to submit clinical records supporting medical necessity at the time of the request may result in adverse determinations and potential delays in medically necessary procedures.

For prompt, accurate reviews, please submit all pertinent documentation with the completed preauthorization request form. The Request for Medical Preauthorization Form and Request for Substance-Related Preauthorization Form are available in the Provider Reference Manual on selecthealthphysician.org.

We appreciate the excellent care you provide our members and your cooperation in making the preauthorization process as efficient as possible.
Appealing Adverse Determinations

There are several types of appeals available in response to a denial of coverage or adverse determination. Understanding the difference in appeals, and where to send them, ensures a more timely review and response.

> Services denied as member responsibility, such as noncovered and some not medically necessary services, should be sent to Member Appeals at appeals@imail.org or by fax at 801-442-0762.

> Coding and bundling issues processed as a provider write-off should be faxed to Coding as directed on the Provider Appeal Form.

The Provider Appeal Form gives examples of each type of appeal, what information is required, and where each appeal should be sent, including the appropriate fax numbers.

Make sure all necessary documentation is submitted on the appeal. All documentation for the date of service should be submitted, not just the documentation related to the service in question.

Submitting appeals to the correct department, with all needed information, helps us respond to your request quickly and with the most accurate determination.

Care Management and Disease Management at SelectHealth

Whether it’s a new diagnosis or a major injury, specially trained Care Managers can help members navigate the healthcare system. SelectHealth Care Managers work alongside Care Managers throughout Intermountain Healthcare. Care Managers act as a liaison between the member and provider to make sure immediate and ongoing needs are met and that the most appropriate care is received. Care Managers also partner with members to establish personal health goals to help the member restore health or manage current health issues.

To help members take control of their chronic condition, our disease management team provides educational materials, access to online resources, newsletters, follow-up phone calls, and the expert support of a Care Manager.

One of the chronic conditions covered by a Disease Manager is asthma. If the member has had one or more visits to the emergency department within a six-month period for asthma OR they have been admitted for an inpatient stay with the primary diagnosis of asthma, the member is considered for disease management. Those currently taking Xolair are also considered for disease management.

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

For members with the RxSelect formulary, SelectHealth has placed a $75 limit on all compounded medications. Compounded medication claims over $75 will require preauthorization. As a reminder, compounded medications are not covered for those with the RxCore formulary.

Covered compounded medications are covered at a Tier 3 level for a number of reasons.

First, compounds are not FDA approved and have not been verified for the quality, safety, and effectiveness of the preparation. Since SelectHealth makes evidence-based formulary decisions, the scarcity of data for compound medications does not meet our standards for placing products in a preferred formulary position. Furthermore, compounded prescriptions can pose a significant safety risk to consumers. In 2012, sterility issues with compounded medications caused 64 deaths and over 750 cases of fungal meningitis. SelectHealth understands that compounds fill a need for those members who cannot take a commercially available product, and we provide coverage at a non-preferred formulary rate. When compounds are covered by SelectHealth, they are priced according to the ingredients along with a dispensing fee, then member cost-sharing is applied based on Tier 3 formulary status.

FDA-approved generic medications are covered at a Tier 1 level on the RxSelect formulary. FDA-approved products with superior safety or clinical merits are covered at Tier 2 (preferred formulary position), and the remaining FDA-approved products and compounds are at Tier 3. Of course, some medications are not covered at all, depending on the member’s formulary. All clinical decisions about formulary placement are made in conjunction with available evidence to ensure our members receive coverage for the safest, most-effective therapies possible. In doing so, our clinical pharmacists work in coordination with physicians and other pharmacists to evaluate medication literature and data and determine benefit structure.

SelectHealth Advantage®, our Medicare Advantage plan, may cover compounds under the Part B or Part D benefit up to a 90-day supply. There is a $150 limit for all compound medications. If all ingredients of the compound are generic, the compound will process at the generic pricing, but if any of the ingredients are brand name, it will process at the brand pricing. If one ingredient in the compound is covered under the Part B benefit, the entire compound is covered under Part B. Part D compounds can only cover the covered Part D ingredients. Pharmacies cannot balance bill Medicare members on compounds.

