Welcome to the second edition of the redesigned Provider Insight® newsletter. As a reminder, this format enables us to post the newsletter online and email it to participating medical and dental practices and facilities. We will no longer print and mail the newsletter in the tabloid format.

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 our members.
Intermountain’s Patient Experience Transparency Initiative

For many years, Intermountain Healthcare® hospitals, Intermountain Medical Group®, and SelectHealth used a third party to collect patient experience data and shared that data with clinicians. By summer, Intermountain will begin sharing patient experience data with the public in a transparent manner. Patients seeing a physician as an outpatient in an office visit setting will be asked nine questions about their interaction with the physician. Surveys will be collected for physicians employed by Intermountain Healthcare and independent physicians who participate on one or more of the SelectHealth provider networks.

KEY ELEMENT OF THE SERVICE QUALITY INITIATIVE

> Dan Jones/Cicero will be the third-party vendor that conducts patient surveys, via phone, for both Intermountain Medical Group and SelectHealth. Another vendor will convert answers to a five-point star rating.

> The Medical Group and SelectHealth have adopted a patient survey that asks the same nine CG CAPHIS provider-specific patient experience questions. The CG CAPHIS survey is a standardized question set used in clinic or group outpatient settings.

> Patients will be notified during the survey that their responses will be used to create a rating and their comments will be posted on Intermountain and/or SelectHealth websites anonymously.

> We began collecting patient surveys using the new questionnaire on March 1.

> All comments will be reviewed. Any questionable comments will be flagged, reviewed, and evaluated before posting. Comments that contain vulgar or profane language will not be posted.

> Physicians will have access to their own data and any comments made by logging onto Intermountain’s physician portal beginning in April.

> Physicians will need at least 30 patient ratings before their ratings will be posted publicly.

> Ratings will roll off on an 18-month cycle.

> Our target date for posting physician-specific star ratings and comments on IntermountainHealthcare.org Provider Search is June 1, 2015.

POTENTIAL BENEFITS OF TRANSPARENCY INITIATIVE – PHASE I PATIENT EXPERIENCE

> Support patient expectations of increased transparency of information.

> Provide patient feedback to individual physicians to validate or improve their service and clinical quality.

> Provide local and national benchmarking comparisons.

> Meet ABMS Maintenance of Certification requirements associated with patient experience.

> Provide information, tools, and education to physicians who want to improve.

We understand this change may raise questions for physicians. If you have questions or would like more information about the initiative, please contact Dr. Brent Wallace, Chief Medical Officer at 801-442-3866 or via email at brent.wallace@imail.org, or Susan DuBois, AVP, Physician Relations and Medical Affairs at 801-442-2840 or via email at susan.dubois@imail.org.
CMS 1500 Form Version 02/12

REQUIRED FOR PAPER CLAIMS
Effective January 1, 2015, we no longer accept older versions of the HCFA/CMS 1500 claim form. If you aren’t sure which version you are using, look for the version date as shown above.

If you have not already done so, we encourage you to order OMB-0938-1197 FORM 1500 (02-12) from your vendor. Information about this form is available on cms.gov.

Refer Members Only to Participating Labs
As a reminder, participating providers are required to refer members to participating labs for their pathology services. This requirement is found in your Participating Provider Services Agreement (PPSA). Many of our members have limited or no benefits for claims submitted from nonparticipating laboratories.

To help our members receive participating benefits, please send all laboratory orders to one of our participating laboratories: Intermountain Laboratory Services and Laboratory Corporation of America (LabCorp) in Utah, or St. Luke’s in Idaho. If you do not have a draw station located in your office, find a participating draw center online. On the “Type of Facility” dropdown menu, select “Laboratory Draw Center.” You can specify the city, ZIP, or county to aid your search. If you need to refer a member for laboratory services not offered by one of these labs, contact Member Services at 800-538-5038.

Chronic and Complex Care Management Services
In 2015 a new code was developed for Chronic Care Management, CPT 99490. The codes for complex chronic care management services were revised for 2015. These codes should only be billed once per calendar month and may only be reported by a single physician.

Complex chronic care management services typically include:

> Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care
> Communication with home health agencies and other community services utilized by the patient
> Collection of health outcomes data and registry documentation
> Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living
> Assessment and support for treatment regimen adherence and medication management
> Identification of available community and health resources
> Facilitation of access to care and services needed by the patient and/or family
> Management of care transitions not reported as part of a transitional care management (99495, 99496)
> Ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service, noted above
> Development, communication, and maintenance of a comprehensive care plan
Chronic Care Management Services (CPT 99490)
Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- Comprehensive care plan established, implemented, revised, or monitored.

CPT 99490 is for non-face-to-face chronic care management services of at least 20 minutes per month. Patients who receive these services should have two or more chronic conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Complex Chronic Care Management Services (CPTs 99487 and 99489)
These services should not be billed if the duration of time spent is less than 60 minutes in a calendar month. The codes are defined as follows:

CPT 99487 Complex chronic care management services, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- Establishment or substantial revision of a comprehensive care plan;
- Moderate or high complexity medical decision making; and
- 60 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.

CPT 99489 Each additional 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month (list separately in addition to code for primary procedure).

Evaluation and Management (E/M) Coding and Guidelines
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 (e.g., new patient, initial, ED) require documentation for all three key components while others (e.g., 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. Generally, 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, 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.

**Modifier –59 and New “–X” Modifiers**

Effective for dates of service beginning January 1, 2015, CMS established four new HCPCS modifiers to define subsets of Modifier –59, which is used to define a “Distinct Procedural Service.” The new modifiers are XE, XS, XP, and XU.

**CODING GUIDELINES**

SelectHealth will accept and recognize the new modifiers but will treat them the same as Modifier –59. The new modifiers should not be used on the same CPT or HCPCS code as Modifier –59. These modifiers may not automatically bypass edits, and documentation may need to be submitted to justify their use.

