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 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.
SelectHealth Recognizes Top-Performing Clinics with Excellence in Healthcare Awards

The SelectHealth Excellence in Healthcare award provides recognition for primary care clinics that deliver exemplary care in clinical quality and patient experience. We present it to clinics that perform in the top 10 percent of all eligible clinics for the following measures:

- Diabetes Management
- Asthma Management
- Childhood Immunizations
- Adolescent Immunizations
- Well-Child Exams for three- to six-year olds
- Well-Adolescent Exams for 12- to 21-year olds
- Breast Cancer Screening (Primary Care and OB/GYN/CNM clinics)
- Colon Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening (Primary Care and OB/GYN/CNM clinics)
- Customer Service for Internal Medicine, Family Practice, Pediatric, and OB/GYN/CNM specialties

In 2016, we presented 161 awards earned by primary care clinics, including pediatric, family practice, internal medicine, and OB/GYN/CNM specialties.

Congratulations to the clinics that earned the Excellence in Healthcare award in 2016:

| Alpine Pediatrics - Orem | Health First Family Medicine |
| Alta Internal Medicine | Holladay Family Practice |
| Callahan Clinic | Intermountain American Fork Internal Medicine |
| Canyon View - Santaquin Medical Clinic | Intermountain Heber Valley Clinic |
| Canyon View - Spanish Fork Clinic | Intermountain Maternal Fetal Medicine Specialists |
| Cedar City Institute of Women’s Health | Intermountain Avenues Specialty Clinic |
| Color Country Pediatrics | Intermountain Bear River Clinic |
| Comfort Care Pediatrics | Intermountain Bountiful Clinic |
| Cottontree Family Practice | Intermountain Budge Clinic |
| Cottonwood OB/GYN | Intermountain Cedar City Clinic |
| David Boettger Pediatrics | Intermountain Comprehensive Care Clinic - Murray |
| Dixie Primary Care | Intermountain Cottonwood Family Practice |
| Families First Pediatrics | Intermountain Cottonwood Internal Medicine |
| Foothill Family Clinic - Draper | Intermountain Draper Clinic |
| Graff Family Practice | Intermountain Hillcrest Pediatrics |
| Granger Medical Clinic - Millcreek | Intermountain Holladay Clinic |
| Granger Medical Clinic - Draper | Intermountain Holladay Pediatrics |
| Granger Medical Clinic - Riverton | Intermountain Kearns Clinic |
| Granger Medical Clinic - West Jordan |  |
Clinical measures are established in accordance with standardized, evidence-based criteria to encourage the best clinical care for SelectHealth members. We appreciate the remarkable efforts of the providers and clinic staff to accomplish this achievement.

“SelectHealth is proud to have such a dedicated network of medical professionals providing high-quality care to our members,” said Russel J. Kuzel, M.D., M.M.M, SelectHealth Vice President and Chief Medical Officer. “We are pleased to offer a program that encourages and supports providers in their work to help members improve and maintain optimal health.”

Award plaques were delivered to the clinics during autumn 2016.
Requests for Documentation: Help Us Help You

We know it can be frustrating to get a medication or procedure reviewed for authorization. However, the Centers for Medicare & Medicaid Services recently required that we perform additional outreach to ensure adequate documentation prior to making a determination. That means if the requesting provider does not submit documentation with the initial request, we must be more proactive in getting that information. To avoid receiving more calls, remember to always send all pertinent clinical information with an authorization request.

We receive many preauthorization and step-therapy requests with little or no supporting documentation. Requests without proper clinical documentation are denied, which generates more work for your staff through resubmissions and appeals. Pharmacy requests are especially time sensitive, and your most recent clinical notes referencing the requested medication and any supporting documentation will help us address these quickly and accurately. Thank you for helping us serve you—and your patients—better!

Expedite Documentation Reviews with Secure Email

To get documentation reviewed more quickly, email it!

Using your secure email system, send requested documentation to the appropriate email address to expedite reviews and ensure documentation remains secure. If you prefer to fax documentation, the secure fax number for each line of business is also listed.

