Welcome to the 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 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 your patients covered by a SelectHealth policy.
Launch of SelectHealth Share Strengthens Our Efforts to Help People Live the Healthiest Lives Possible

Last summer, SelectHealth announced an innovative way to partner with employers and their employees to achieve better health, better care, and more affordable and predictable health insurance premiums. The new SelectHealth ShareSM product represents many years of planning and effort from Intermountain Healthcare® and SelectHealth.

Starting in 2016, SelectHealth Share, effective January 1, 2016, offers more affordable and predictable rates; it’s a three-year plan with guaranteed rates in years two and three. For participating large employers, the guaranteed rate of increase for years two and three is 4 percent—closer to the general inflation rate and well below the healthcare inflation rate, which is roughly 6.5 percent. “This rate structure is revolutionary and transformative in the health insurance market,” said Patricia Richards, President and Chief Executive Officer of SelectHealth.

With SelectHealth Share, everyone involved in the plan plays an active role and shares accountability for maintaining the health of plan members:

> Employers support and engage their employees in a culture of health.
> Employees collaborate in making decisions that affect their care and its cost.
> Providers participate in a compensation model that’s based on productivity, quality, service, and total-cost-of-care goals.
> SelectHealth provides innovative benefit plans that engage members to encourage better health.

“This is a sustainable model that drives continued innovation, affordable costs, and better health outcomes,” Patricia said. “Numerous tools are used to support this unique arrangement, including advanced product designs, engaging wellness programs, care management, digital and telehealth communication applications, and cost transparency. We believe a highly engaged, collaborative relationship between individuals and their providers is the foundation for high-value care at an affordable cost, while helping people live the healthiest lives possible.”

We recognize one of the most effective ways to improve the health of a community is to foster engagement with employers and employees in achieving better health. Initially, we are offering the SelectHealth Share product to large employer groups in qualifying areas. The following list illustrates some of the commitments employers and employees agree to when enrolling in the Share product:

**EMPLOYER ENGAGEMENT RESPONSIBILITIES**

> Minimum of 85 percent of the eligible employees who reside in the SelectHealth Share network service area must enroll in the Share plan, or be covered by other eligible coverage (e.g., spouse’s medical plan)
> Minimum benefit design requirements (for Qualified High Deductible Health Plan [QHDHP] and/or traditional plan)
> HSA contribution (i.e., employer matches employee contribution up to 25 to 50 percent of the annual deductible amount)
> Employer contribution of at least 70 percent of the aggregate premium across all rating tiers (i.e., single, two-party, family)
> Meet all of the requirements of the Healthy Living product (e.g., provide a wellness incentive, establish a wellness council, quarterly wellness activities, support a tobacco-free environment, healthy food options, violence-free worksite)
> Annual member engagement review with SelectHealth
  • Implement/improve measures identified in the annual review that will substantially make a difference in member engagement and/or support appropriate utilization
> Minimum 50 percent participation with member engagement requirements; 60 percent and 70 percent respectively in the subsequent two years.
MEMBER ENGAGEMENT RESPONSIBILITIES

> Create a My Health account
> Set up and fund an HSA account
> Choose a Primary Care Provider (PCP) from the Share network at a Patient Centered Medical Home (PCMH)—Personalized Primary Care or Advance Primary Care
> Participate in a wellness program (Healthy Living or another if preapproved by SelectHealth)
  * Health Reimbursement Account (HRA)—includes biometric screening (annual completion, within the first 90 days of the plan year)
  * Digital coaching (if identified as needed)
  * Educational modules (two per year)
  * Activity campaigns (two per year)
  * The Weigh to Health® program (incentive provided after the program is completed)
> Participate in disease management/care management programs as appropriate

“SelectHealth Share offers tangible savings to patients and the community,” said Patricia Richards. “We believe this approach, which is based on a sustained commitment from all participating parties, is the future of healthcare.”

View the SelectHealth Share sales brochure.

Standards for Timely Member Access

We recognize the importance of supporting members in a timely and appropriate way as they seek the medical and behavioral health care they need. We’ve established standards to help ensure that every member receives care within an appropriate time. These standards apply to each of our products and are specific to the type of care being sought.