According to the CMS *National Correct Coding Initiative Policy Manual*, “Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI edit if the Medicare restrictions are fulfilled.” (CHAP 1, pg. 21)

“Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass an NCCI edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.” (CHAP 1, pg. 25)


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**Modifier –59 Distinct Procedural Service**

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier –59 is used to identify procedures or services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.

Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, that modifier should be used rather than Modifier –59. Modifier –59 should only be used if no more descriptive modifier is available, and the use of Modifier –59 best explains the circumstances.

**Note:** Modifier –59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same day, Modifier –25 may be more appropriate.

**Modifier –XE** Separate encounter, a service that is distinct because it occurred during a separate encounter

**Modifier –XS** Separate structure, a service that is distinct because it was performed on a separate organ/structure

**Modifier –XP** Separate practitioner, a service that is distinct because it was performed by a different practitioner

**Modifier –XU** Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service
Mid-Level Providers Required to Credential or Follow “Incident To” Rules

Effective January 1, 2014, all mid-level providers billing under a provider’s license (e.g., PAs, NPs, PT assistants) were required to either be credentialed or follow “Incident To” rules. We continue to receive many claims from noncredentialed PAs and NPs who are not in compliance with “Incident To.” Many government-sponsored health plans require the rendering physician to bill directly for his or her services and do not support an “Incident To” policy. Credentialing PAs and NPs enables us to fully comply with government regulations. We will continue to deny claims from noncredentialed PAs and NPs that are not in compliance with “Incident To” rules. This decision applies to all lines of business.

We believe PAs and NPs play an important role in the care of our members. Credentialing these providers allows us to reimburse them directly for their services. It also allows provider-specific tracking for quality improvement purposes and may allow PAs and NPs to participate in quality improvement activities in the future.

If a PA or NP in your office is not credentialed, call your Provider Relations representative at 800-538-5054 to begin the credentialing process. PAs and NPs are eligible to participate on any network on which his or her supervising physician participates.

Non-Medically Indicated (Elective) Deliveries Prior to 39 Weeks Gestation

Non-medically indicated elective delivery prior to 39 weeks of gestation carries risks to the newborn without counterbalancing benefits and is costly in terms of neonatal care. Babies delivered earlier than 39 weeks are two to three times more likely to be admitted to intensive care. Elective delivery earlier than 39 weeks may also increase the rate of cesarean delivery. To mitigate potential complications, SelectHealth and Intermountain Healthcare are enacting the following policy.

Effective July 1, 2015, for all Utah SelectHealth Commercial and SelectHealth Community Care plans, every scheduled pre-39 week delivery will be reviewed to ensure the case either (1) met one or more nationally-accepted indications, or (2) had been approved as an exception by Intermountain Healthcare Maternal Fetal Medicine (with a written note by an MFM physician in the electronic medical record). For scheduled pre-39 week deliveries found to have not met either of these 2 criteria, the following financial sanctions will occur:

- Obstetric provider: A sanction will be applied to the applicable global maternity claims for the amounts that SelectHealth would have paid toward delivery charges. This will apply to all contracted professional providers.
- Intermountain facility: The Intermountain facility at which delivery occurs will be sanctioned for the cost of the delivery.

The SelectHealth member (the patient) will continue to be responsible to pay her normal cost-sharing amounts, and will not be sanctioned. An explanation code will be noted on the Remittance Advice indicating that the services were not allowed due to quality improvement program limitations (as outlined in the PPSA).

To ensure an anticipated scheduled pre-39 week delivery meets an acceptable indication(s), providers should use the Scheduled Delivery Documentation form.

If a physician is concerned that his or her reason for scheduling a pre-39 week delivery might not meet one or more nationally-accepted indications, he or she is encouraged to discuss the case with their regional Maternal Fetal Medicine physician prior to trying to schedule the case.

Learn more in the Intermountain Elective Labor Induction CPM.
Coverage of Advanced Lipid Panels

Several laboratory vendors provide advanced lipid profiling, including fractionation of LDL cholesterol and associated cardiovascular genetic testing along with an array of other tests that have not been shown to change health outcomes and are not recommended by the American College of Cardiology or other authoritative bodies. SelectHealth does not cover this testing and considers it unproven and not medically necessary.

While many of these laboratory providers inform practitioners they will not hold members responsible for any balance not reimbursed by the health plan, SelectHealth does not pay for noncovered services. Members are responsible for the cost of these advanced lipid panels, which can cost as much as $4,000.

Avastin No Longer Covered on Claims by Physicians Billing C9257

Avastin (bevacizumab) is a Vascular Endothelial Growth Factor (VEGF) inhibitor approved by the U.S. Food and Drug Administration (FDA) for the treatment of several oncologic conditions. Though not FDA approved, bevacizumab is frequently used off label for the treatment of age-related macular degeneration and other ophthalmic conditions. The dose of bevacizumab for ocular use is much smaller than doses used for oncology, and as a result, bevacizumab must be compounded before being administered as an intravitreal injection. In 2014, Noridian Healthcare Solutions released guidelines addressing coverage of bevacizumab when being billed through Medicare. These guidelines require that HCPCS J3590 unclassified biologics is reported when a compounded intravitreal injection is given.

For many years, SelectHealth covered bevacizumab for ocular use on commercial plans, as long as it was billed with HCPCS C9257 Injection, bevacizumab, 0.25 mg. To standardize the billing practices for this medication, SelectHealth will discontinue reimbursing claims for C9257 billed by physicians, effective June 1, 2015. Instead, all claims for bevacizumab for ocular use will be required to use code J3590 for all lines of business. The use of Avastin for oncology indications should continue to be billed using HCPCS J9035 Injection, bevacizumab, 0.10, after preauthorization has been obtained.