Benefit Changes: Preventive Lab Services

Effective January 1, 2017, for SelectHealth commercial plan members, the lab services listed here are no longer covered as preventive, but are covered under medical benefits when billed with covered diagnosis codes:

- CPT 81000-81005 Urinalysis
- CPT 84443 Thyroid-Stimulating Hormone (TSH)*
- CPT 80053 Comprehensive Metabolic Panel
- CPT 80048 Basic Metabolic Panel
- CPT 80050 General Health Panel

*In individuals older than age one

When making policy decisions, SelectHealth evaluates coverage based on many factors, including evidence-based guidelines provided by public health agencies and the positions of leading national professional organizations. The coverage of these lab tests as preventive, or screening labs, is not supported by Intermountain Healthcare Primary Clinical Programs, Intermountain Population Health Management, the American College of Physicians®, or the American Academy of Family Physicians.

If you have questions about this policy change, please contact your Provider Relations representative. For questions about a specific member’s benefits, call Member Services at 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.
Know Your Network Participation Status

Do you know which of our networks (e.g., Select Care, Select Med, Select Value) are considered participating for your practice? To ensure that providers understand which networks they’re on, regulatory agencies have requested that we reach out to you. We recently conducted an email/phone call campaign and found that many offices were unsure of their network status.

Network participation is based on the SelectHealth agreements or amendments you have signed. Review your network participation on selecthealthphysician.org by clicking on “Provider & Facility Search” then entering the provider’s name. Networks are listed in the “SelectHealth Plans” drop-down under each provider’s name.

We are also required to have providers validate their basic office demographic data on a quarterly basis. Your validation will allow us to have the most up-to-date information in our directories.

Utah: Data validation attestations will be sent to your office by mail or email, depending on the preference you select when responding. Providers can designate an office manager or other proxy to review and update this information each quarter. To make updates or corrections, mail or fax the completed attestation form back to us, or make corrections directly to your profile on our website.

Idaho: Data validation attestations will be sent to your office by fax each quarter. To make updates or corrections, mail or fax the completed attestation form back as instructed on the form.

Thank you for helping us maintain accurate provider information.

Care Managers Can Help You

Whether it be a new illness, injury, or a chronic condition, a Care Manager can help your patient deal with the stress of coordinating a full continuum of care and navigating the system to meet their medical needs. They can also provide educational materials, DME supplies, and answers to most medication questions. Care managers offer great support for every need from medical crises to episodic care for chronic conditions.

We also offer expert disease managers who provide ongoing support for members with chronic conditions such as asthma, COPD, diabetes, heart failure, hepatitis, HIV, and hemophilia. Disease managers help members control chronic conditions to prevent or delay dangerous and costly complications.

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.

Implementing iCentra for Intermountain and Affiliated Providers

Intermountain Healthcare is committed to providing our employed and affiliated physicians access to technology that helps them practice evidence-based medicine. Our goal is to enable collaboration and help provide high-quality care for the community. A key part of this goal is having an advanced clinical and financial information system. That’s why we’re collaborating with Cerner to configure iCentra.

OPTIMIZING CARE

For the last several years, Intermountain has been working on iCentra, a customized EHR, to include our billing system, practice management system, and patient portal. Our Care Process Models have been built into iCentra, which will guide all providers through best practices.
The upgrade to iCentra will be complete by the end of 2017, with implementations in the Central Region and Primary Children’s Hospital (PCH) in 2017. Due to the large size of the Central Region, it will be divided into three implementations. Our first implementation is scheduled for February 25, which will ensure all three phases of the Central Region and PCH will be completed by the end of the year. The staged approach also allows Intermountain to provide our physicians and caregivers the necessary resources and support to help with their adoption and transition to iCentra. We have implemented many lessons learned from our previous implementations, and teams utilize these lessons as they continue region-specific builds and configurations.

**IMPLEMENT WHEN READY PHILOSOPHY**
Intermountain facilities will only go live on iCentra when we know the system is ready and all physicians and caregivers can use iCentra to continue providing high-quality care while keeping patients safe. Teams need time to become efficient on iCentra; proficiency will come from ongoing use and daily support for many weeks after going live on the system. Our iCentra project and region leaders continuously monitor several important factors to indicate a region's readiness.

Caregivers will soon be using one system as they move between facilities instead of HELP2 and our other legacy systems. Having the patient's complete record available to all physicians—employed or affiliated—will enhance the patient experience. Once all hospitals and clinics are live on the new system, the iCentra project team can focus their efforts on system improvements based on feedback from all regions.