MEMBER MEDICAL ACCESS STANDARDS:

> Members with non-life-threatening emergent medical conditions will have access to care within six hours.
> Members with urgent medical conditions will have access to specialty-appropriate medical services within 24 hours of the request for service, in or out of network.
> Members needing well-person care or chronic illness routine evaluations will have access to specialty-appropriate, in-network services within 30 calendar days of the request for services. This standard does not apply to routine eye refractions or hearing screens. The standard shall be within 21 calendar days for well newborns under one month of age.
> Members needing school physicals will have access to a Primary Care Provider (PCP) within 30 calendar days of request for services.
> Female members will have the option of direct access to a women’s health specialist for women’s routine and preventive healthcare services.
> Participating providers or their designees (PCPs and SCPs) will be available for telephone consultation to members consistent with the access granted by the provider for non-SelectHealth members.

ACCESS STANDARDS FOR MEMBERS SEEKING BEHAVIORAL HEALTH SERVICES:

> Members with life-threatening behavioral health conditions (crises) will have access to acute medical care 24 hours a day, seven days a week, in or out of network.
> Members with non-life-threatening emergent behavioral health conditions will have access to care within six hours.
> Members with urgent behavioral health conditions will have access to care within 48 hours of the request for service.
> Members with routine behavioral health problems will have access to care within ten business days.
ACCESS STANDARDS FOR MEMBERS SEEKING SERVICES FROM ANY PROVIDER:

> Providers will see members within an average of 30 minutes after the member’s arrival for an office visit.

> Providers will maintain hours of operation that are convenient to members and do not discriminate against members based upon insurance coverage or payment method.

> Participating providers or their designees will be available for telephone consultation to members consistent with the access granted by the provider for their non-SelectHealth patients.

> Providers or their comparable specialty-covering providers will be available to their patients by phone for emergency/urgent situations 24 hours a day, seven days a week.

ACCESS STANDARDS AND RESPONSIBILITIES OF SELECTHEALTH

> SelectHealth will maintain a procedure for providing care outside of the plan’s provider network when network providers are unavailable or inadequate to provide a member’s covered medical services.

> SelectHealth will monitor the availability of participating non-English speaking providers to ensure the availability of services that can be provided in a culturally competent manner.

Restructure of Health Services Responsibilities

To improve efficiency, we have redesigned the operational structure for our Health Services (Care Management) department. We expect this internal process change will make it easier for your office to interact with us.

Health Services staff are assigned by lines of business:

> Commercial plans
> SelectHealth Advantage (Medicare)
> SelectHealth Community Care® (Medicaid) (Utah only)

With this restructure, providers calling Health Services at 800-442-5305 now use phone options to select from line of business or preauthorization before the call is directed to that area. This method allows callers to quickly connect with the appropriate person.

In addition, each business area now has a unique fax number. So we can respond to your needs quickly, please use our new fax numbers:

Commercial – 801-442-0825
SelectHealth Advantage – 801-442-0302
SelectHealth Community Care – 801-442-0625
Preservice Authorization Requests – 801-442-0517*

*This is a corrected number that we listed incorrectly on a recent letter mailing.

The restructure allows our staff to develop expertise in their particular lines of business, resulting in more efficient responses to your needs. We look forward to developing a closer relationship with your office as we continually explore ways to serve you better.

If you have questions, email shlobchange@selecthealth.org.
Use Our Improved Appeals Form

To simplify appeals submission, we created a new form that includes phone numbers and addresses by appeal type. To improve processing efficiency, we assigned teams to specific appeal types and lines of business. This helps the form get to the right team. The form identifies which circumstances indicate a member appeal and which are a provider appeal. It should only be used to submit appeals, and not for other documentation purposes.

Remember, you don’t need to submit a copy of the claim or Explanation of Benefits (EOB) with the appeal. We just need three things:

> Claim number
> Appeal form
> Copies of relevant documentation, or a note where to find documentation electronically (e.g., Help2, iCentra)

View our Appeals form.

Read Our Updated Preventive Care Guidelines

Intermountain Healthcare and SelectHealth use preventive care recommendations to help providers improve preventive care services. This is accomplished through standardizing national recommendations, connecting provider resources, and developing clinical tools for managing preventive processes.

The recommendations are a combination of national preventive care guidelines that have been reviewed and approved by the Intermountain Medical Group leadership and the SelectHealth Quality Improvement committee. These guidelines are updated at least every two years or as national recommendations change.