Coverage Determination for Vitamin D Assay Testing

For dates of service beginning July 1, SelectHealth Advantage and SelectHealth Community Care, will cover the following lab testing only when medically indicated based on CMS guidelines: CPT 82306 Vitamin D; 25 hydroxy, and CPT 82652 Vitamin D; 1, 25 (OH) 2 vitamin D. In addition, limits will be initiated by SelectHealth consistent with the CMS annual frequency with which these tests may be performed based on their medical necessity criteria.

The following information outlines the current CMS guidelines, subject to change as CMS updates their guidelines.

- Screening for vitamin D deficiency is not covered.
- The various component sources of vitamin D (such as stored D or diet-derived D) are included in one 25 OH vitamin D assay or one 1, 25 (OH) 2 vitamin D assay.
- Once a beneficiary has been shown to be vitamin D deficient, further testing is medically necessary only to ensure adequate replacement has been accomplished. Monitoring therapeutic replacement would not be expected to exceed two assays per year. Once therapeutic range has been reached, testing would not be expected to exceed one (1) assay per year.
- Repeated testing with both assays would not be expected.
CPT 82306 Vitamin D; 25 hydroxy, includes fraction(s), if performed

Vitamin D; 25 hydroxy is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed above. The diagnosis must be currently present for the procedure to be eligible for payment, and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient’s medical record must support the medical necessity for the test(s).

CPT 82652 Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed

Vitamin D; 1, 25 Dihydroxy is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed above. The diagnosis must be currently present for the procedure to be eligible for payment, and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient’s medical record must support the medical necessity for the test(s).

As a reminder, these guidelines are established by CMS and are subject to their updates. Contact your laboratory services provider to verify whether the procedure is currently covered with the presenting diagnosis. We anticipate a SelectHealth medical policy regarding these lab tests will be available by July 1, with more specific information. Reimbursement policies are available at selecthealthphysician.org.
Pharmacy Preauthorization Form Available

Medication preauthorization is sometimes necessary before coverage by SelectHealth due to cost, site of service, prescribing requirements, safety concerns, and/or other circumstances. Access a list of medications requiring preauthorization or other requirements for coverage on selecthealthphysician.org. Click on “Pharmacy,” then on “Drugs with Special Requirements.”

Select the appropriate plan type for the member: Standard/Commercial (RxSelect® and RxCore®), Medicare (SelectHealth Advantage), or Medicaid (Community Care). It is important to select the correct plan type because medication coverage and preauthorization requirements are subject to eligibility, limitations, and exclusions of each plan. After selecting the plan type, you will see a list of medications with special requirements for coverage, as shown above.

Each listed medication will indicate if preauthorization or step therapy is required for coverage and if the medication is covered under the medical or pharmacy benefit, if approved.

> If step therapy is listed, then alternative medication(s) must be tried before the medication requested is covered. Selecting the “View PDF” link will provide the specific step therapy requirements.

> For drugs requiring preauthorization, the “View PDF” link will pull up the preauthorization form for each medication. Using the specific preauthorization form for each medication will save time and ensure a more accurate review for consideration of coverage.

- If a medication requiring authorization does not have a specific form available on the website, the “General Exception Form” may be used.
- Print and fill out the form in its entirety.
- Fax the completed form to SelectHealth at 801-442-3006 for commercial and Community Care members or 801-442-0413 for SelectHealth Advantage members.
For SelectHealth Advantage members, medications may be paid under the Medicare Part B or Part D benefit, depending on the type of medication. Refer to the Drugs with Special Requirements site and click on “SelectHealth Advantage” to view specific preauthorization requirements for these members and whether the medication is paid under the Part B or Part D benefit. Please call Pharmacy Services at 855-442-9988 with questions.

SelectHealth strives to review all medication preauthorization requests within 72 hours of receipt; however, this time may vary based on the complexity of a review and if the necessary information was provided with the original request.*

*The 72-hour time frame is not applicable on all lines of business.

CONTACT SELECTHEALTH PHARMACY SERVICES:
Please call Pharmacy Services with questions about requirements for the following plans:
- Commercial plans - 800-442-3129
- SelectHealth Advantage – 855-442-9988
- SelectHealth Community Care – 800-442-3129

Coverage Determination for Toxicology Services
For 2015, SelectHealth will accept CPT 80300-80304, 80320-80377, and 83992; and HCPCS G0431-G0439 and G6030-G6058 codes for toxicology testing. The appropriateness of coverage for the 8XXXX codes will be evaluated in the future.

Immunization Update and ACIP Highlights
The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) met on February 26 to provide guidance on vaccines. Below are the key highlights:
- The preferential recommendation for LAIV (FluMist) in children ages 2 through 8 years was revoked. LAIV and IIV (inactivated influenza vaccine) are both appropriate options for healthy children in that age group who have no contraindications or precautions.
- 9-valent Human Papilloma Virus vaccine (HPV9) is recommended according to the same ages and dosing intervals as the previous recommendation for 4-valent HPV (HPV4) for females and males. A series started with HPV4 may be finished with HPV9. There is no recommendation for added doses of HPV9 for those who have already completed the HPV4 series.
- Meningococcal B vaccine (either two doses of Bexsero® or three doses of Trumenba®) is recommended for high risk individuals ages 10 and above including those with complement component deficiency, those treated with eculizumab, those with functional or anatomic asplenia, microbiologists exposed to Neisseria meningitis, and in an outbreak situation.
- One dose of the Yellow Fever Vaccine is sufficient for lifelong immunity with a few exceptions: women who were pregnant when vaccinated need one more dose prior to next travel, those with HIV when vaccinated, and those who received a hematopoietic stem cell transplant after vaccination and are sufficiently immunocompetent.