If you have questions about iCentra or would like more information, please visit intermountainphysician.org/icentra or email iCentra@imail.org.

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**SelectHealth Covers The Weigh to Health® Program**

Weigh to Health is a six-month, evidence-based, standardized program that addresses weight management and lifestyle changes using a three-fold approach—nutrition, physical activity, and behavior modification. The Weigh to Health program includes a combination of individual and group sessions with a registered dietitian and other health professionals to provide your patients with the skills they need to lose weight and improve their health.

Most SelectHealth plans cover the upfront cost of the Weigh to Health program for patients with a BMI ≥30 OR a diagnosed weight-related comorbidity like high cholesterol, hypertension, or cardiovascular disease.

Orientations are held regularly (typically monthly) so patients can begin at their convenience at a facility near them. For more information and a list of facilities where Weigh to Health is offered, please visit intermountainhealthcare.org/nutrition. Click on “Services” then “Weigh to Health Nutrition Program.”

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**How effective is Weigh to Health?**

In 2015:

- 94.6% of participants completed the program
- 20.5% experienced at least a 5% reduction in weight, 50% of those experienced a 10% reduction in weight
- 33.1% increased to 150 minutes per week of physical activity
- 62.7% began eating breakfast 7 days per week
- 43.1% practiced mindful eating for 7 meals per week
- 37.5% regularly consumed 5 or more servings of fruits and vegetables per day
- 69.9% consumed 0 sweetened beverages
SELECTHEALTH ADVANTAGE
Prohibition on Balance Billing Qualified Medicare Beneficiary Program Individuals

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

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

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

QMB BALANCE-BILLING CLARIFICATIONS YOU SHOULD BE AWARE OF
It is imperative that you are aware of these policy clarifications to ensure compliance with QMB balance billing requirements.

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

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

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

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

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

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

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

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

FEATURING TOPICS...
- Credentialing
- Electronic Claims and Clearinghouses
- Medical Documentation
- Medicare Updates
- Mental Health
- Payer Panels
- Productivity and Revenue
...AND MUCH MORE!

Don’t miss this FREE, full-day opportunity to learn from experts in our community.
SELECTHEALTH COMMUNITY CARE

Medicaid Restriction Program

Utah Medicaid’s Restriction Program offers safeguards against inappropriate and excessive use of Medicaid services. Members may be referred to and enrolled in the program if they meet specific guidelines. Restriction criteria include any one of the following, based on 12 months of eligibility:

- Four or more Primary Care Providers (PCPs) used during a maximum of 12 months
- Four or more pharmacies used in a maximum of 12 months
- Three or more different providers prescribing drugs with abuse potential in a two-month period
- Six or more prescriptions with abuse potential filled in a two-month period
- Five or more nonemergent ER visits in 12 months

Many restricted program members require additional education and support to appropriately utilize healthcare resources. Upon meeting restriction criteria, the initial goals include establishing a PCP and connecting the members with a Care Manager at SelectHealth to support the member in correcting their overutilization.

We understand provider offices face unique challenges in working with this higher-needs population. Our Care Managers are available to assist you in coordinating care along the way.

Care Managers will work closely with your medical assistant or clinic Care Manager to find in-network specialists for referrals, enter the required authorizations, and talk with the member on a regular basis regarding their utilization of medical services.

Once a member is identified for restriction, we inform the PCP of the reasons for enrolling the member into the restriction program as well as the other providers the member currently sees. Whenever possible, we strive to keep the member connected to the PCP with whom he or she was established prior to restriction.

Oxygen Services Available From Intermountain Homecare

Effective January 1, Medicaid Oxygen of Utah/Alpine Home Medical no longer supplies oxygen services for SelectHealth Community Care members. Affected members were notified in December that they could obtain these services from Intermountain Homecare. Please be aware of this change if you have patients in need of oxygen services. Visit Intermountain Homecare for a list of locations that provide oxygen services, or call 385-887-7320.
SELECTHEALTH DENTAL

The Centers for Medicare & Medicaid Services (CMS) Delay Enforcing Prescriber Enrollment Requirements

CMS has announced the delayed enforcement of the prescriber enrollment requirements, previously set for February 1, 2017, until January 1, 2019. This means providers, including dentists, who prescribe medications for Medicare beneficiaries such as SelectHealth Advantage members have until 2019 to enroll in Medicare to continue prescribing for these members.