Only a 30-day supply is covered on Medicaid plans. The coverage is similar to commercial with a $75 maximum (plus a $3 copay when applicable). A compound will only be covered if it includes covered medications (covered NDCs) on the Community Care formulary.

References:
Immunization Update and ACIP Highlights

The Advisory Committee on Immunization Practices (ACIP) of the CDC met on February 24 to provide guidance on vaccines. Below are the key highlights:

- The 2016-2017 Influenza Vaccine recommendations were approved, and most restrictions for giving any influenza vaccine to egg-allergic recipients were removed.
- The FDA approved use of the 9vHPV vaccine in males ages 16 through 26 years, and Merck will retire the 4vHPV vaccine in 2016.
- CDC has developed a set of goals to address the Zika virus, including vaccine development.
- Evidence was presented supporting future recommendations regarding rotavirus vaccine, 2-dose 9vHPV vaccine, Men-ACWY vaccine in persons with HIV, Japanese Encephalitis vaccine, and Cholera vaccine.

Read the full report.

HEDIS Measurement: Breast Cancer Screening

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed healthcare plans.

Breast cancer is the second-leading cause of cancer death in women, exceeded only by lung cancer. The chance that breast cancer will be responsible for a woman’s death is about 1 in 36 (about 3 percent). Death rates from breast cancer have been declining since about 1989, with larger decreases in women younger than 50. These decreases are believed to be the result of earlier detection through screening and increased awareness, as well as improved treatment.¹
Mammography can detect breast cancer earlier when it’s more treatable. A mammogram is a safe test used to discover any signs of breast cancer. The United States Preventive Services Task Force recommends that women ages 50 to 74 have a screening mammogram every two years.²

This HEDIS measure calculates the percentage of women ages 50 to 74 who had at least one mammogram within the past 27 months.

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

**MEMBER OUTREACH**

- An interactive voice response telephone system offers the option of having a mammogram scheduling representative contact members for help scheduling their mammogram. It also gathers information about what barriers exist for breast cancer screenings. These barriers will be analyzed by population and additional interventions may be developed to address them.
- We send a mailer to members in need of a breast cancer screening. These are mailed, in English and Spanish, to commercial and Medicaid members in Utah and Idaho. It includes mammography center phone numbers. This brochure goes to women who receive the IVR phone call by Eliza.
- A quarterly program encourages each region to assist members in scheduling mammograms.

**PROVIDER OUTREACH**

- Monthly cancer screening reports are sent to PCP and OB/GYN providers showing which of their patients are due for cancer screening services.
- Breast cancer screenings are included in the Primary Care and Women & Newborn reports, public reporting, and Excellence in Healthcare awards.

If you would like more information, or if you are interested in learning more about other SelectHealth Quality Improvement programs, email Quality Improvement or call 801-442-7425.

References:

**SELECTHEALTH ADVANTAGE**

Get a Jump on 2016 Fraud, Waste, and Abuse, and General Compliance Training Requirements

The Centers for Medicare & Medicaid Services (CMS) announced changes to the current process for Medicare Fraud, Waste, and Abuse (FWA) and General Compliance Training. CMS participating providers who have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS are deemed to have met the CMS FWA training requirements. Deeming is at the level of the entity’s participation/accreditation (whether for the individual or entire organization.) Please note that deemed providers must still complete the General Compliance Training.

Effective January 1, 2016, First-Tier, Downstream, and Related Entities (FDRs), as well as delegated groups, are required to complete both trainings via the Medicare Learning Network (MLN) website. The trainings must be completed by each individual provider/practitioner with the group rather than one person representing the group collectively. The updated regulation requires providers/practitioners to complete training within 90 days of contracting with SelectHealth and annually thereafter. Each provider will need to submit an attestation to SelectHealth (one certificate for each training).
Encouraging SelectHealth Advantage® Members to Live Healthier Lifestyles

One of the core focuses at SelectHealth is encouraging our members to live healthier lifestyles to delay or prevent many chronic diseases and disabilities. To promote this, we are offering Healthy Living℠, an online wellness platform that rewards SelectHealth Advantage members for making healthy choices like exercising regularly and having an Annual Wellness Visit.