Read detailed information about the ACIP immunization guidelines.
SelectHealth Promotes New Mobile App

We’re happy to announce that the SelectHealth app is now available through the Google Play® and Apple App® stores! This free app allows SelectHealth members to access useful tools and data related to their plan whenever—and wherever—they need it.

SelectHealth members can:

- View, fax, or email SelectHealth ID Cards
- Search for participating doctors and facilities
- See Intermountain InstaCare® wait times and locations, and reserve their place in line before they arrive
- Access EOBs, determine amounts owed, and more
- Find out who is covered on their plan and view benefits
- Look at year-to-date medical and dental expenses
- See how medications are covered on their plan

Many members have started using the helpful features of this application. We recommend that you spend a few minutes navigating the application to become familiar with the features that may affect your office. Not only will this app help members become more informed, it will help your practice operate more efficiently.

New Provider Profile Images Needed for IntermountainHealthcare.org

UPLOAD A NEW, HIGH-QUALITY PROVIDER PROFILE IMAGE THIS WEEK

Please upload a new, high-quality photo of yourself to your Intermountain Provider Profile page. Your new image will show up on numerous Intermountain websites and applications. If you don’t upload a new image, you’ll only have a generic placeholder image on your provider profile and it won’t get as many page views. (Photos have already been collected for all Intermountain Medical Group providers.)

IMAGE GUIDELINES

- Upload only photo for which you own the copyright
- Source = Original file
- Large resolution: Image dimensions should be approximately 2,400 pixels wide by 3,200 pixels tall
- File size should be approximately 1mb to 3mb
- File format should be .jpeg (sometimes shown as .jpg)
- Image should be in portrait orientation
ICD-10: Brain Injuries

A traumatic brain injury (TBI) is described as a head injury that disrupts the normal function of the brain as a result of the head hitting an object or vice versa. Coding a TBI in ICD-9 required one code, 854 (intracranial injury of other and unspecified nature), without any additional specification. In ICD-9, there are sixteen available subcategories to append to 854, indicating whether the injury is with or without an open intracranial wound.

With the increased specificity offered by ICD-10, most of the TBI codes map as a one-to-many ratio, providing 83 possible ICD-10 codes. For example, ICD-9 code 854.06 maps to seven possible ICD-10 codes, as shown in the table below.

### ICD-10 codes for Intracranial Injury

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-9 Description</th>
<th>ICD-10 Code</th>
<th>ICD-10 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>854.06</td>
<td>Intracranial injury of other and unspecified nature, without mention of open intracranial wound, with loss of consciousness</td>
<td>S06.1X9A</td>
<td>Traumatic cerebral edema with loss of consciousness of unspecified duration, initial encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S06.2X9A</td>
<td>Diffuse traumatic brain injury with loss of consciousness of unspecified duration, initial encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S06.309A</td>
<td>Unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, initial encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S06.819A</td>
<td>Injury of right internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, initial encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S06.829A</td>
<td>Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, initial encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S06.899A</td>
<td>Other specified intracranial injury with loss of consciousness of unspecified duration, initial encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S06.9X9A</td>
<td>Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter</td>
</tr>
</tbody>
</table>

Get to the Heart of ICD-10

ICD-10 offers greater specificity in coding. Understanding the level of specificity is fundamental to a smooth transition into ICD-10. Physician documentation will help coders select the correct code to use.

Here’s an example of how specificity is crucial in the documentation: “Coronary Atherosclerosis of Native Coronary Artery,” 414.10, is the ICD-9 code used for Coronary Artery Diseases. With ICD-10, the base code will change and have five suffixes to offer more specificity.

The ICD-10 codes used to report this will be I25.10, I25.110, I25.111, I25.118, and I25.119. The base diagnosis, I25—Coronary Atherosclerosis of Native Coronary Artery, will be supplemented by suffixes to specify if chest pain is present and if so, what type (unstable, documented spasm, unspecified). It is critical that the documentation reflects enough information to support the suffix used in coding.

270/271 Eligibility

SelectHealth sends providers a detailed 271 response to an Eligibility and Benefit Inquiry (270). Responses include:

- Benefit information including copay and coinsurance for specific service types
- Real-time accumulators and limits including family and individual deductible, out-of-pocket, and visit limits
- Coordination of Benefit information
- Third-party administrator information if known

To initiate participation in the Eligibility Benefit Inquiry and Response with SelectHealth, call the SelectHealth EDI team at 801-442-5442. Please view the 270/271 Companion Guide online.
SELECTHEALTH ADVANTAGE

Fraud, Waste, and Abuse Training and Attestation Available Online

Providers who participate on the SelectHealth Advantage network are required to complete annual Fraud, Waste, and Abuse (FWA) and general compliance training. This is a requirement for all providers and entities that provide services to Medicare-eligible members.

An electronic attestation regarding completion of the training and other Medicare compliance requirements is available on selecthealthphysician.org and must be submitted by the contracted provider using his or her NPI. The FWA training requirements also apply to employees in your office who perform services related to the SelectHealth Advantage program. Providers and/or employees may review the training collectively—such as during a staff meeting. For multiple providers to complete the attestation at one time, they should enter the NPI numbers of all providers in attendance on the log-in screen.

Office managers can assist providers with this requirement by facilitating a group meeting to review the training.

If you have questions, call SelectHealth Provider Relations at 800-538-5054.

Documentation and Coding: What Is the Role of Risk Adjustment?

Medicare Advantage (MA) plans receive payments from the Centers for Medicare and Medicaid Services (CMS) to cover healthcare costs of members of that MA plan. These payments allow MA plans to pay for members’ medical costs and offer more robust benefits and services than Fee-For-Service Medicare such as fixed copays, wellness benefits, care management, and local customer service, among others. Patients who enroll in MA plans appreciate these additional benefits and services, which could not be offered without the CMS payments to the MA plan.