The American Dental Association (ADA) is working with CMS to resolve concerns of dentists throughout the nation in relation to this rule. We are following progress of these negotiations closely and will keep you informed as we learn more.

Review the most current information about prescriber enrollment requirements on the CMS website.

SelectHealth Dental Coding Guidelines

The ADA adds, deletes, and modifies dental codes every year. To ensure your office is submitting claims with the most accurate codes, please make certain you are using the 2017 edition of your Current Dental Terminology (CDT) coding book.

The following coding tips will help expedite claims processing:

BONE GRAFTING PROCEDURES

Note: If the correct CDT code is not used, the procedure will be denied as “inaccurate code.” Review the guidelines to help determine the most appropriate code to bill:

> **D4263** bone replacement graft – retained natural tooth – first site in quadrant
  
  Use when bone grafting is performed on a retained natural tooth

> **D7950** osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report
  
  Use when there has been a previous extraction and there is now a need to augment or reconstruct the bone to increase the height, width, or volume of the ridge

> **D7953** bone replacement graft for ridge preservation – per site
  
  Use at the time of a tooth extraction with no implant placed

> **D6104** bone graft at time of implant placement
  
  Use at the time of an implant placement, even if the tooth was extracted on the same day

> **D4249** CLINICAL CROWN LENGTHENING – HARD TISSUE
  
  > Clinical patient records must be submitted indicating a full tissue flap was reflected and there was removal of existing bone to improve the crown-to-root ratio, followed by the placement of sutures.

  > Use when it is not intended that the crown preparation and impressions would be performed on the same day, but would occur following adequate healing time after the surgical procedure.
PERIODONTAL CHARTING REQUIREMENTS

> All periodontal charting submitted must include the patient’s name and the date the probing was performed.
> Periodontal treatment performed cannot exceed 90 days following the submitted probing.

D3331 TREATMENT OF ROOT CANAL OBSTRUCTION; NONSURGICAL ACCESS

For use of this code, one or both of the following conditions must be present:

> Blockage of the canal by a foreign body, including but not limited to a pulp stone, broken post, or separated instrument.
> Calcification of 50 percent or more of the length of the canal in question. We require the submission of a narrative and/or clinical notes, accompanied by a radiographic image with an endodontic instrument in place indicating the level of blockage. If these conditions are not met, the root canal obstruction will be denied as inclusive to the primary endodontic procedure.

D2980 CROWN REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

This code will be considered for payment if the material used in the fabrication of the crown (porcelain, resin, or metal) has failed. This code cannot be used for the payment of an access opening created by endodontic therapy.

CLOSURE OF AN ENDODONTIC ACCESS OPENING ON AN EXISTING CROWN

Use one of the following one-surface filling codes:

> D2330 resin-based composite – one surface, anterior
> D2391 resin-based composite – one surface, posterior
> D2140 amalgam – one surface, primary or permanent

The use of D2950 core buildup, including any pins when required will be considered only for cases in which an existing crown is not already present or prior to re-cementation of the existing crown.

CDT 2017 DENTAL PROCEDURE CODES, AVAILABLE IN PRINT OR E-BOOK, IS NOW AVAILABLE

> As noted by the ADA, “In August 2000, the CDT was designated by the Federal Government as the national terminology for reporting dental services on claims submitted to third-party payers, in accordance with authority granted by the Health Insurance Portability and Accountability Act (HIPPA) of 1996.”
> CDT is the ONLY HIPAA compliant code set for reporting dental procedures.


View SelectHealth 2017 Dental Code Requirements outlining documentation needed for some dental codes.
CODING AND REIMBURSEMENT, MEDICAL, POLICIES, AND NEW TECHNOLOGY ASSESSMENTS

New Codes and Conscious Sedation

The latest versions of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) include over 700 updates. Remember to use your 2017 coding books to ensure your coding selections are the most up-to-date. Some notable CPT changes include codes for cardiovascular surgery, bunions, biomechanical, psychotherapy, and angiography (though there are quite a few more).