HERE’S HOW MEMBERS PARTICIPATE:

> Choose two or more wellness activities to earn at least 60 reward points.

> Record the completion of wellness activities using our online form any time from January 1 to December 14.

> Redeem 60 or more reward points for a Visa or Amazon gift card. For 2016, the gift card amount is $15.

Read more about the Healthy Living program, and encourage your patients who are SelectHealth Advantage members to participate and claim the rewards that come from Healthy Living.

Use the links below to access the General Compliance and FWA training on the MLN website. Scroll to the Downloads section of the webpage and select the Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

You can also access the training and attestation on selecthealthphysician.org.

KEEP PROPER RECORDS

Please keep completion certificates or other proof of training for at least ten years. If you use training logs or reports as evidence of completion, they must include:

> Employee names
> Dates of employment
> Dates of completion
> Passing scores (if documented)

Individuals who complete training through the MLN Module will be able to generate a certificate of completion, which FDRs should retain as evidence that their employees have completed the required training. These certificates must be submitted to CMS and/or SelectHealth upon request.

FDRs who complete the training using their own training module will need to retain evidence demonstrating that the CMS training was incorporated and not modified, as well as evidence that each employee completed the training.

SelectHealth still requires FDRs to attest to completion of the training requirements. If you have questions about this training requirement, please contact SelectHealth Compliance or your Contract Administrator.
**SELECTHEALTH COMMUNITY CARE**

**Discontinuing SelectHealth ID Card for Community Care (Medicaid) Members**

As of April 1, 2016, SelectHealth no longer issues ID Cards to new Community Care members. The intent is to simplify the experience for both the member and provider by eliminating the need to carry two cards. The state-issued Medicaid ID serves a multitude of purposes and is the member’s primary Medicaid services card.

Our system allows billing and inquiries using the Medicaid ID number (in addition to the SelectHealth ID). Our staff is trained to look members up for benefits and claims questions using this number. Eligibility should be verified each time a member presents for services, as it may vary by month. The state’s eligibility lookup tool provides not only the member’s eligibility status, but also which plan they are enrolled on, whether any copays apply, and if they have any provider restrictions. This step may be completed online or by phone.

> Medicaid Eligibility Lookup tool
> Eligibility phone (AccessNow): 801-538-6155

For questions or concerns regarding benefits and claims, call SelectHealth Member Services at 855-442-3234.

**Is Your Office Meeting Medicaid Access and Availability Standards?**

Utah Medicaid has established availability standards to ensure that Medicaid members, including those on SelectHealth Community Care, have timely access to quality care. These standards are outlined in our SelectHealth Community Care Provider Reference Manual and include medical and behavioral health appointment access standards depending on the severity of the need.

The reference manual also outlines how SelectHealth will monitor members’ access to care.

 Providers participating on our Community Care network are required to be familiar with and comply with these recommendations as part of their PPSA, and SelectHealth is required to monitor appointment wait times. Providers not adhering to the Access and Availability standards are subject to corrective action as outlined previously in this newsletter.

Review the Access and Availability section of our SelectHealth Community Care Provider Reference Manual.

**Major Life Changes**

Did you know that a Community Care member experiencing a major life change like moving, pregnancy, or a significant shift in income can affect their Medicaid eligibility? Encouraging patients to contact the Department of Workforce Services (DWS) to update their information in a timely manner improves accuracy and timing of communications and plan benefits.

Pregnant members are also encouraged to contact DWS postpartum to see if they are eligible for continued Medicaid coverage. Should circumstances change, making them no longer eligible for Medicaid, they may qualify for a Special Enrollment Period (SEP) for an individual plan through the Federally Facilitated Marketplace. Navigators from Take Care Utah provide one-on-one assistance to those seeking insurance coverage. Not sure where to begin? Member Services can answer questions and help these members know what to do. Call them at 855-442-3234.