The amount of the payments to MA plans that allow for the additional benefits and services are based on the health and chronic medical conditions of members in the plan, as determined by physician documentation and coding of the MA enrollees’ chronic medical conditions. Therefore, the ability of the MA plan to be successful is dependent on the accuracy of physician documentation and coding of chronic medical conditions.

The process to determine the health and chronic medical conditions of members for the purpose of calculating payments to the MA plan is called “Risk Adjustment.” The methodology assigns a Risk Adjustment Factor (RAF) or “risk score” to each Medicare Advantage member. Each member’s risk score is multiplied by a fixed dollar amount, based on where the member lives, to determine the expected costs of providing care for that member. The resulting amount is what CMS pays the MA plan to cover their members’ medical costs, benefits, and plan-related services.

Risk scores are derived from the diagnosis codes reported on physician and hospital inpatient and outpatient claims data during a one-year time frame. Therefore, accurate and complete diagnosis (ICD-9 and soon ICD-10) coding is essential to appropriately reflect the chronic medical conditions and expected costs of the MA membership.

Only codes for chronic conditions that would be expected to increase healthcare costs are included in the calculation of the risk score. Consequently, coding with greater specificity results in a more accurate representation of the risk score than reporting nonspecific codes. Codes for acute or nonspecific conditions and redundant codes (two codes for different varieties of the same condition) are not included in the risk scoring.

The more specific the coding, the more accurate the risk score, with a resulting payment to the MA plan that more closely reflects the health status/illness burden of the individual MA member.
SelectHealth has several training opportunities available, including presentations and workshops, printed materials, and in-person training. Contact Provider Relations at 800-538-5054 or via email to learn more.

**SELECTHEALTH COMMUNITY CARE**

SelectHealth offers a Medicaid product, SelectHealth Community Care, in four Utah counties: Davis, Salt Lake, Utah, and Weber. The following information applies to providers participating in the SelectHealth Community Care network in these counties.

Coordinating Benefits With Medicaid

Coordination of Benefits (COB) is the process of determining which of two or more insurance policies will have the primary responsibility of processing/paying a claim and the extent to which the other policies will contribute. COB is intended to prevent the duplication of benefits when a member is covered by more than one insurance carrier, including other health insurance, retiree benefits, auto insurance, and workers’ compensation.

For members on SelectHealth Community Care, the Medicaid program is usually the payer of last resort, meaning that all other payers are considered before Medicaid. SelectHealth is the primary payer only in the following situations:

- Services provided are for prenatal care
- Services provided are pediatric preventive services
- Services provided are for a child who is in custody of the state

*Services must be covered under the state plan to be eligible for payment by Medicaid or SelectHealth.

Verify Eligibility of SelectHealth Community Care Members

When seeing SelectHealth Community Care patients, it’s important to verify Medicaid eligibility before providing care. State Medicaid eligibility can change on a month-to-month basis, and double-checking eligibility is the best way to make sure everyone is covered. Please use the Eligibility Lookup Tool and review the following cards to verify Medicaid eligibility:
Balance Billing

We want to remind providers that SelectHealth Community Care members may not be balance billed by contracted or non-contracted providers for denied non-covered services unless:

- The provider has an established policy for billing all patients for services not covered by a third party.
- The patient is advised prior to receiving a non-covered service that the plan will not pay for the service.
- The patient agrees to be personally responsible for the payment.
- A written agreement is made between the provider and the patient that details the service and the amount to be paid by the patient.
- The Medicaid Financial Agreement Form is completed by the provider and member.

When these requirements are met, the remittance advice may still show a contractual obligation but balance billing may be appropriate.

SELECTHEALTH DENTAL

Introducing Our New Dental Provider Relations Manager, Kim Robinson

Kim became the Dental Manager on March 1. “I am excited to be joining the Dental Team, and look forward to meeting with dentists and their office staffs, across the state. I am elated to have the opportunity to build positive and productive relationships with our valuable SelectHealth Dental partners.”

Prior to becoming the Dental Manager, Kim worked in a similar capacity with medical providers as the Provider Relations Manager for the North Region, since 2006. She has had numerous accomplishments and gained the respect of those with which she’s worked.

“I am eager to be of service and assist our dental providers and community in successfully meeting the oral health needs of our SelectHealth members.”

Updates About Pediatric Dental Benefits and Predeterminations

Due to the Affordable Care Act (ACA) and essential health benefits, some of our medical plans include preventive pediatric dental benefits. Members with this benefit are eligible to receive preventive pediatric dental services by presenting their medical ID Card. This benefit applies to members 18 years of age and younger.

- If a member presents his or her medical ID card in your office for services regarding a child, call Member Services to check their eligibility for these services.
- We will no longer provide predeterminations for pediatric preventive dental benefits under the medical product.

Call Member Services at 800-538-0538 to determine benefits for any patient.

CMS Enrollment Requirement for Dental Providers to Prescribe to Medicare Members

CMS recently published a final rule regarding qualified prescribers who write prescriptions for Part D drugs. The requirement applies to physicians and other healthcare practitioners, including dentists, with valid medication prescription authority under state law.

Effective December 1, 2015, Medicare Prescription Drug Plans and Medicare Advantage plans that include prescription drug coverage, such as the SelectHealth Advantage plan, will be required to deny coverage for Part D drugs except in the following circumstances:

- The prescriber is enrolled in the Medicare program in an approved status, or
- Has a valid opt-out affidavit on file with an A/B Medicare Administrative Contractor

Visit Medicare to enroll
Learn how to opt out
CMS has indicated that prescribers of Part D drugs must submit their Medicare enrollment applications or opt-out affidavits to their Medicare Administrative Contractors (MACs) by June 1, 2015, or earlier. This ensures there is sufficient time to process the applications or opt out affidavits and avoid having patients’ prescription drug claims denied by their Part D plans beginning December 1, 2015.