Another important CPT change was the addition of six new conscious sedation codes. This change affected over 400 codes that previously included reimbursement for conscious sedation. Please note, SelectHealth commercial lines of business will continue to bundle payment for conscious sedation with the payment of the procedure, just as we did for 2016 since we are using the 2016 Relative Value Units (RVUs) to determine the fee schedule for 2017. Below are the new conscious sedation codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99151</td>
<td>Moderate sedation services provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in monitoring the patient’s level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age</td>
</tr>
<tr>
<td>99152</td>
<td>Moderate sedation services provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in monitoring the patient’s level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older</td>
</tr>
<tr>
<td>99153</td>
<td>Moderate sedation services provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in monitoring the patient’s level of consciousness and physiological status; each additional 15 minutes intraservice time, (list separately in addition to code for primary service)</td>
</tr>
<tr>
<td>99155</td>
<td>Moderate sedation services provided by the same physician or other qualified healthcare professional other than the physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age</td>
</tr>
<tr>
<td>99156</td>
<td>Moderate sedation services provided by the same physician or other qualified healthcare professional other than the physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older</td>
</tr>
<tr>
<td>99157</td>
<td>Moderate sedation services provided by the same physician or other qualified healthcare professional other than the physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (list separately in addition to code for primary service)</td>
</tr>
</tbody>
</table>
Appropriately Coding Evaluation and Management (E/M) Services

The documentation and use of Evaluation and Management services is based on three “key” components:

1. History
2. Physical Exam
3. Medical Decision-Making

The E/M key components are the building blocks to determine appropriate levels of E/M codes. Some encounters (new patient, initial, and ED) require documentation for all three key components while others (established, subsequent) only require two of the three components. These key components are used to satisfy the documentation requirements for E/M coding.

Time may be another factor in determining appropriate E/M levels, but it should be the exception not the rule. As a general rule, SelectHealth expects providers to bill based on meeting the three key components appropriate to the CPT level billed.

Finally, medical necessity must support the level of service reported. For example, the treatment of a simple uninfected bug bite would not qualify for a comprehensive level of service regardless of the history and physical exam documented or the time listed in performing the evaluation and management of the condition.

Medical Policy Update Bulletin

The Medical Policy Update Bulletin is a quarterly notice of recently approved and revised medical policies—including an overview or summary of changes as well as the new and revised policies in their entirety. 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 we provide coverage for the procedures listed. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted medical policy, the provisions of the posted policy will prevail.

Note: In 2017, ICD-9 codes will be removed from all policies.