Read the updated preventive care guidelines here:

> Adult, Adolescent, and Child
> Preconception Care and Uncomplicated Pregnancy

Frequently Asked Questions about Pharmacy Preauthorization

How do I find out if the medication being prescribed for a SelectHealth member requires preauthorization?

We have a convenient online preauthorization lookup tool. Here’s how to use it:

1. Go to selecthealthphysician.org, click on “Pharmacy” on the left side of the page, then on “Drugs with Special Requirements.”
   Or, you can click here and then save the page to your favorites.

2. Select the appropriate plan for the member:
   - Commercial Plans
   - SelectHealth Community Care (for Medicaid members)
   - SelectHealth Advantage (for Medicare members)

3. Search for the medication alphabetically or by a partial name. Some things to keep in mind:
   - Only medications that have additional requirements or require preauthorization are listed on these websites. If the medication is not listed, it does not have additional requirements.
   - Medications without additional requirements are not necessarily covered. To check coverage, visit: selecthealth.org/pharmacyresources for commercial

How can I help ensure a quick review and response on a preauthorization request?

Please submit ALL relevant information with a preauthorization. Take your time and complete the entire preauthorization form. We enjoy our interactions with our physician partners, but we’d much rather be calling with a review decision than asking for more information.
What if I have questions about drug coverage or preauthorization?

Want an update on a preauthorization you submitted?

Wondering if a medication is covered or has any special requirements?

Need to know if a medication needs a B vs. D determination for Medicare?

Need to know what B vs. D even means?

Call us—we’re here to help! You can reach us at 800-442-3129 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 3:00 p.m.

SelectHealth websites have the most accurate and up-to-date preauthorization information and forms.

We cannot guarantee the accuracy of information obtained from non-SelectHealth websites.

We strongly encourage you and your office to use our websites as your primary source of drug coverage and preauthorization information for SelectHealth members.

Get Your Electronic Remittance Advices Quickly

Need a Remittance Advice (RA) in a hurry? We know your time is valuable—here’s how to quickly access your RAs online:

> Submit an Electronic Remittance Interchange (EDI) 835 transaction request to receive an RA electronically. Most EDI systems can also be configured to automatically post payment details to your patient accounts. To initiate participation on any EDI transaction with SelectHealth, call our EDI team at 800-538-5099.

> View an RA through our secure online Provider Benefit Tool. From selecthealthphysician.org, click on “Secure Content Login.” Log in with your user name and password, click on “Provider Benefit Tool,” and then “RA Lookup.” Simply enter the check’s reference ID to view the RA for that check.

• If you don’t have an account, visit selecthealthphysician.org and follow the instructions in the lower-left corner of the page. Complete and return the forms provided to receive your user name. With the Provider Benefit Tool, you can securely view your patients’ claims, eligibility, and RA information.

To better manage the number of requests for faxed RAs, Member Services, the EDI team, and Provider Relations will not fax an RA until five or more days have passed since the check issue date. With our electronic RAs, there’s no need to wait. Explore how our electronic solutions can benefit your office.
Change in Major/Minor Surgery Definitions

Healthcare delivery has changed significantly over the last 20 years. We recently reviewed and updated the definitions of major and minor surgery in our plan documents. To more accurately represent truly “minor” procedures, we updated our definitions for major and minor surgery. For example, historically, services performed in an office setting were considered “minor surgery.” As offices have become more sophisticated, the lines between office-based procedures, surgical/endoscopy center procedures, and outpatient have blurred, and we have correspondingly changed our definitions. To create a clearer delineation between major and minor surgery, we adopted these definitions, effective January 1, 2016, for new and renewing groups and individuals:

**MAJOR SURGERY**
A surgical procedure having one or more of the following characteristics:

a. Performed within or upon the contents of the abdominal, pelvic, cranial or thoracic cavities;
b. Typically requiring general anesthesia;
c. Has a level of difficulty or length of time to perform which constitutes a hazard to life or function of an organ or tissue; or
d. Requires special training to perform.

**MINOR SURGERY**
A minor surgery is anything not categorized as major.

The relevance of this change is that member responsibility varied in part on this classification. Minor surgeries often require only a copay (fixed dollar amount), whereas major surgeries may require coinsurance (percent of allowed charges). To guard against a situation in which a member might seek care at a potentially “less safe” place of service to avoid paying more, the new definition removes the site of service as a consideration.