Department of Workforce Services: 866-435-7414

Take Care Utah (Navigators): [http://takecareutah.org/](http://takecareutah.org/) or by calling 2-1-1
SELECTHEALTH DENTAL

Medicare Part D Prescriber Enrollment Requirement Update

In an effort to minimize the potential of disrupting Medicare beneficiaries’ access to needed Part D medications, CMS is delaying enforcement of the Part D Prescriber Enrollment Requirements until February 1, 2017.

With the delay, CMS is strongly encouraging prescribers of Part D drugs (except those who meet the definition of “other authorized prescribers”) to submit their Medicare enrollment applications or opt-out affidavits before August 1, 2016. This should provide sufficient time to process the prescribers’ applications or opt out affidavits and thus prevent prescription drug claims associated with their prescriptions from being rejected by Part D plans beginning February 1, 2017.

Refer to Part D Prescriber Enrollment for additional information.

Review Provider Responsibilities in SelectHealth Dental PPSA

Participating dental providers agree to adhere to common practices to ensure our members receive the highest quality dental care at the lowest appropriate cost. The following clauses from the SelectHealth Dental Participating Provider Service Agreement are important reminders to ensure claims are paid quickly and correctly.

> Notification of practice changes (II.15) - Provider agrees to notify SelectHealth of any changes to practice location(s) including but not limited to address changes, additional/fewer locations, contract information, etc. as soon as reasonably possible.

> Billing with Provider Identification Number (II.8.c) Provider shall bill using an appropriate provider number or other identification number agreed to by SelectHealth, and shall comply with federal and state regulations regarding electronic billing, when applicable.

> Billing Only Services They Perform (II.12) Provider agrees to adhere to the ethical standards of the profession and to avoid all improper billing or other unprofessional practices.

We appreciate the opportunity to partner with dental providers across the state to provide oral health care. If you have any questions, please contact Kim Robinson, Dental Provider Relations Manager.
CODING AND MEDICAL POLICIES, AND NEW TECHNOLOGY ASSESSMENT

Coding and Reimbursement Policy Update 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 Medical 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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEW POLICIES</strong></td>
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<tr>
<td>569</td>
<td>Urine Drug Testing in the Outpatient Setting (New)</td>
<td>1/1/2016</td>
<td>SelectHealth Commercial plans cover urine drug testing in the outpatient setting in limited circumstances when coverage criteria are met. (See criteria on policy) SelectHealth does not cover Point of Care (POC) urine drug testing using immunoassay methodology, G0479, excluding the emergency room visit. (Drug tests, presumptive, any number of devices or procedures by instrumented chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service) is not covered for any indication as current evidence demonstrates this testing lacks adequate sensitivity and specificity for its intended purpose and alternative methods are available. This methodology is not felt to be medically necessary. Testing frequency limits also established in policy.</td>
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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.

Note: New medical policies will not include ICD-9 after January 1, 2016. All other medical policies will include ICD-9 and ICD-10 codes through 2016. In 2017, ICD-9 codes will be removed from all policies.
SelectHealth covers IV antibiotics in the treatment of Lyme disease in limited circumstances when oral antibiotics have failed to eradicate the infection or patient is unable to take oral antibiotics.

**Coverage Criteria:**

A course of up to four weeks of intravenous (IV) antibiotic therapy is considered medically necessary for individuals with laboratory-confirmed Lyme disease whose diagnosis has been established by a board certified infectious disease specialist meeting ANY of the following criteria:

1. Myocarditis associated with second- or third-degree atrioventricular block, or with first-degree heart block when the PR interval is prolonged to 30 milliseconds or greater; or
2. Persistent or recurrent joint swelling (that is, arthritis) after an initial 1 month trial of oral antibiotics
3. Acute or chronic neurological disease affecting the central or peripheral nervous system, including ANY of the following:
   a. Meningitis
   b. Any neurologic syndrome with cerebrospinal fluid (CSF) pleocytosis
   c. Peripheral neurologic syndromes with normal CSF (including radiculopathy, diffuse neuropathy, mononeuropathy multiplex, or cranial neuropathy) if severe or following treatment failure with oral antibiotic therapy
   d. Encephalomyelitis
   e. Encephalopathy.