<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>593</td>
<td>Stem Cell Therapy for Orthopedic Application (NEW)</td>
<td>8/29/2016</td>
<td>Coverage under Commercial Plan: SelectHealth does NOT cover mesenchymal stem cell therapy. It is considered investigational for all orthopedic applications, including use in repair or regeneration of musculoskeletal tissue. SelectHealth does NOT cover allograft bone products containing viable stem cells, including but not limited to demineralized bone matrix (DBM) with stem cells, as this is considered investigational for all orthopedic applications due to a lack of evidence supporting safety and efficacy.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Date</td>
<td>Coverage under Commercial Plan:</td>
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</tr>
<tr>
<td>595</td>
<td>Minimally Invasive Fusion of the Sacroiliac Joint (NEW)</td>
<td>10/20/2016</td>
<td><strong>Coverage under Commercial Plan:</strong> SelectHealth covers minimally invasive fusion of the sacroiliac (SI) joint only using the iFuse Implant System® as a proven technology. <strong>Criteria for coverage (ALL must be met):</strong> 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. Persistent SIJ pain of moderate to severe severity despite conservative therapy (&gt;5 on 10 point VAS scale) 2. Documentation reflects SIJ pain confirmed with at least 3 physical examination maneuvers that stress the SI joint (e.g., distraction test, compression test, thigh thrust, FABER (Patrick’s) test, Gaenslen’s maneuver, sacral sulcus tenderness) and cause the patient’s typical pain 3. Confirmation of the SIJ as a pain generator with a 75% or greater acute decrease in pain upon fluoroscopically guided diagnostic intra-articular SI joint block using local anesthetic 4. Failure to adequately respond* to at least 6 months of non-surgical treatment consisting of non-steroidal anti-inflammatory drugs and/or opioids (if not contraindicated) including ALL of the following: a. Course of physical therapy b. Activity Modification c. SIJ steroid injection 5. Other diagnoses have been excluded through thorough clinical and radiological evaluation (e.g., L5/S1 compression, hip osteoarthritis) *Failure to respond is defined as continued pain interfering in activities of daily living or resulting in functional disability <strong>EXCLUSIONS:</strong> Minimally invasive SIJ fusion is NOT indicated for patients with the following: • Less than 6 months of back pain; • Failure to pursue conservative treatment of the SI joint (unless contraindicated); • Pain not confirmed with a diagnostic SI joint block; • Existence of other pathology that could explain the patient’s pain. 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.</td>
</tr>
<tr>
<td>600</td>
<td>Genetic Testing: Spinal Muscular Atrophy (NEW)</td>
<td>11/14/2016</td>
<td><strong>Coverage under Commercial Plan:</strong> SelectHealth covers genetic testing (SMN1 and SMN2) to diagnose infants suspected of having spinal muscular atrophy who have manifested symptoms suggestive of the disorder when ordered by an appropriate pediatric neuromuscular specialist, medical geneticist, or genetic counselor. SelectHealth covers carrier testing for spinal muscular atrophy (SMN1 and SMN2) to plan members when one of the following criteria is met (any ONE) 1. The individuals have a previously affected child with the genetic disease 2. The individual being tested has a first-degree relative with SMA or SMA-like disease 3. Individual is the reproductive partner of an individual affected with or carrier of SMA or SMA-like disease SelectHealth does NOT cover genetic testing for spinal muscular atrophy in any other setting including asymptomatic/pre-symptomatic screening in newborns as this is considered investigational.</td>
</tr>
<tr>
<td>596</td>
<td>First and Second Trimester Integrated Screening for Down Syndrome (NEW)</td>
<td>9/29/2016</td>
<td><strong>Coverage under Commercial Plan:</strong> SelectHealth covers first and second trimester-integrated screening for Down syndrome including nuchal translucency and quad testing, as the medical literature has shown this testing to positively affect the health outcomes of plan members.</td>
</tr>
<tr>
<td>597</td>
<td>Autologous Serum Eye Drops (NEW)</td>
<td>11/30/2016</td>
<td><strong>Coverage under Commercial Plan:</strong> SelectHealth does NOT cover autologous serum eye drops as it is considered experimental/investigational.</td>
</tr>
<tr>
<td>580</td>
<td><strong>Corneal Cross-linking for Treatment of Keratoconus (NEW)</strong></td>
<td>11/30/2016</td>
<td><strong>Coverage under Commercial Plan:</strong> SelectHealth does NOT cover corneal cross-linking for the treatment of keratoconus as this is considered investigational/experimental as current evidence is insufficient to determine long-term safety and efficacy.</td>
</tr>
<tr>
<td>591</td>
<td><strong>Computerized Spinal Analysis in Chiropractic Care (NEW)</strong></td>
<td>12/02/2016</td>
<td><strong>Coverage under Commercial Plan:</strong> SelectHealth does NOT cover computerized spinal analysis in the determination of spinal alignment or other spinal assessment as there is a lack of evidence demonstrating improvement in health outcomes with use of this technology. This is considered investigational/unproven.</td>
</tr>
<tr>
<td>592</td>
<td><strong>Percutaneous Tenotomy or Percutaneous Faciotomy (Tenex) (NEW)</strong></td>
<td>12/06/2016</td>
<td><strong>Coverage under Commercial Plan:</strong> SelectHealth does NOT cover percutaneous tenotomy or percutaneous fasciotomy (Tenex Health TX System or TX1, TX2) as it is considered unproven in the management of chronic tendonitis/tendinosis.</td>
</tr>
<tr>
<td>603</td>
<td><strong>PancraGEN Molecular Diagnostic Test for Evaluation of Pancreatic Cysts (NEW)</strong></td>
<td>11/29/2016</td>
<td><strong>Coverage under Commercial Plan:</strong> SelectHealth does NOT cover PancraGEN molecular diagnostic test for evaluation of pancreatic cyst as it is considered unproven.</td>
</tr>
</tbody>
</table>

