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.
Provider Development: New Name, Same Great Service

Did you notice that we combined our Provider Relations and Provider Contracting departments? In mid 2016, we combined these two departments to form Provider Development under the leadership of Tom Wahlen, Assistant Vice President. This transition promotes enhanced coordination between teams responsible for facility and provider relationships and streamlines our ability to respond to the needs of each group.

We want to assure you that the great relationships and service you’ve enjoyed from your Provider Relations representatives, and those that vendors and facilities appreciate from their Provider Contracting analysts, will continue seamlessly.

The realignment in the Provider Development department fosters even greater support and collaboration among SelectHealth and our provider community as we place greater emphasis on population health and helping people live the healthiest lives possible.

We Hear You

We know our providers are driven to practice evidence-based care, and that is why we strive to provide coverage for these types of services. Evidence-based healthcare is clearly in the best interest of our members and patients—after all, these are our families, friends, and neighbors. Throughout its history, Intermountain has been committed to providing quality care by creating principles of standardized healthcare, which include the development of care process models and guidelines through clinical programs that use evidence-based medicine and local expertise. And as an integrated system, SelectHealth medical teams support this approach as well.

Patient safety and care efficiencies are being addressed on individual levels as well as through Population Health and the Geographic Committees. In an effort to align SelectHealth benefits, policies, and coverage determinations with these groups, SelectHealth has incorporated a Medical Director or CMO to participate.

One of our goals is to coordinate our benefits with established best practices. There may be times when the clinical guidelines or proposed approaches to manage a population may conflict with CMS regulations or SelectHealth member materials. SelectHealth medical directors may provide a unique perspective to the clinical programs concerning coverage principles. Our participation may allow for changes in SelectHealth plan coverage when appropriate, or adjustment in the guideline when CMS or SelectHealth coverage does not align with the guideline.

We want to help further the discussion. If you’d like one of us to attend a forthcoming clinical program work group or geographic committee meeting, please let us know. Likewise, we may send you a request to be invited when we feel there may be a benefit to our involvement in a discussion. Feel free to reach out to any one of the contacts below regarding future discussions.

Russ Kuzel, Vice President and Chief Medical Officer
Russ.Kuzel@selecthealth.org

Ken Schaecher, Medical Director
Ken.Schaecher@selecthealth.org

Krista Schonrock, Medical Director
Krista.Schonrock@selecthealth.org

Scott Whittle, Medical Director
Scott.Whittle@selecthealth.org

Roy Gandolfi, Medical Director
Roy.Gandolfi@imail2.org
Avoid CMS-1500(02-12) Claim Form Rejections

Claims with misaligned data slow down claim processing and can cause claim rejections. The CMS 1500(02/12) form has a number of changes that require significant adjustments to the print layout to ensure proper alignment of data. Please be aware of the changes below to avoid claim rejections due to improperly aligned claims.

ITEM 17
To the left of the dotted vertical line preceding the provider’s name, a new qualifier, identifying the provider’s role, must be entered. Medicare will reject claims submitted without one of the following valid provider qualifiers:

- DN - referring provider
- DK - ordering provider
- DQ - supervising provider

ITEM 21
1. A new indicator is required to specify the diagnosis code set on the claim. In the “ICD Ind” field found in the top right corner of item 21, enter either a “9” to indicate the ICD-9 diagnosis code set or a “0” to indicate the ICD-10 diagnosis code set. Claims submitted without a valid ICD indicator will be rejected.

   Note: ICD-9 and ICD-10 diagnosis codes cannot both be used on the same claim form.

2. Up to 12 diagnosis codes are now entered on the lines lettered A to L (instead of 1-4) and the lines read from left to right (instead of up and down).

We have noticed several incorrectly submitted 02-12 forms with diagnosis codes on lines A, C, I, and K only. Also note that we cannot accept the old 08-05 version template because it is not aligned properly for the new 02-12 form. Centers for Medicare & Medicaid Services (CMS) will reject claims with diagnosis codes submitted in nonconsecutive lines.

ITEM 24E
The diagnosis pointer must now be entered using the reference letter (A-L) from item 21 of the corresponding primary diagnosis for the date of service and procedure performed. Please do not report the diagnosis pointer in item 24e of the 02-12 claim using a number instead of a letter. CMS will reject claims submitted with a number(s) or with multiple letters in item 24e.

New Opportunities to Utilize SelectHealth Care Management

We thank those of you who participated in our recent WebEx regarding the SelectHealth preauthorization process with the SelectHealth Benefit Determination team! We look forward to our continued interaction through future WebEx meetings, including one about our Care Management program.

Our Care Managers would like to work directly with you to help our members live the healthiest lives possible. Our team is comprised of over 40 registered nurses and LCSWs, including specialists in certain diseases and behavioral health.