As a reminder, Medicare enrollment is not required for your participation on the Dental Advantage network. You can continue to see SelectHealth Advantage members and be reimbursed for dental services that are covered under the member’s optional dental benefit. The new regulation applies strictly to the requirements for coverage of prescription drugs you may prescribe to patients who are Medicare beneficiaries. Please be aware, however, that if you do not enroll with Medicare or submit an opt-out affidavit, starting December 1, 2015, SelectHealth will be required to deny coverage for any prescriptions you may write for a SelectHealth Advantage member.

**Paperless Electronic Reappointment Application**

Starting this year, Intermountain Healthcare and SelectHealth are using a paperless electronic reappointment application. This will be done online using a secure Intermountain Healthcare website. You will be contacted prior to your reappointment time with instructions on how to access the necessary information. Intermountain is using a standard application for all SelectHealth providers. There will be some sections of the electronic reappointment application that may not apply:

- Continuing Medical Education does not apply to dentists.
- Board Certification only applies if you are a pediatric dentist and have privileges at an Intermountain Healthcare facility.

A section that will apply to all providers is References—the electronic application requires three references to be entered. This is a change to the Dental Reappointment application; however, with the standard application, it is now required for all providers.

All reappointment information will be sent via email. If you do not currently have email, please establish an email account and send your email address to Odum Smith or fax it to 801-442-0431 to ensure your reappointment documents reach you when you are due for recredentialing.

If you have questions or concerns, please contact Odum Smith at 801-442-2873.
# Medical Policy and New Technology Assessment

## Medical Policy Update Bulletin

A quarterly notice of recently approved and/or revised Medical Policies is provided for your review. By accessing the Medical Policy Update Bulletin, you can view new and/or 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 Bulletin does not indicate that SelectHealth provides coverage for the procedures listed. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted Medical Policy, the provisions of the posted policy will prevail.