Change in Urine Drug Testing Coverage

Effective January 1, 2016, we will implement a new medical policy governing urine drug testing. As greater efforts are taken to reduce the misuse and abuse of controlled substances, many providers and facilities have implemented “routine” urine drug testing, both qualitative and quantitative. Though many recommendations from various organizations exist, no nationally recognized standard exists, prompting significant variance in practice. We worked with Intermountain clinical laboratory experts, the Intermountain Healthcare Chronic Pain and Functional Restoration Guidance Council, and local pain management leadership to develop a standard coverage policy to help guide providers on coverage of urine drug testing.

Here are the key elements of this testing:

1. **For management of chronic, non-cancer pain, any ONE of the following tests will be allowed:**
   a. **Point-of-Care testing:** Drug screen, other than chromatographic; any number of drug classes, by CLIA-waived test or moderate complexity test, per patient encounter (G0434 for CMS and 80300 for Commercial plans are covered codes). Limit 12 tests per year.
   b. **Testing using gas chromatography/mass spectrometry (GC/MS) and liquid chromatography/tandem mass spectrometry (LC/MS/MS) (80303, 80304, and 80377 are covered Commercial plan codes). ALL of the following criteria must be met:**
      i. Either qualitative GC/MS or quantitative LC/MS/MS may be performed.
      ii. Testing must be performed by a contracted vendor.
      iii. Frequency of testing will depend on medical necessity. Limit 12 tests per year.
2. For management of substance abuse disorder and drug rehabilitation, any ONE of the following tests will be allowed:
   
a. **Point-of-Care testing:** Drug screen, other than chromatographic; any number of drug classes, by CLIA-waived test or moderate complexity test, per patient encounter (G0434 for CMS and 80300 for Commercial plans are covered codes). Limit 24 tests per year.

b. **Testing using gas chromatography/mass spectrometry (GC/MS) and liquid chromatography/tandem mass spectrometry (LC/MS/MS) (80303, 80304 and 80377 are covered commercial codes).** ALL of the following criteria must be met:
   
i. Either qualitative GC/MS or quantitative LC/MS/MS may be performed.
   
ii. Testing must be performed through a contracted vendor.
   
iii. Frequency of testing will depend on medical necessity. Limit 24 tests per year.

Point-of-Care (POC) urine drug testing using immunoassay methodology for any indication will not be covered as current evidence demonstrates this testing to lack adequate sensitivity and specificity for its intended purpose, and alternative methods are available. Therefore, we determine this test to be not medically necessary.

The complete medical policy, #569 – Urine Drug Testing in the Outpatient Setting can be accessed in “Policies & Procedures” at selecthealthphysician.org.

**HEDIS Measurement: Chlamydia Screening in Women (CHL)**

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

**CHLAMYDIA SCREENING IN WOMEN (CHL)**

Chlamydia is a common sexually transmitted infection (STI) caused by the bacteria *Chlamydia trachomatis*. The Centers for Disease Control and Prevention (CDC) recommends that all sexually active women ages 25 and younger get screened for chlamydia every year. Chlamydia continues to be under reported due to a lack of screening. Chlamydia is now recognized as one of the most common and among the most damaging of all STDs seen in the United States today and Utah lags well behind the national rate for screening. *Chlamydia trachomatis* infections continue to be the most frequently reported communicable disease in Utah and the U.S. In 2013, 7,542 cases of chlamydia were reported in Utah.¹ Chlamydia accounts for 56 percent of all nationally-notifiable diseases reported in Utah. Case reports have been increasing steadily over the years. This increase is due to expanded screening efforts and not to an actual increase in the number of people with chlamydia. Fewer than half of sexually active young women are screened annually as recommended by the CDC. In 2014, Utah ranked 46th among all 50 states in chlamydial infections.² This measure calculates the percentage of women ages 16 to 24 who were identified as sexually active and who had at least one test for chlamydia during 2014.

To support the HEDIS screening objectives, SelectHealth is taking the following steps:

> SelectHealth collaborates with the Utah Department of Health (UDOH) to identify barriers and discuss best practices in an effort to improve screening rates in Utah.

> Chlamydia screening recommendations are included in our Women’s Health & Healing monthly brochure mailed to women due for cervical or breast cancer screenings.
Chlamydia screening rates at the clinic and provider level are reported in Primary Care and OB/GYN/CNM providers that participate in the SelectHealth Quality Payment Programs.