SelectHealth Care Management helps our members:

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

Upcoming initiatives in our Care Management program include a letter mailed to you when your member is enrolled, and a WebEx for more in-depth information including an opportunity to ask questions. Two new care management programs will be added in the fourth quarter of 2017; PTSD and hypertension.
If you would like to refer a member to Care Management or you have questions about the program, please call us at 800-442-5305, and choose the appropriate option:

- SelectHealth Advantage (Medicare): Option 1
- SelectHealth Community Care (Medicaid): Option 2
- All other SelectHealth plans: Option 4

Catch up on CMEs with Online Clinical Learning Days

Clinical Learning Day modules are now available online to all providers. These courses are valuable resources for Continuing Medical Education (CME). Providers are able to pay for and view the information at their convenience. Access a catalog of online modules today.

Explore Intermountain Healthcare’s Online Annual Report to the Community

Intermountain Healthcare’s Annual Report to the Community is now available online and includes videos and interactive features. The stories, statistics, and accomplishments captured in the Annual Report are a meaningful snapshot of the important work of the providers and caregivers who treat patients at Intermountain.

“The report’s theme—Helping People Live the Healthiest Lives Possible—is our mission and the focus of all we do,” said Intermountain President and CEO Marc Harrison, MD. “The report shares examples of how we’re working ‘upstream’ to improve health and prevent illness, how we provide leading-edge medicine at an affordable cost, and how we use new digital resources such as TeleHealth to reach people and improve care. We’re innovating and transforming healthcare in very exciting ways.”

A few highlights from our Annual Report to the Community include:

- **Extraordinary Care—Quad Style.** Indie, Esme, Scarlett, and Evangeline Gardner are active, healthy toddlers today thanks in part to the exceptional care they received as preemies by neonatologist, Dr. Stephen Minton and caregivers in the Newborn Intensive Care Unit at Utah Valley Hospital.

- **Rapid Team Response Minimizes Brain Damage After Stroke at Zion National Park.** For Chuck Dobry, a vacation from Michigan to Zion National Park included a potentially fatal stroke. But Chuck quickly returned to full, active health—and even finished his Utah vacation—thanks to his wife, Diane’s prompt recognition of stroke symptoms followed by fast emergency response and leading-edge care by specialists and caregivers at both Dixie Regional Medical Center and—via TeleHealth—Intermountain Medical Center.

- **Alex’s New Heart Gives Life, Love.** Alex Homer is one of more than 150 children who has received a heart transplant at Primary Children’s Hospital. Alex’s story demonstrates the life-changing care and collaboration that happens each day at Primary Children’s.
iCentra Now Live at LDS Hospital, TOSH, and Intermountain Medical Center

On May 6 and July 15, respectively, hospitals and clinics in the second and third phases of the Central Region implementation (CR2 and CR3) went live on iCentra. LDS Hospital, TOSH, and Intermountain Medical Center and their associated Medical Group clinics are now using iCentra. We also have 160 affiliated physician clinics in CR2 and 235 affiliated clinics in CR3 now using iCentra—approximately half of which have “View Only” access, which allows affiliated clinics to see patient test results, reports, etc. The remaining half have “View Only” plus “Surgery Scheduling,” a workflow that enables an affiliated clinic to request a scheduled time for a procedure and propose orders for that procedure.

iCentra implementations are disruptive and challenging, but iCentra is the “electricity” of Intermountain Healthcare—it will run data at Intermountain and give caregivers the decision support they need as they care for our patients. Intermountain is committed to a successful transition and we are looking forward to our contracted and affiliated providers being able to more easily access and share patient information, which will enhance collaboration and improve outcomes. As caregivers have learned to use iCentra, onsite support teams were available in facilities to assist them for several weeks. Intermountain teams made rounds on all affiliated physician clinics to assist in the resolution of issues and provide additional support and training as needed.

We are taking a very aggressive optimization policy as we continue iCentra implementations. Each new implementation looks different than those in previous regions due to continuous changes and enhancements. We actively solicit suggestions from real caregivers using iCentra to make improvements based on how they are using it—as a result, improvements continue alongside the builds for new regions. By the time the final group goes live this fall, they will be using a very refined version of iCentra.

The next and final group to implement iCentra will be Primary Children’s Hospital and the affiliated University of Utah clinics. The “go live” date is October 21, 2017, and caregiver training will begin August 21.
HEDIS 2017 Exceeds Expectations

Thank you for participating in the 2017 Healthcare Effectiveness Data and Information Set (HEDIS) quality measurement process. We appreciate your cooperation and timeliness in submitting the requested medical record information and/or accommodating the on-site appointment with the chart review nurses. The annual HEDIS project begins again in February 2018. For 2018, the National Committee for Quality Assurance (NCQA) has set the final deadline for collecting HEDIS data as May 8. HEDIS results are used by consumers to help in the selection of a health plan, which means your office could acquire new patients.

Again, thank you for your valuable time and attention in sending charts to us by fax, mail, secured email, or allowing us access to your Electronic Medical Record (EMR) system. Allowing us direct remote EMR access is the best way to reduce impact to your staff and office equipment. Each year, more and more locations are allowing EMR access. When EMR access is granted, we only need one or two accounts to access the specific members on our list. We submit a list of the charts we will review and we never look at any other charts. We review only the minimum necessary information to complete our review. If you would like to speak to someone regarding our HEDIS EMR data collection process, please contact Darin Clark at 801-442-7427 or by email.