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Name</th>
<th>Policy Effective Date</th>
<th>Summary of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>556</td>
<td>Responsive Cortical Neurostimulation in the Treatment of Epilepsy (NEW)</td>
<td>9/16/2014</td>
<td>New policy was developed following an M-Tech review for Neuropace. Commercial plan covers responsive cortical neurostimulation in the treatment of epilepsy when criteria are met. SelectHealth Advantage follows commercial plan policy as there are no specific guidelines for responsive cortical neurostimulation in the treatment of epilepsy. SelectHealth Community Care may cover subject to the Utah Medicaid coverage status of codes applied to the procedure. These codes will need to be found on the State of Utah Medicaid Look Up Tool to confirm coverage. For covered codes, since there are no specific Utah Medicaid criteria, commercial plan policy will apply.</td>
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<tr>
<td>557</td>
<td>Radiofrequency Ablation of the Genicular Nerve (NEW)</td>
<td>9/1/2014</td>
<td>New policy was developed for Radiofrequency Ablation of the Genicular Nerve. Commercial Plan does NOT cover radiofrequency ablation of the genicular nerve in the treatment of osteoarthritis or any other indication as SelectHealth has found this procedure to be not medically reasonable and necessary since current evidence is insufficient to determine the efficacy and safety of this technology. SelectHealth Advantage does NOT cover radiofrequency ablation of the genicular nerve in the treatment of osteoarthritis or any other indication as SelectHealth has found this procedure to be not medically reasonable and necessary since current evidence is insufficient to determine the efficacy and safety of this technology. SelectHealth Community Care does NOT cover radiofrequency ablation of the genicular nerve in the treatment of osteoarthritis or any other indication as SelectHealth has found this procedure to be not medically reasonable and necessary since current evidence is insufficient to determine the efficacy and safety of this technology.</td>
</tr>
<tr>
<td>558</td>
<td>Interspinous Fixation (Fusion) Devices (NEW)</td>
<td>10/6/2014</td>
<td>New policy was developed for Interspinous Fixation (Fusion) Devices. Commercial Plan does NOT cover interspinous fixation devices alone for decompression of spinal stenosis or in combination with spinal fusion as they are considered experimental and investigational. SelectHealth Advantage limits coverage of interspinous fixation devices/spacers to their FDA approved indications. Any other use of these devices is NOT covered as investigational. SelectHealth Community Care does NOT cover interspinous fixation devices. There are no specific guidelines for interspinous fixation (fusion) devices. Commercial plan policy will apply.</td>
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<tr>
<td>559</td>
<td>Sphenopalatine Ganglion (SPG) Injection in the Management of Headaches (NEW)</td>
<td>11/5/2014</td>
<td>New policy was developed for Sphenopalatine Ganglion (SPG) Injection in the Management of Headaches. Commercial Plan does NOT cover sphenopalatine ganglion (SPG) block for the treatment of acute and chronic headaches as current evidence is insufficient to determine efficacy and safety of this procedure. SelectHealth Advantage does NOT cover this procedure consistent with CMS (LCD) L34775 and L34779. CMS does not list headaches as a covered diagnosis for these procedures, commercial plan policy will apply. SelectHealth Community Care does NOT cover sphenopalatine ganglion (SPG) block for acute and chronic headaches.</td>
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<tr>
<td>Policy Number</td>
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<tr>
<td>560</td>
<td>Magnetic Resonance Guided Focused Ultrasound For Essential Tremor (NEW)</td>
<td>12/3/2014</td>
<td>New policy was developed for Magnetic Resonance-Guided Focused Ultrasound for Essential Tremor. Commercial plan policy does NOT cover magnetic resonance guided focused ultrasound in the management of essential tremor as it is considered investigational. SelectHealth Advantage does NOT cover magnetic resonance guided focused ultrasound in the management of essential tremor as SelectHealth has determined it to be not medically reasonable and necessary. SelectHealth Community Care does NOT cover the procedure as C9734 is a non-covered code with the State of Utah Medicaid Program.</td>
</tr>
<tr>
<td>561</td>
<td>Vectra DA for Management of Rheumatoid Arthritis (NEW)</td>
<td>1/9/2015</td>
<td>New policy was developed for Vectra DA Blood Test for Rheumatoid Arthritis. Commercial plan does NOT cover Vectra DA blood test for rheumatoid arthritis as it is considered investigational. SelectHealth Advantage does NOT cover Vectra DA blood test as there are no specific guidelines from the local MAC, Noridian - jurisdiction F. Commercial plan policy will apply. SelectHealth Community Care does NOT cover Vectra DA as there are no Utah Medicaid specific guidelines. Commercial plan policy applies.</td>
</tr>
<tr>
<td>562</td>
<td>Corneal Hysteresis Testing (NEW)</td>
<td>1/12/2015</td>
<td>New policy was developed for Corneal Hysteresis Testing. Commercial plan does NOT cover as the procedure is considered investigational. SelectHealth Advantage does NOT cover the procedure consistent with (LCD) L24473 and L27445. SelectHealth Community Care does NOT cover as code 0181T is a non-covered code with the State of Utah Medicaid program and code 92145 had no coverage status at time of the review.</td>
</tr>
<tr>
<td>236</td>
<td>Robotic Assisted Surgery (REVISED)</td>
<td>9/29/2014, 2/24/2015</td>
<td>The addition of the Heller myotomy was added to the covered procedures in the robotic policy. “For cancer indications only” added after pharyngeal procedures under Commercial plan policy.</td>
</tr>
<tr>
<td>246</td>
<td>Mechanical Insufflation-Exsufflation Therapy for the Clearance of Airway Secretions (Coughassist device) (REVISED)</td>
<td>9/29/2014</td>
<td>An extensive revision was done on the Mechanical Insufflation-Exsufflation Therapy for the Clearance of Airway Secretions (Coughassist device). Commercial plan covers mechanical insufflation-exsufflation devices as medically necessary for patients with neuromuscular disorders with significant impairment of chest wall and/or diaphragmatic movement resulting in difficulty clearing secretions, a demonstrated reduction in peak cough expiratory flow rate of &lt;3L per second and for whom standard treatments (e.g., chest percussion and postural drainage, etc.) have not been successful in adequately mobilizing retained secretions. SelectHealth Advantage covers mechanical insufflation-exsufflation device consistent with Medicare Local Coverage Determination L12744. Where Medicare policy does not explicitly outline coverage, commercial plan policy will apply. SelectHealth Community Care covers mechanical insufflation-exsufflation devices for traditional Medicaid, subject to prior authorization, using criteria in the Medicaid Look up tool for code E0482. This device is not covered for non-traditional Medicaid. Code A7020 is covered up to every five years with quantity limit applied consistent with the State of Utah Medicaid Program.</td>
</tr>
<tr>
<td>538</td>
<td>Gene Expression Testing for Indeterminate Thyroid Nodule Biopsy (REVISED)</td>
<td>10/13/2014</td>
<td>A revision of Gene Expression Testing for Indeterminate Thyroid Nodule Biopsy with the criteria under the Commercial plan policy has been clarified.</td>
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<tr>
<td>357</td>
<td>Genetic Expression Profiling for Monitoring Acute Rejection in Cardiac Transplant Patients (Allomap) (REVISED)</td>
<td>8/28/2014</td>
<td>A revision was made to the Gene Expression Profiling for Monitoring Acute Rejection in Cardiac Transplant Patients (ALLOMAP). The revision of the policy changed #2, Criteria for Coverage, from &gt;18 years to &gt;15 years and #11 Exclusion Criteria, adding &lt;15 years.</td>
</tr>
<tr>
<td>260</td>
<td>DNA Analysis of Stool for Colon Cancer Screening (Pregen, Pregen-Plus and Cologuard) (REVISED)</td>
<td>10/15/2014</td>
<td>A revision was made to the DNA Analysis of Stool for Colon Cancer Screening (Pregen, Pregen-Plus and Cologuard) policy. The addition of Cologuard was added to be covered by SelectHealth Advantage. The coding for this test for Medicare is B1479, as Medicare does not cover HCPCS S3890.</td>
</tr>
<tr>
<td>320</td>
<td>Interspinous Distraction Devices/Spacers (REVISED)</td>
<td>10/8/2014</td>
<td>Former “X-Stop” policy extensively revised to include many other devices.</td>
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<tr>
<td>Policy Number</td>
<td>Policy Name</td>
<td>Policy Effective Date</td>
<td>Summary of Change</td>
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<tr>
<td>497</td>
<td>Genetic Testing: Lynch Syndrome Screening/Testing for Colorectal Cancer (REVISED)</td>
<td>10/20/2014</td>
<td>“The revision was made under the Commercial Plan Policy with the addition of the following language. &quot;In instances where tissue specimen are not available, genetic testing for MLH1, MSH2, MSH6 and PMS2 will be allowed without first doing Immunohistochemistry.””</td>
</tr>
<tr>
<td>493</td>
<td>Molecular Profiling of Tumors to Guide Cancer Therapy (REVISED)</td>
<td>11/14/2014</td>
<td>A revision was made to the Molecular Profiling of Tumors to Guide Cancer Therapy policy. The addition of FoundationOne has been added to the policy as NOT covered.</td>
</tr>
<tr>
<td>281</td>
<td>Gene Expression Profiling in the Management of Breast Cancer (REVISED)</td>
<td>1/1/2015</td>
<td>A revision was made to the Gene Expression Profiling in the Management of Breast Cancer. MammaPrint has been added to the policy as covered when criteria are met.</td>
</tr>
<tr>
<td>415</td>
<td>Breast Tomosynthesis (REVISED)</td>
<td>1/9/2015</td>
<td>A revision was made to change from noncovered to covered, effective 1/1/15, as outlined in the policy. Updated codes were added to the policy.</td>
</tr>
<tr>
<td>185</td>
<td>Negative Pressure Wound Therapy (Vacuum Assisted Wound Closure) (REVISED)</td>
<td>1/20/2015</td>
<td>A revision was made to the Negative Pressure Wound Therapy (Vacuum Assisted Wound Closure) following an M-Tech review of the SNaP® device. SelectHealth now covers NPWT using the nonmechanical SNaP® device in limited circumstances.</td>
</tr>
<tr>
<td>289</td>
<td>Genetic Testing: Cystic Fibrosis (REVISED)</td>
<td>2/1/2015</td>
<td>An extensive revision done on the Genetic Testing: Cystic Fibrosis (CF) policy. Most of the revision is under the Commercial Plan Policy for who would be covered for the test.</td>
</tr>
<tr>
<td>553</td>
<td>Urolift System® For The Treatment of Benign Prostatic Hyperplasia (REVISED)</td>
<td>1/1/2015</td>
<td>SelectHealth Advantage now covers this procedure consistent with Medicare Local Coverage Determination L24308.</td>
</tr>
<tr>
<td>474</td>
<td>Genetic Testing: BRCA1 and BRCA2 For Breast and Ovarian Cancer (REVISED)</td>
<td>2/20/2015</td>
<td>Changes in the policy:</td>
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<td>• “Diagnosed at any age with ≥1 close blood relatives* on the same side of the family diagnosed with breast and/or epithelial ovarian/fallopian tube/primary peritoneal cancer less than 50 years of age.”</td>
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<td></td>
<td></td>
<td></td>
<td>• “Diagnosed at any age and there are ≥2 close blood relatives* on the same side of the family with breast cancer or epithelial ovarian, fallopian tube, or primary peritoneal cancer at any age”</td>
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<tr>
<td>540</td>
<td>Hereditary Cancer Syndrome Multiplex Gene Panels (REVISED)</td>
<td>3/1/2015</td>
<td>Under the Commercial Plan Policy section clarification was made to the three criteria that need to be satisfied for coverage.</td>
</tr>
<tr>
<td>243</td>
<td>Artificial Spinal Disc Replacement (REVISED)</td>
<td>12/16/2014</td>
<td>SelectHealth commercial plan now covers Mobi-C for both one-level and two-level total disc replacement. All other covered cervical discs remain covered only for a single level.</td>
</tr>
<tr>
<td>223</td>
<td>Continuous Glucose Monitoring (CGM) Systems With and Without Real Time Monitoring (REVISED)</td>
<td>3/6/2015</td>
<td>Extensive changes to this policy were made including changes to the coverage for the professional CGM device. Changes included,</td>
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<td></td>
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<td>• Type 1 or type 2 diabetic patients on insulin with HgbA1C (A1C) changed from &gt;7 to &gt;7.5</td>
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<td>• Type 1 or 2 diabetic patients on insulin with recurrent hypoglycemic events</td>
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<td></td>
<td>• Type 1 or 2 diabetic patients on insulin with recurrent with wide glucose excursions (daily fluctuation of 200 mg/dl or more)</td>
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<td></td>
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<td>• Changes were also made to personal real-time continuous glucose monitoring for home use. These changes included: lowering the age limits for Type 1 diabetic patients from age 8 to ≥2 for coverage of Dexcom monitor only.</td>
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<td>• Reduced requirement for self-testing from ≥6 to ≥4</td>
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<td>Changed the requirements for replacements to now only being allowed when ALL of the following criteria are met:</td>
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<td>• Reduced requirement from 80% compliance to 50% compliance with the devices within a 90-day period instead of 30 days.</td>
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<td>• Reduced requirement of 3 diabetic medical provider visits to 2 diabetic medical provider visits within 12 months.”</td>
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</tbody>
</table>
Technology Assessment (M-Tech) News