And antibiotic used is:

- Ceftriaxone (Rocephin®), cefotaxime (Claforan®), or Penicillin G
- Azithromycin (Zithromax®) in individuals with betalactam allergy or intolerance.

SelectHealth does not cover IV antibiotics for individuals with Lyme disease when above criteria are not met, including when the following IV drugs are used. Their use is considered investigational and not medically necessary:

- Carbapenems (e.g., doripenem, ertapenem, imipenem, meropenem)
- First-generation cephalosporins (e.g., cefazolin)
- Fluconazole
- Fluoroquinolones (e.g., levofloxacin, moxifloxacin).

SelectHealth does not cover other uses of intravenous (IV) antibiotic therapy for Lyme disease are considered investigational and not medically necessary, including, but not limited to any of the following:

1. Prophylactic treatment of individuals who have reported a tick bite but have no clinical findings suggestive of Lyme disease
2. Treatment of chronic fatigue syndrome or fibromyalgia attributed to Lyme disease
3. Initial treatment of Lyme arthritis without coexisting neurological symptoms
4. Treatment of persistent Lyme-associated arthritis after 2 prior courses of antibiotic therapy
5. Repeat or prolonged courses (greater than 4 weeks) of intravenous antibiotics.
6. Patients with symptoms consistent with systemic exertion intolerance disease fibromyalgia, in the absence of objective clinical or laboratory evidence for Lyme disease
7. Patients with seronegative Lyme disease in the absence of CSF antibodies
8. Cranial nerve palsy (e.g., Bell’s palsy) without clinical evidence of meningitis
9. Antibiotic-refractory Lyme arthritis (unresponsive to 2 courses of oral antibiotics or to 1 course of oral and 1 course of intravenous antibiotic therapy)
10. Patients with vague systemic symptoms without supporting serologic or CSF studies;
11. Patients with a positive ELISA test, unconfirmed by an immunoblot or Western blot test
12. Patients with an isolated positive serologic test in the setting of multiple negative serologic studies
13. Patients with chronic (>6 months) subjective symptoms (“post-Lyme syndrome”) after receiving recommended treatment regimens for documented Lyme disease. Repeat or prolonged courses (e.g., greater than 4 weeks) of IV antibiotic therapy are considered not medically necessary.

SelectHealth does NOT cover repeat PCR-based direct detection of B. burgdorferi as a justification for continuation of IV antibiotics beyond 1 month in patients with persistent symptoms or as a technique to follow therapeutic response. Use in these circumstances are considered investigational.

SelectHealth does NOT cover the certain other testing used to identify Lyme disease for the purpose of treating or following patients who have undergone treatment of Lyme disease as use of this testing is considered investigational. Excluded tests include the following:

- PCR-based direct detection of B. burgdorferi in urine samples in all clinical situations.
- Genotyping or phenotyping of B. burgdorferi.
- Other diagnostic testing, including, but not limited to C6 peptide ELISA or determination of levels of the B lymphocyte chemoaatractant CXCL13 for diagnosis or monitoring treatment.
- The direct probe technique and the quantification technique for detection of B. burgdorferi.

SelectHealth does not cover intramuscular antibiotics as a treatment of any aspect of Lyme disease. Use of intramuscular antibiotics is considered investigational and not medically necessary.