SELECTHEALTH ADVANTAGE

CMS Broadens Hepatitis B Screening Coverage

Consistent with Medicare guidelines, screening for Hepatitis B Virus (HBV) is covered when ordered by a primary care physician or practitioner within the context of a primary care setting. In addition to existing guidelines for pregnant women, screening for HBV will be covered for asymptomatic, nonpregnant adolescents and adults at high risk for HBV infection (as defined by CMS). CMS has determined that repeated screening would be appropriate annually only for beneficiaries with continued high risk who do not receive a hepatitis B vaccination.
Reminder: See Every SelectHealth Advantage Patient Every Year

One of the best ways to improve the health and wellness of the SelectHealth Advantage population is to encourage these members to receive an annual comprehensive medical exam. We cover an Annual Wellness Visit (AWV) and a preventive exam or Evaluation and Management (E&M) visit on the same date of service. The code combinations in the following chart help identify the services rendered for the comprehensive exam:

During the comprehensive exam, remember to fully document and code all chronic conditions. When billing a comprehensive exam, documentation must include the following elements:

- Documentation that supports both codes
- Evaluation and assessment of all chronic medical conditions
- Current treatment plan for each condition
- Medical conditions coded with accurate and specific ICD-10

Every SelectHealth Advantage patient in your practice should be seen each calendar year. If you need a list of your patients who have not had the recommended services, please contact your SelectHealth Provider Relations representative.

<table>
<thead>
<tr>
<th>Service</th>
<th>Coding Combination</th>
<th>Modifier Requirement</th>
<th>Member Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Visit plus a Preventive Exam, Initial Visit</td>
<td>G0438 Annual Wellness Visit, including a personalized prevention plan of service, initial visit AND 99387 Initial comprehensive preventive medicine evaluation and management, 65 years and older</td>
<td>No modifier needed</td>
<td>No copay applies</td>
</tr>
<tr>
<td>Annual Wellness Visit plus a Preventive Exam, Subsequent Visit</td>
<td>G0439 Annual Wellness Visit, including a personalized prevention plan of service, subsequent visit AND 99397 Periodic comprehensive preventive medicine reevaluation and management, 65 years and older</td>
<td>No modifier needed</td>
<td>No copay applies</td>
</tr>
<tr>
<td>Annual Wellness Visit plus an E&amp;M Initial Visit</td>
<td>G0438 Annual Wellness Visit, including a personalized prevention plan of service, initial visit AND 99201-99205 Office visit for evaluation and management of a new patient, minor to high severity</td>
<td>A –25 modifier must be added to 99201-99205 procedure codes</td>
<td>Member copay applies to E&amp;M service</td>
</tr>
<tr>
<td>Annual Wellness Visit plus an E&amp;M Subsequent Visit</td>
<td>G0439 Annual Wellness Visit, including a personalized prevention plan of service, subsequent visit AND 99211-99215 Office visit for evaluation and management of an established patient, minimal to high severity</td>
<td>A –25 modifier must be added to 99211-99215 procedure codes</td>
<td>Member copay applies to E&amp;M service</td>
</tr>
</tbody>
</table>
CMS Stars Program

CMS works to ensure the delegated responsibility to care for Medicare Advantage members is offered to high-quality health plans and provider networks such as SelectHealth Advantage. The Stars measurement program is designed to monitor and reward clinical quality outcomes and excellent customer service. This is how health plans are held accountable to provide high-quality benefits and services to the Medicare beneficiaries they are entrusted to serve.

STARS MEASURES

One way to look at the Stars measures is by who controls the rating:

SelectHealth-driven measures are those for which SelectHealth has a direct impact on the ratings we receive. For example:

- For foreign language speakers, getting a translator on the phone and the member’s question answered in less than 6 minutes.
- Forwarding an appeals case that requires an evaluation by the Independent Review Entity (IRE) within the required time frame.
- Providing excellent customer service and delivering accurate information to members who call for assistance.
- Quickly resolving claims and/or benefit issues.

Provider-driven measures toward our rating are those that happen at the physician offices where our members seek care. For example:

- Providing information about the member’s health and their care plan in terms they understand.
- Access to schedule office visits in a reasonable time frame.
- Performing annual screenings and evaluations.
- Partnering with members to improve health outcomes and close gaps in care (CAHPs/HEDIS/Stars/HOS).

Member-driven measures are those in which a patient’s response to surveys determines our rating. These measure the patient’s perception of the care they received and the subsequent recall of those perceptions when surveyed. For example:

- Health outcome survey (HOS) in which a patient is asked if certain health concerns were discussed with their provider.
- CAHPs patient experience surveys in which patients are asked about their experience with staff and physicians following physician visits, results, member recall, and perception of service.