M-Tech is the SelectHealth formal process for reviewing emerging healthcare technologies (procedures, devices, tests and “biologics”) for the purpose of establishing coverage benefits. Existing technologies are, at times, 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>Powered and Non-powered Negative Pressure Wound Therapy</td>
<td>1/20/2015</td>
<td>Cover in certain circumstances. Current evidence demonstrates the SNaP negative pressure wound system to have similar efficacy to standard NPWT systems in the treatment of chronic wounds. It is covered as being a proven therapy. Further, given the lack of evidence related to other non-motorized and/or disposable wound therapy devices’ effectiveness and safety, we recommend denial of coverage for the V.A.C Via or PICO devices as unproven/investigational. See Medical Policy #185</td>
</tr>
</tbody>
</table>

*Date Reviewed does not necessarily reflect the date of implementation of coverage policy.

Other technologies currently under active assessment by the M-Tech Committee include the following. As the reviews are completed, affected providers will be notified as necessary, and results will also be posted in this newsletter:

- Cryoablation for Desmoid Tumors
- Epifix Skin Substitute
- HBOT for Reynaud’s Disease
- MAGEC Spine Rods
- MRgFUS for Bone Mets
- MRgFUS for Prostate Cancer
- MRgFUS for Uterine Fibroids
- Propel Stent for Sinusitis
- Total Body MRI for Li-Fraumeni

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 or call 801-442-7585.

All SelectHealth medical policies and technology assessments can be viewed on our provider website. Click on “Policies & Procedures” and enter your login information.