SelectHealth does not cover any home healthcare services such as nursing visits to administer noncovered antibiotics, maintenance of central venous catheters, or home care supplies for patients in whom the IV therapy is not covered.
### REVISED POLICIES

<table>
<thead>
<tr>
<th>Policy</th>
<th>Description</th>
<th>Date</th>
<th>Details</th>
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</thead>
</table>
| 567    | Blepharoplasty, Brow Ptosis Repair and Reconstructive Eyelid Surgery (Revised) | 12/7/2015 | Changes made under **Commercial Plan Policy**: “except for ectropion, entropion, anophthalmaic socket and trichiasis repairs where visual fields are not necessary” has been relocated under

A. Results of complete (taped and untapped) bilateral visual field examinations including visual points seen and not seen (except for ectropion, entropion, anophthalmaic socket and trichiasis repairs where visual fields are not necessary)

Under Coverage Criteria:
1. Blepharoptosis replaced levator resection in several areas.
2. Under Brow ptosis repair the word “BOTH” was removed and replaced with “at least one”
3. Section on trichiasis, ectropion or entropion rewritten for clarification
4. Criteria Under Eyelid surgery in patients with an anophthalmaic socket replaced with new language as below

   III. Eyelid surgery in patients with an anophthalmaic socket (has no eyeball) is considered reconstructive and medically necessary when BOTH of the following criteria are present:
   - Patient has an anophthalmaic condition
   - Patient is experiencing difficulties fitting or wearing an ocular prosthesis.

| 308 | Selective Internal Radiation Therapy (SIRT, Radioembolization) (Revised) | 12/7/2015 | Language changes made under **Commercial Plan Policy:**

   **Added coverage for:**

   Hepatic metastases from neuroendocrine tumors with diffuse and symptomatic disease when systemic therapy has failed to control symptoms

| 268 | Pelvic Vein Procedures for Pelvic Congestion Syndrome and Pelvic Varices (Revised) | 11/23/2015 | Added a section under the description on transcatheter sclerotherapy. The entire **Commercial Plan Policy** section was reworked by adding criteria for Pelvic Congestion Syndrome and Pelvic/Labial Varicosities.

| 158 | Oxygen Coverage (Revised) | 1/15/2016 | Section in **SelectHealth Commercial Plan** was rewritten to clarify coverage of portable oxygen as follows:

Note: The patient must demonstrate a need to ambulate beyond 50 foot limits of stationary system on a regular basis. Portable systems must be necessary for ADLs (in and about the home/work) or required travel beyond physician office visits, recreational travel, etc.

| 497 | Genetic Testing: Lynch Syndrome Screening/Testing for Colorectal Cancer (Revised) | 1/16/2016 | **SelectHealth Commercial Plan** revised with addition of requirement for genetic counseling and listing of specific coverage criteria

**SelectHealth covers genetic testing for Lynch/HNPCC syndrome for members under limited circumstances when specific criteria are met.**

**Coverage Criteria (Must meet ALL)**

1. Member being tested is >18 years old or 10 years younger than the earliest age of onset in the family, whichever is less
2. Member has been evaluated and testing recommended by a Genetic Counselor/Medical Geneticist
3. The presence of at least one of the following:
   a. Colorectal cancer diagnosed younger than age 50
   b. Individual with endometrial cancer younger than age 50
   c. Presence of synchronous, metachronous colorectal, or other HNPCC-associated tumors, regardless of age
   d. Colorectal cancer with the MSI-H histology diagnosed in a patient who is under age 60
   e. Colorectal cancer diagnosed with one or more first-degree relatives with an HNPCC-related tumor, with one of the cancers diagnosed under age 50
   f. Colorectal cancer diagnosed in two or more first- or second-degree relatives with an HNPCC-related tumor, regardless of age
   g. Known Lynch syndrome in the family
   h. Meeting Amsterdam criteria (all):
      i. at least three members of the family with colorectal cancer and at least one is a first degree relative of the other two
      ii. at least two generations of the family have colorectal cancer
      iii. one of the cases diagnosed before the individual was 50 years of age