How Ratings Impact the Health Plan, Provider Network, and Members

- Higher Star ratings affect a plan’s ability to offer better benefits to members (like additional coverage for eyeglasses or exercise programs), lower premiums, and maintain/grow our membership.
- Direct and indirect impact: Supporting processes or other departments to meet Stars ratings is as important as those providing direct member-facing services.
- Achieving a high Stars rating (4 or 5) is a badge of honor for the health plan and our provider network, illustrating the excellent products, care, and services we provide our members.
SELECTHEALTH COMMUNITY CARE

Medicaid Face-to-Face Encounter Certification for Home Care/DME

Please be aware of a new Medicaid requirement for home care and Durable Medical Equipment (DME) ordered for SelectHealth Community Care members. Effective July 1, ordering physicians must certify that a face-to-face encounter occurred prior to ordering home care or DME.

- The new requirement only applies to those services covered by Medicare
- Telehealth visits qualify as a face-to-face encounter
- The current fee-for-service (FFS) Medicaid policy does not appear to be changing, as Medicaid feels requirements enforced for FFS already comply with the rule
- Home health organizations participating with SelectHealth Community Care are already compliant with the regulation
- These are the same requirements already in place for Medicare beneficiaries

If you have questions regarding this requirement, please contact your SelectHealth Provider Relations representative.

SELECTHEALTH DENTAL

What's New in Dental

For nearly a decade, SelectHealth Dental—in partnership with our network of dental providers—has been working to provide consistently superior services to our members, and we believe our efforts are paying off. Just this past April, SelectHealth once again had the privilege of participating with the Utah Dental Association at their 2017 Convention. While there, we received numerous positive feedback comments on how our multifaceted staff has worked to help our dental providers, often times with the request that we pass on kudos for a job well done to internal groups including: Member Advocates, Recoveries, Member Services, Coding Review, Business Systems, and so on.

NEW INITIATIVES FOR PARTICIPATING DENTISTS

Have you heard about these three Initiatives?

1. The Annual General Compliance and Fraud, Waste, and Abuse Trainings and Attestations
2. Directory Attestation
3. Prescriber Enrollment Requirements*

*Originally set for a February 1, 2017 deadline—this has been extended to January 1, 2019.

We’ve received more than a few inquiries asking why SelectHealth is requiring dental providers to complete these. If you have questions, please read on!

1. The Annual General Compliance and Fraud, Waste, and Abuse (FWA) Trainings and Attestations

Common concerns we’ve heard from dental providers regarding General Compliance and FWA training include:

- “Why is SelectHealth requiring me to do these Initiatives?”
  - Actually, the three initiatives are not from SelectHealth, but are from the Centers for Medicare & Medicaid Services (CMS). SelectHealth is merely passing the requirement on from CMS to all applicable Providers
- “Your participating SelectHealth provider does not accept Medicare (or) your participating provider does not have any patients who are Medicare enrollees. Why is this required?”
  - It is an annual CMS requirement for dental providers who are contracted with the SelectHealth Dental Advantage plan to complete and attest to General Compliance and FWA training.

If you are not sure whether or not you are currently contracted with SelectHealth Dental Advantage, please check your profile on our Provider Directory. If you’ve received notification on any of the three initiatives, but your online profile does not show Dental Advantage as one of your accepted insurance plans, please call Provider Development at 800-538-5054 and ask them to look at your current active plan information.
2. Directory Attestation

Effective January 1, 2016, CMS began requiring organizations to update and verify the information about providers they list in provider directories. The requirements specify that the “provider” must attest to the accuracy of their data at least every 90 days. There are potentially significant fines for SelectHealth if errors are found in the Dental Advantage directory.

We send out an email each quarter asking the providers to review their information and notify us/make any needed updates via PWP. We are now instructing providers that they need not do an attestation every quarter—they are free to ignore our email request if they do not have anything new to report.

Thank you for promptly helping us update and maintain your provider information. If you have any questions or difficulty with completing the process, please contact Provider Data Services at 801-442-5300.

3. Prescriber Enrollment Requirements

In an effort to minimize the potential disruption of Medicare beneficiaries’ access to Part D medications, CMS is delaying enforcement of the Part D Prescriber Enrollment Requirements until January 1, 2019.

Refer to CMS Part D Prescriber Enrollment for additional information.

CODING AND REIMBURSEMENT, MEDICAL POLICIES, AND NEW TECHNOLOGY ASSESSMENT

Coding Reminders

> **New codes from CMS** – CMS has released multiple new CPT and HCPCS codes in the past few months. To remain current on these updates, please refer to the CMS website.

> **Assigning category Z3A codes** – Codes in category Z3A (weeks of gestation) may be assigned to provide additional information about a pregnancy. Category Z3A codes should not be assigned as the primary/first-listed diagnosis.

> **Billing Bilateral Procedures** – To receive the appropriate reimbursement for bilateral procedures, report the procedure on two lines (once with a –LT modifier and once with –RT) rather than reporting once with a –50 modifier.

Billing Units for CPT 95165 for Provisions of Antigens for Immunotherapy

The proper use of CPT 95165 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses) has been a source of confusion for several years. However, since 2000, the description of this code in CPT coding books has essentially remained unchanged. Note the phrase at the end of the description: “Specify number of doses.”