**REvised POLICIES**

| 193 | **Varicose Vein Procedures (Revised)** | 9/21/2016 | **Commercial Plan:** A fourth system was added as not covered because it is considered experimental, investigational, or unproven to the policy. SelectHealth does not cover the following varicose vein treatments, added #4: Medical adhesive (also referred to as cyanoacrylate superglue, n-butyl-cyanoacrylate) (e.g., VenaSeal® Closure System). |
| 496 | **Tumor Treatment Fields for the Treatment of Glioblastoma Multiforme (Revised)** | 10/20/2016 | **Commercial Plan:** Coverage changed from not covered to Cover when criteria are met. SelectHealth does NOT cover tumor treatment field therapy outside its FDA approved indications or for any other tumor type or location. **Coverage Criteria (ALL must be present)**
1. Tumor treatment field therapy is being used in one of the following FDA approved indications
   a. Histologically-confirmed glioblastoma multiforme (GBM), following histologically- or radiologically-confirmed recurrence in the supra-tentorial region of the brain after receiving chemotherapy. The device is intended to be used as a monotherapy, and is being used as an alternative to standard medical therapy for GBM after surgical and radiation options have been exhausted.
   b. Use with temozolomide (TMZ) is indicated for the treatment of adult patients with newly diagnosed, supratentorial glioblastoma following maximal debulking surgery and completion of radiation therapy together with concomitant standard care chemotherapy.
2. The individual receiving therapy is >22 years of age
3. The member does not have an active implanted medical device (e.g., deep brain stimulators, spinal cord stimulators, pacemakers, defibrillators)
4. No bullet fragments in the area
5. No intraventricular shunts are present
6. No skull defects (e.g., missing bone with no replacement) are present
Authorization of rental equipment used in tumor treatment therapy field is limited to 6 months and that re-authorization of the device is contingent on use of the device a minimum of 18 hours/day and evidence for disease stabilization or improvement confirmed by MRI.
SelectHealth does NOT cover electrical field therapy for any other tumor type or circumstance as current evidence in other malignancies is insufficient to reach conclusions regarding efficacy and safety in these circumstances. |
<p>| 534 | <strong>Formulas and Other Enteral Nutrition (Revised)</strong> | 10/9/2016 | <strong>Commercial Plan:</strong> Changed policy to exclude Enzyme packed cartridges (e.g., Relizorb™ (Alcresta Pharmaceuticals)) for enzyme replacement in patients receiving enteral tube feedings. |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Title</th>
<th>Effective Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>543</td>
<td>Subcutaneous Mastectomy for Fibrocystic Breast Disease (Revised)</td>
<td>9/14/2016</td>
<td><strong>Commercial Plan:</strong> The mg on tamoxifen was reduced from 20 mg to 10 mg based on available studies.</td>
</tr>
<tr>
<td>351</td>
<td>Phototherapies for the Treatment of Skin Conditions (Revised)</td>
<td>10/24/2016</td>
<td><strong>Commercial Plan:</strong> Merged policy #170 PUVA Therapy (Photochemotherapy) into #351 Phototherapies For The Treatment of Psoriasis to make one policy. Policy #351 title changed to &quot;PHOTOTHERAPIES FOR THE TREATMENT OF SKIN CONDITIONS&quot;. Policy #170 PUVA Therapy (Photochemotherapy) has now been archived. Also added clarifying language related to when coverage of phototherapy for indications beyond psoriasis are allowed.</td>
</tr>
<tr>
<td>133</td>
<td>Insulin Pumps (Revised)</td>
<td>11/1/2016</td>
<td><strong>Commercial Plan:</strong> Aligned coverage language in policies #133, #223, and #548 to be consistent across policies.</td>
</tr>
<tr>
<td>223</td>
<td>Continuous Glucose Monitoring (CGM) Systems With and Without Real-Time Monitoring (Revised)</td>
<td>11/1/2016</td>
<td><strong>Commercial Plan:</strong> Aligned coverage language in policies #133, #223, and #548 to be consistent across policies.</td>
</tr>
<tr>
<td>548</td>
<td>Closed-Loop Insulin Delivery System (Revised)</td>
<td>11/2/2016</td>
<td><strong>Commercial Plan:</strong> Aligned coverage language in policies #133, #223, and #548 to be consistent across policies.</td>
</tr>
<tr>
<td>492</td>
<td>Oral Appliances for Sleep Apnea (Revised)</td>
<td>11/9/2016</td>
<td><strong>Commercial Plan:</strong> Revised limitations and exclusions language to clarify what is covered or not covered separately as part of oral appliance coverage. Specific language now states: <strong>Limitations/Exclusions:</strong> SelectHealth considers all visits associated with evaluation and fitting, including any imaging or functional testing as bundled into the payment of the device and will not cover as separate service.</td>
</tr>
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**ARCHIVED**