Additional considerations:
- When testing an unaffected, at-risk member, if a deleterious Lynch syndrome mutation is known in the member’s family genetic testing for that mutation is all that is medically necessary
- IHC/MSI tumor testing should precede genetic testing. In instances where tumor specimen is not available, genetic testing for MLH1, MSH2, MSH6 and PMS2 should be allowed
<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Title</th>
<th>Effective Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>222</td>
<td>Genetic Testing: Inheritable Colon Cancer (Revised)</td>
<td>1/16/2016</td>
<td>Commercial Plan Policy revised to require genetic counseling and list specific coverage criteria. Coverage Criteria: 1. Evaluation and recommendation by a Genetic Counselor/Medical Geneticist not affiliated with the lab performing the test.</td>
</tr>
<tr>
<td>133</td>
<td>Insulin Pumps (Revised)</td>
<td>1/14/2016</td>
<td>SelectHealth Commercial Plan: Lowered coverage to age 2 for Animas® Vibe® Insulin Pump and Continuous Glucose Monitoring (CGM) System for individuals with diabetes meeting coverage criteria for insulin pump.</td>
</tr>
<tr>
<td>193</td>
<td>Varicose Vein Procedures (Revised)</td>
<td>1/11/2016</td>
<td>Added the following language under SelectHealth Commercial Plans: 1 - #2b under Coverage of Specific Therapies: For incompetent perforating veins (must meet at least one) 2 - Under SelectHealth does not over the following varicose vein treatments because each is considered experimental, investigational, or unproven (this list may not be all-inclusive): 1. Transilluminated powered phlebectomy (TIPP, Tri'Vex) 2. Cryostripping (including cryoaulation, cryofreezing) of any vein 3. Subfascial endoscopic vein surgery (SEPS)</td>
</tr>
<tr>
<td>385</td>
<td>Genetic Testing: Long QT Syndrome (Revised)</td>
<td>12/29/2015</td>
<td>SelectHealth Commercial Plan additional criteria added as follows: Clinical circumstance in which LQTS Genetic Testing is covered include ANY of the following: 1. Comprehensive LQTS genetic testing by multi-gene next generation sequencing is recommended for any patient in whom a cardiologist has established a strong clinical index of suspicion for LQTS based on examination of the patient’s clinical history, family history, and expressed electrocardiographic (resting 12-lead ECGs and/or provocative stress testing with exercise or catecholamine infusion) phenotype. 2. Comprehensive LQTS genetic testing is recommended for any asymptomatic patient with QT prolongation in the absence of other clinical conditions that might prolong the QT interval (such as electrolyte abnormalities, medications, hypertrophy, bundle branch block, etc., i.e., otherwise idiopathic) on serial 12-lead ECGs defined as QTc ≥480 ms (prepuberty) or ≥500 ms (adults). 3. Mutation-specific genetic testing is recommended for family members and other appropriate relatives subsequently following the identification of the LQTS-causative mutation in an index case. 4. Reflex deletion/duplication testing is indicated only if sequencing is negative.</td>
</tr>
<tr>
<td>354</td>
<td>Balloon Sinuplasty for Chronic Sinusitis (Revised)</td>
<td>1/1/2016</td>
<td>SelectHealth Commercial Plan: Policy modified to reflect coverage in office-setting ONLY Effective 1/1/16</td>
</tr>
<tr>
<td>129</td>
<td>Hyperbaric Oxygen Therapy (HBO2/ HBOT) (Revised)</td>
<td>2/3/2016</td>
<td>SelectHealth Commercial Plan: Acute Idiopathic Sudden Sensorineural Hearing Loss was added as covered condition if specific criteria met. Criteria include: 1. Condition must be present for &lt;14 days, 2. There must be formal audiology testing demonstrating hearing loss of ≥41Db 3. The patient is on concomitant systemic steroids 4. Patient age ≤60 Initial 10 treatments would be approved with additional 10 treatment approvable if patient has improvement</td>
</tr>
<tr>
<td>534</td>
<td>Formulas and Other Enteral Nutrition (Revised)</td>
<td>2/12/2016</td>
<td>SelectHealth Commercial Plans: Clarification of coverage of enteral supplies only: 1. Supplies only- In some circumstances the patient/member may be receiving a noncovered enteral feeding such as pureed ‘natural’ food or noncovered ‘OTC’ enteral formula not otherwise covered. In these instances, the patient/member may still qualify for the enteral supplies. Enteral supplies may be allowed coverage if the request meets all other criteria except the specific “The requested enteral formula can only be obtained through a pharmacy with a provider prescription.”</td>
</tr>
</tbody>
</table>
### REVISED POLICIES

|   | Heart Transplant: Children (Under age 18) (Revised) | 2/16/2016 | Under Commercial Plan criteria, HIV positivity has been changed from an absolute contraindication to a relative contraindication with criteria as outlined below.