In recent audits regarding the use of this code, discrepancies were found in billing practices for all provider specialties. These findings have prompted research into CPT, NCCI, and CMS guidelines, as well as seeking input from local physicians to help determine appropriate and consistent reimbursement policies for these services. As possibilities for future medical and coding and reimbursement policies are being considered, we would like to remind all providers of current CPT and CMS guidelines.

SelectHealth expects all providers to follow the instructions for CPT 95165 as described and published by the AMA and specify the number of doses for each vial of antigen regardless of the number of antigens administered.
Coding and Reimbursement Policy Bulletin

A quarterly notice of recently approved and revised Coding and Reimbursement Policies is provided for your review. By accessing the Coding and Reimbursement Policy Update Bulletin, you may view new and revised Coding and Reimbursement policies in their entirety, along with an overview or summary of changes. The appearance of a policy in the Coding and Reimbursement Policy Update Bulletin indicates that SelectHealth has recently adopted or revised a Coding and Reimbursement Policy. The Coding and Reimbursement Policy Update Bulletin does not indicate that SelectHealth provides coverage for the procedures listed. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted Coding and Reimbursement Policy, the provisions of the posted policy will prevail.

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Name</th>
<th>Policy Effective Date</th>
<th>Summary of Change</th>
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<tbody>
<tr>
<td><strong>REVISED POLICIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Post-Operative Debridement Following FESS (Revised)</td>
<td>05/30/2017</td>
<td>SelectHealth Commercial: Prior to May 31, 2017, if CPT 31231 or 31237 is billed within 90 days after a FESS procedure, it will be changed to S2342. After May 31, 2017, we will no longer change codes 31231 or 31237 if billed within 90 days after a FESS procedure. They will deny and providers will be required to submit a corrected claim billing S2342. SelectHealth Advantage and SelectHealth Community Care: No changes. Both lines of business will continue to reimburse 31237 as S2342 is not covered.</td>
</tr>
<tr>
<td>55</td>
<td>Ultrasound Guidance for Joint Tendon Sheath Trigger Point Injections (Revised)</td>
<td>06/07/2017</td>
<td>Clarification of language under SelectHealth Commercial: If documentation proves medical necessity, codes 20550–20553 may be paid on appeal when billed with 76942. Injection code range updated from 20605–20610 to 20600–20611.</td>
</tr>
<tr>
<td>61</td>
<td>Multiple Procedure Reduction for Radiology Procedures (Revised)</td>
<td>03/22/2017</td>
<td>SelectHealth Commercial, SelectHealth Advantage, and SelectHealth Community Care: Updated language to read “For subsequent units and procedures provided prior to 01/01/17, a 25-percent reduction will be applied for the Professional (-26) portion of the services rendered. For subsequent units and procedures provided on or after 01/01/17, a 5-percent reduction will be applied for the Professional (-26) portion of the services rendered.” Added codes 74712 and G0297 to this policy.</td>
</tr>
<tr>
<td>73</td>
<td>Multiple Procedure Reduction for Cardiology Procedures (Revised)</td>
<td>01/01/2017</td>
<td>SelectHealth Commercial, SelectHealth Advantage, and SelectHealth Community Care: Will follow the CMS policy that applies a payment reduction for multiple units or multiple diagnostic cardiology services when multiple units of diagnostic cardiology services and/or multiple procedures are billed for the same patient by the same provider on the same date of service. The payment reduction will be made to the Technical (-TC) portion of the services rendered.</td>
</tr>
<tr>
<td>74</td>
<td>Multiple Procedure Reduction for Ophthalmology Procedures (Revised)</td>
<td>01/01/2017</td>
<td>SelectHealth Commercial, SelectHealth Advantage, and SelectHealth Community Care: Will follow the CMS policy that applies a payment reduction for multiple units or multiple diagnostic ophthalmology services when multiple units of diagnostic ophthalmology services and/or multiple procedures are billed for the same patient by the same provider on the same date of service. The payment reduction will be made to the Technical (-TC) portion of the services rendered.</td>
</tr>
<tr>
<td>75</td>
<td>Supervised Anesthesia (Revised)</td>
<td>04/01/2017</td>
<td>SelectHealth Commercial, SelectHealth Advantage, and SelectHealth Community Care: Will follow the CMS policy in applying a 50-percent reduction in payment of the allowed amount for anesthesia services submitted with modifiers QK, QX, and QY due to the shared anesthesia services provided.</td>
</tr>
</tbody>
</table>
Medical Policy Bulletin

A quarterly notice of recently approved and revised Medical Policies is provided for your review. By accessing the Medical Policy Update Bulletin, you may view new and revised Medical Policies in their entirety, along with an overview or summary of changes. The appearance of a medical policy in the Medical Policy Update Bulletin indicates that SelectHealth has recently adopted or revised a Medical Policy. The Medical Policy Update Bulletin does not indicate that SelectHealth provides coverage for the procedures listed. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted Medical Policy, the provisions of the posted policy will prevail.