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<tr>
<td>170</td>
<td>PUVA Therapy (Photochemotherapy) (Archived)</td>
<td>11/03/2016</td>
<td>Archived policy as this therapy is now under policy #351.</td>
</tr>
<tr>
<td>324</td>
<td>First Trimester-Integrated Screening for Down's Syndrome (Archived)</td>
<td>11/18/2016</td>
<td>Archived policy, as this therapy is now under policy #596</td>
</tr>
<tr>
<td>213</td>
<td>Inhibin A Prenatal Testing (As Part of Antenatal Quad Screening) (Archived)</td>
<td>11/11/2016</td>
<td>Archived policy as this therapy is now under policy #596</td>
</tr>
</tbody>
</table>
Technology Assessment ("M-Tech") News at SelectHealth

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>Tumor Treatment Fields (TTF) for the Treatment of Glioblastoma Multiforme</td>
<td>September 27, 2016</td>
<td>Coverage in Limited Situations. Evidence has demonstrated the safety of TTF as monotherapy and as an alternative to standard medical therapy after surgical and radiation options have been exhausted. The evidence of improved patient outcomes, especially as a first-line therapy is more limited but has shown an improvement in overall and progression-free survival. See Medical Policy #496</td>
</tr>
<tr>
<td>Minimally Invasive Surgical (MIS) Sacroiliac (SI) Joint Fusion</td>
<td>September 27, 2016</td>
<td>Coverage in Limited Situations. The literature regarding MIS SI joint fusion illustrates clinically relevant patient improvements compared to conservative therapies or open SI joint fusion. There is substantial evidence from both short-term and long-term, cohort and randomized controlled studies to know the effects of iFuse on patient outcomes. Studies also demonstrate minimally invasive implant surgery using the iFuse system also appears to have lower morbidity and complication issues than open SI joint fusion. Evidence is lacking for other minimally invasive systems and thus, only the iFUSE system is currently covered. See Medical Policy #595</td>
</tr>
<tr>
<td>PancraGENTM Molecular Diagnostic Test for Evaluation for Pancreatic Cysts</td>
<td>November 29, 2016</td>
<td>Denied as Investigational. Current evidence is insufficient to establish clinical utility of this testing compared to standard alternative testing of pancreatic cysts. Additionally, use of this test would not seem to be cost effective and does not offer substantially improved clinical outcomes over current approaches to managing pancreatic cysts. See Medical Policy #603</td>
</tr>
<tr>
<td>Commercial Fecal Preparations in Fecal Microbiota Transplant</td>
<td>November 29, 2016</td>
<td>Covered. Though not FDA approved, current evidence supports the OpenBiome commercially prepared fecal microbiota product has equal safety and efficacy to the freshly prepared fecal specimens. See Medical Policy #522</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 are listed below. As the reviews are completed, notices will be sent to stakeholders accordingly to inform them of SelectHealth coverage determinations.

- Bariatric surgery
- Colon cancer recurrence testing
- ConfirmMDx® prostate cancer test
- Decipher® Prostate Cancer Classifier
- Entarra Gastric Pacemaker for gastroparesis
- Inspire® for the treatment of OSA
- iStent® for glaucoma
- 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
Neurostimulator for treatment of obstructive sleep apnea (OSA)
> Pancreatic Transplant Alone (PTA)
> Prolaris® for prostate cancer
> Pharmacogenomic testing for psychiatric medication management
> Renal autotransplant
> Selective Internal Radiation Therapy (SIRT) for liver cancer
> Sublingual immunotherapy
> vBloc® for weight loss

If you have questions regarding coverage of these or any other technologies or procedures or if you would like us to consider coverage for an emerging technology, please email us 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.”

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.