Relative Contraindications (the following has been added)

#2 HIV positivity (can be considered if ALL of the following)
  a. no active or prior opportunistic infections or CNS lymphoma, or visceral Kaposi sarcoma,
  b. clinically stable and compliant on combination antiretroviral therapy (cART) for 43 months,
  c. have undetectable HIV RNA, and have CD4 counts >200 cells/μl for >3 months

Also added criteria #7 to relative contraindications:

#7 (other than non-proliferative retinopathy) has been added and or persistent poor glycemic control (HbA1C>7.5% despite optimal effort).

|   | Heart Transplant: Adult (Revised) | 2/16/2016 | Changes were made under **Commercial Plan criteria:**

**Absolute Contraindications:**

1. #2 (other than non-proliferative retinopathy), chronic infections, leg ulcers, or persistent poor glycemic control (HbA1C>7.5% despite optimal effort)
2. #15 Irreversible kidney disease was deleted
3. #16 HIV positivity was deleted
4. #14 severe pathology on was added to the line

**Relative Contraindications:**

1. #2 (Body Mass Index >35 kg/m² was added and 130% of ideal body weight was deleted.
2. #34 HIV positivity (can be considered if ALL of the following)
   a. no active or prior opportunistic infections or CNS lymphoma, or visceral Kaposi sarcoma,
   b. clinically stable and compliant on combination antiretroviral therapy (cART) for 43 months
   c. have undetectable HIV RNA, and have CD4 counts >200 cells/μl for >3 months

|   | External Cardioverter Defibrillator (Revised) | 2/29/2016 | Changes are under **Commercial Plan; criteria for coverage include:**

The first 30 days after myocardial infarction (MI) in patients with an ejection fraction (EF) <35%, has been changed to the first 40 days. Also, word “OR” has been added with within 3 months of CABG or PCI with ejection fraction (EF) <35%.

2. As a bridge to ICD risk stratification and possible implantation for patients:
   - Had ventricular tachycardia (VT) or ventricular fibrillation (VF) within 48 hours of a myocardial infarction (MI)
   OR
   - The first 40 days after myocardial infarction (MI) in patients with an ejection fraction (EF) <35% OR
   - Within 3 months of CABG or PCI with ejection fraction (EF) <35%
Technology Assessment (“M-Tech”) News at SelectHealth

“M-Tech” is the SelectHealth formal process for reviewing emerging healthcare technologies (procedures, devices, tests and “biologics”) to establish coverage benefits. Existing technologies are, at times, also examined through this process.

No new technologies have been assessed in the last quarter of 2015 or in 2016 to date.

Technologies currently under active assessment by the M-Tech Committee include those listed below. Notices will be sent to stakeholders to inform them of completed reviews and SelectHealth coverage determinations.

- Bariatric Surgery
- Cologuard for Colorectal Cancer Screening
- ConfirmMDx Prostate Cancer Test
- Decipher Prostate Cancer Classifier
- Entarra Gastric Pacemaker for Gastroparesis
- Hemorrhoid RFA Ablation
- iStent for Glaucoma
- Ligament Sparing knee replacement devices (e.g., Biomet Vanguard XP knee)
- 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
- Pharmacogenomic testing for Psychoactive Medications
- Prolaris for Prostate Cancer
- SIRT for Liver Cancer
- SphenoCath SPG Block for Migraine Management
- Sublingual Immunotherapy
- VBLOC for Weight loss

- Vermillion OVA1 for Ovarian Cancer
- Whole Genomic Sequencing/Whole Exome Sequencing in Oncology to Target Cancer Therapies

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. Click on “Secure Content” and enter your log in information. Then click on “Policies and Procedures” in the left navigation and then on “Medical Technology Assessment Program” in the center section for additional information.