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<tr>
<td><strong>NEW POLICIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>602</td>
<td>Genetic Testing: Epilepsy (New)</td>
<td>05/19/2017</td>
<td>Commercial Plan&lt;br&gt;SelectHealth does NOT cover genetic testing for epilepsy, as it is considered investigational/experimental given the lack of identified direct clinical utility to this testing on patient management.</td>
</tr>
<tr>
<td>604</td>
<td>NanoKnife® Oncobionic System® (New)</td>
<td>05/24/2017</td>
<td>Commercial Plan&lt;br&gt;SelectHealth does NOT cover the NanoKnife® Oncobionic System for cancer treatment, as it is considered experimental/investigational.</td>
</tr>
<tr>
<td>608</td>
<td>Hypoglossal Neurostimulator (Inspire® Upper Airway Stimulation) (New)</td>
<td>03/14/2017</td>
<td>Commercial Plan&lt;br&gt;SelectHealth does NOT cover hypoglossal nerve stimulation for the management of obstructive sleep apnea, as it is currently considered unproven.</td>
</tr>
<tr>
<td>610</td>
<td>Pancreas Transplants (New)</td>
<td>04/18/2017</td>
<td>Combined policies #140 Combined Pancreas/Kidney Transplants, #161 Pancreas, and #248 Pancreas-After-Kidney (PAK) Transplant; and added new coverage criteria for #610 Pancreas Transplant Alone (PTA).&lt;br&gt;Please see policy for coverage.</td>
</tr>
<tr>
<td>611</td>
<td>Penile Implants (New)</td>
<td>04/27/2017</td>
<td>Commercial and SelectHealth Advantage Plans&lt;br&gt;SelectHealth does NOT cover penile implants as a standard benefit. Only plans with a sexual dysfunction rider will cover penile implants when the following criteria are met:&lt;br&gt;1. The history and physical exam of the member are consistent with sexual dysfunction.&lt;br&gt;a) The member has a medical (organic) condition that directly contributes to sexual dysfunction;&lt;br&gt;AND&lt;br&gt;b) Appropriate covered medical therapies have been tried and failed, such as testosterone replacement therapy, if appropriate or intracavernous aprastadil injections or suppositories, or PDE5 inhibitors.</td>
</tr>
<tr>
<td>613</td>
<td>Endobronchial Valves (New)</td>
<td>05/17/2017</td>
<td>Commercial Plan&lt;br&gt;SelectHealth does NOT cover endobronchial valves for any indication, as they are considered investigational.</td>
</tr>
<tr>
<td>614</td>
<td>Synthetic Cartilage Implant (Cartiva®) for Hallux Rigidus/Limitus (New)</td>
<td>06/01/2017</td>
<td>Commercial Plan&lt;br&gt;SelectHealth covers the Cartiva® Synthetic Cartilage Implants for use in the treatment of patients with painful degenerative or post-traumatic arthritis (hallux limitus or hallux rigidus) in the first metatarsophalangeal joint with or without the presence of mild hallux valgus.&lt;br&gt;SelectHealth does NOT cover Cartiva Synthetic Cartilage Implants for any other indication, as it is considered experimental/investigational.</td>
</tr>
<tr>
<td><strong>REVISED POLICIES</strong></td>
<td></td>
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</tr>
<tr>
<td>115</td>
<td>Cryosurgery for Prostate Cancer (Revised)</td>
<td>03/13/2017</td>
<td>Commercial Plan&lt;br&gt;Modified wording to provide clarification. New language now reads:&lt;br&gt;SelectHealth covers cryosurgical ablation for localized prostate cancer as either initial or salvage therapy in patients with T1-T3 disease.&lt;br&gt;SelectHealth does NOT cover subtotal cryosurgical ablation for prostate cancer to one lobe or partial lobe. This meets the plan’s definition of investigational/experimental.</td>
</tr>
</tbody>
</table>
### REVISED POLICIES

<table>
<thead>
<tr>
<th>Policy Code</th>
<th>Policy Title</th>
<th>Effective Date</th>
<th>Revised</th>
<th>Description</th>
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<tbody>
<tr>
<td>179</td>
<td>Spinal Cord (Dorsal Column) Stimulation for the treatment of Chronic Pain (Revised)</td>
<td>03/24/2017</td>
<td>Commercial Plan</td>
<td>Added clarifying language to denote high-frequency spinal cord stimulation is not covered. Language now reads: SelectHealth covers non-high-frequency spinal cord stimulation (SCS) when ALL the criteria are satisfied AND any one of the diagnoses listed has been established. SelectHealth does NOT cover high-frequency sacral nerve stimulation, as it is considered investigational/experimental.</td>
</tr>
<tr>
<td>190</td>
<td>Pancreas Islet Cell Transplants (Revised)</td>
<td>04/12/2017</td>
<td>Commercial Plan</td>
<td>Policy separated from pancreas transplant policy and is now a stand-alone policy. Additionally, SelectHealth now covers autologous pancreas islet transplantation for patients undergoing a near-total or total pancreatectomy for severe refractory chronic pancreatitis. However, SelectHealth will NOT cover autologous pancreas islet transplantation for any other indication, as it is considered investigational. SelectHealth will NOT cover islet cell allotransplantation (i.e., transplantation of islet cells from a donor), as it is considered experimental/investigational.</td>
</tr>
<tr>
<td>193</td>
<td>Varicose Veins (Revised)</td>
<td>05/25/2017</td>
<td>Commercial Plan</td>
<td>Language related to the number of sessions allowed was modified to allow for improved clarity as to the coverage intent. The new language now reads: <strong>Treatment session</strong> &gt; Coverage will be considered for two initial sessions. Examples of these initial two sessions may include: a. One operative session each leg; or b. One operative session encompassing all deep treatments to both legs followed by a second session to treat more superficial treatment to both legs; or c. One operative session encompassing the anterior segments of both legs, then a second session to treat posterior elements of both legs.</td>
</tr>
<tr>
<td>222</td>
<td>Genetic Testing: Inheritable Colon Cancer (Revised)</td>
<td>05/02/2017</td>
<td>Commercial Plan</td>
<td>The HNPCC-related tumors were added to the policy. The policy now states: HNPCC-related tumors include: Colorectal, endometrial, gastric, ovarian, pancreas, ureter, and renal pelvis, biliary tract, brain (usually glioblastoma), and small intestinal cancers, as well as sebaceous gland adenomas and keratoacanthomas.</td>
</tr>
<tr>
<td>351</td>
<td>Phototherapies for the Treatment of Skin Conditions (Revised)</td>
<td>05/26/2017</td>
<td>Added clarifying language to define skin conditions under criteria for coverage. The criteria for coverage now states: <strong>(Must meet all)</strong> &gt; Patient has 1 of the following diagnoses: • Extensive, severe psoriasis (defined as psoriasis involving 10% BSA) refractory to topical therapy, or nonbiologic systemic therapy • Cutaneous T-cell lymphoma (CTCL)/mycosis fungoides • Any of the skin conditions listed above with involvement of the palms or soles also refractory to topical or nonbiologic medical therapy &gt; Patient requires UV light treatments at least 3 times per week &gt; Treatment is being prescribed by a dermatologist &gt; Provider has documented member as having demonstrated measurable improvement with initial treatment in the provider’s office after a minimum of 12 visits occurring within a 60-day period &gt; Provider has documented member to have &gt;90% compliance with office-based therapy and has been provided written documentation of the risks of home therapy</td>
<td></td>
</tr>
<tr>
<td>387</td>
<td>Genetic Testing: FGFR1 for Lobular Breast Carcinoma (Revised)</td>
<td>02/16/2017</td>
<td>Added the word “Breast” to the title for clarification.</td>
<td></td>
</tr>
<tr>
<td>Policy Number</td>
<td>Description</td>
<td>Date</td>
<td>Effective Date</td>
<td>Policy Type</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
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</tr>
</tbody>
</table>
| 463           | Panniculectomy/Abdominoplasty (Revised) | 04/27/2017 | 04/27/2017     | Commercial Plan | Added clarifying language to the section on when panniculectomy is not covered. The exclusion language now reads: The following are considered not medically necessary (list is not all inclusive):  
> The procedure(s) is performed solely to enhance the patient’s appearance, as this is considered cosmetic in nature  
> Permanent overstrecthing, with or without diastasis recti, of the anterior abdominal wall secondary to massive weight loss or pregnancy, resulting in a large pendulous or protruding abdomen  
> Suction-assisted lipectomy (liposuction) as a primary procedure because it is considered cosmetic  
> Abdominoplasty performed by liposuction only for localized areas of fat deposits  
> Panniculectomy/liposuction performed in the arms and/or legs (e.g., brachioplasty)  
> Correction of low back pain because in most individuals this condition is multifactorial and the primary cause may not be the abdominal panniculus  
> Poorly fitting clothes  
> Problems with hygiene  
> Difficulty exercising  
> Breathing difficulties  
> Trouble bending to put on socks and shoes, and to wash lower extremities  
> Walking, sitting, or even eating meals at a table  
> Stretch marks that sometimes open and bleed  
> Patient no longer able to work |
| 481           | Juvenile Cartilage Allograft Tissue Implantation (Revised) | 05/16/2017 | 05/16/2017     | Commercial Plan | Policy title modified to reflect the availability of additional products to DeNovo® NT Graft. The summary of medical information and references were updated based upon a May 2017 health technology assessment. Policy otherwise unchanged, as juvenile cartilage allograft remains not covered and is considered investigational. |
| 494           | Cytoreductive Surgery (CRS) with Associated Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (Revised) | 05/22/2017 | 05/22/2017     | Commercial Plan | Policy modified to now provide coverage of HIPEC in two circumstances:  
1. Mucinous appendiceal with pseudomyxoma peritonei  
2. Diffuse malignant peritoneal mesothelioma  
SelectHealth continues to exclude (CRS) and (HIPEC) for any other indications, as it is considered investigational. |
| 497           | Genetic Testing: Lynch Syndrome Screening/Testing for Colorectal Cancer (Revised) | 05/02/2017 | 05/02/2017     | Commercial Plan | The HNPCC-related tumors were added to the policy. The policy now states:  
HNPCC-related tumors include: Colorectal, endometrial, gastric, ovarian, pancreas, ureter, and renal pelvis, biliary tract, brain (usually glioblastoma), and small intestinal cancers, as well as sebaceous gland adenomas and keratoacanthomas. |
| 585           | Gastric Pacing/Gastric Electrical Stimulation (GES) (Revised) | 03/13/2017 | 03/13/2017     | Commercial Plan | Policy changed to reflect updated coverage to now cover gastric pacing/gastric electrical stimulation for patients failing conservative therapy in limited circumstances. Please see policy for criteria. |
| 140           | Combined Pancreas/Kidney Transplant (Archived) | 04/17/2017 | 04/17/2017     | Combined into two policies. #610 Pancreas Transplants and #190 Pancreas Islet Cell Transplant. |
| 161           | Pancreas and Islet Cell Transplant (Archived) | 04/17/2017 | 04/17/2017     | Combined into one policy. #610 Pancreas Transplants. |
| 248           | Pancreas-After-Kidney (PAK) Transplant (Archived) | 04/17/2017 | 04/17/2017     | Combined into one policy. #610 Pancreas Transplants. |
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.

While no new technology recommendations were announced, technologies currently under active assessment by the M-Tech Committee include the following. As the reviews are completed, notices will be sent to stakeholders accordingly to inform them of SelectHealth coverage determinations:

- Bariatric Surgery
- Colon Cancer Recurrence Testing
- ConfirmMDx® Prostate Cancer Test
- Decipher® Prostate Cancer Classifier
- Enterra® Gastric Pacemaker for Gastroparesis
- Inspire System as a Therapy to Treat Sleep Apnea
- 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
- Pancreatic Transplant Alone
- Prolaris® for Prostate Cancer
- Pharmacogenomic Testing for Psychiatric Medication Management
- SIRT for Liver Cancer
- Sublingual Immunotherapy
- vBloc® for Weight loss

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.

Use PromptPA for Online Pharmacy Preauthorization Requests

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

What you will need to use PromptPA:

- Patient’s SelectHealth member ID
- Patient’s name and date of birth as they appear on their SelectHealth insurance card
- Patient’s zip code
- Internet Explorer. (Using other internet browsers may cause display issues)

The PromptPA portal can be accessed at: https://selecthealth.promptpa.com

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.
SelectHealth Formulary Decisions

The Pharmacy & Therapeutics Committee met in May. Decisions from that meeting include:

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Change</th>
<th>Effective Date</th>
<th>Formularies Impacted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cesamet*</td>
<td>Add PA, QL – GF</td>
<td>8/1/2017</td>
<td>RxSelect/RxCore/SelectHealth Community Care</td>
</tr>
<tr>
<td>Dronabinol</td>
<td>Add PA, QL – GF</td>
<td>8/1/2017</td>
<td>RxSelect/RxCore/SelectHealth Community Care</td>
</tr>
<tr>
<td>Akynzeo*</td>
<td>Move to T2, QL</td>
<td>8/1/2017</td>
<td>RxSelect/RxCore</td>
</tr>
<tr>
<td>Akynzeo*</td>
<td>Move to T3, QL</td>
<td>8/1/2017</td>
<td>SelectHealth Advantage</td>
</tr>
<tr>
<td>Sancuso*</td>
<td>Add PA – GF</td>
<td>8/1/2017</td>
<td>RxSelect/SelectHealth Community Care</td>
</tr>
<tr>
<td>Humalog* Pens and Vials*</td>
<td>Move to NC for Idaho formularies, remain NC for Utah formularies</td>
<td>Idaho 7/1/2017 new starts; 9/1/2017 existing users</td>
<td>RxSelect/RxCore</td>
</tr>
<tr>
<td>Humulin* Pens and Vials*</td>
<td>Move to NC for Idaho formularies, remain NC for Utah formularies</td>
<td>Idaho 7/1/2017 new starts; 9/1/2017 existing users</td>
<td>RxSelect/RxCore</td>
</tr>
<tr>
<td>Novolog* Pens and Vials*</td>
<td>Add to T2 for Idaho formularies, remain on T2 for Utah formularies</td>
<td>7/1/2017</td>
<td>RxSelect/RxCore</td>
</tr>
<tr>
<td>Lantus*, Tresiba*, Levemir*, Toujeo*</td>
<td>Add ST of Basaglar* first – GF</td>
<td>7/1/2017</td>
<td>SelectHealth Community Care</td>
</tr>
</tbody>
</table>

Key -
GF: Grandfathered; ST: Step Therapy; PA: Preauthorization; QL: Quantity Limit; NC: Not Covered; MB: Medical Benefit; T1: Tier 1; T2: Tier 2; T3: Tier 3; T4: Tier 4

Drugs marked with an asterisk (*) will include direct communication(s) to the member, doctor, and/or pharmacy detailing the change.