Chlamydia screening is included in the SelectHealth Women and Newborns Quality Payment Program for OB/GYN/CNM providers.

SelectHealth recognizes clinics that perform in the top 10 percent for chlamydia screening through the SelectHealth Excellence in Healthcare Awards.

If you would like more information, or if you are interested in learning more about other SelectHealth Quality Improvement programs, contact the Quality Improvement department at 800-374-4949 or qualityimprovement@selecthealth.org.

References:

Chlamydia Screening in Women (CHL)


What’s New with You?

Have you had a provider leave your practice? New providers coming in? Changes of address, phone numbers, or operating hours? We need to know! It’s important that our members have access to correct information when they’re viewing our online Provider Directory. In addition, the Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) require us to have correct information available to our members. Visit selecthealthphysician.org and click on “Provider & Facility Search” to review your practice information. To update your information, contact your Provider Relations representative at 800-538-5054.
Editing Your Provider Web Portal Profile

Did you know that you can manually edit your Intermountain Physician Web Profile in just a few minutes?

By navigating and logging in to your Intermountain profile, any provider with the proper credentials can update his or her resume, office information, “accepting new patients” status, credentialing info, and more. Giving providers more control of their profile allows for quick updates that are crucial if something isn’t showing up correctly.

To access your profile, visit intermountainphysician.org/pwp, enter your username and password, and click “Login.” You’ll then be at your Physician Web Profile home page, which provides step-by-step instructions on how to edit each page of your profile.

When you are done editing a page, click the “Continue” button at the bottom of the page, and the Web Profile tool will automatically save the information and move you to the next tab. Once you’ve completed all five pages and you’re ready to finalize all of your changes, click the “Finish” button at the bottom of the page. This will submit all of your changes into our system for review. Because some of the changes may not happen immediately, we’ll send you an email letting you know when the changes are published on your profile.
SELECTHEALTH ADVANTAGE

From Out-of-Network to In-Network: A Cost-saving Journey with Members in Mind

There’s no way around it—healthcare is expensive, and costs are still going up. According to a recent article in The New York Times, “Inpatient hospital costs account for nearly 30 percent of health care spending in the United States and are increasing by a little less than two percent a year, adjusted for inflation.” As an integrated system, SelectHealth and Intermountain Healthcare in Utah and St. Luke’s Health System in Idaho are dedicated to providing high-quality healthcare while judiciously managing costs. We know how important it is for healthcare to be affordable for our members. It’s part of a threefold vision—better health, better care, and lower costs. For our Medicare plans, that means keeping premiums at low or no cost, and offering no-deductible plan options. This is why it’s more important than ever to refer patients to providers that are participating on SelectHealth Advantage.

Our SelectHealth Advantage members have access to thousands of doctors in our network who share our commitment to providing high-quality care at an affordable cost. To keep member costs as low as possible, in 2016 all of our Medicare Advantage plans will be Health Maintenance Organizations (HMOs). This means that all members will need to see providers who participate in our SelectHealth Advantage network. Your help in referring your SelectHealth Advantage patients to participating specialists will be vitally important through this transition. If members choose to see a provider outside of the network, they will be responsible for those costs. The only exception: when emergency care is needed. Members are covered anywhere, anytime for emergency care services.

Our comprehensive network includes access to Intermountain hospitals and clinics, St. Luke’s Health System, and more than 2,000 quality providers.

Members having trouble finding a doctor or making an appointment can call one of our Member AdvocatesSM at 800-515-2220. Representatives are available weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

Together, we are working to keep high-quality care and outcomes accessible and affordable for our Medicare Advantage members.

Reminder: Only One More Month to See Every SelectHealth Advantage Patient Before the End of the Year

Every SelectHealth Advantage patient in your practice should be seen annually. When you do, be sure to:

> Monitor, Evaluate, Assess, and/or Treat (MEAT) all chronic conditions for each patient to be sure all medical needs are met.

> Evaluate for appropriate preventive services, completing an Annual Wellness Visit and/or Preventive Exam, if applicable.

> Document and code all chronic and co-morbid conditions to be sure you have captured all appropriate diagnoses at the highest level of specificity.

If you need a list of your patients who have not had the recommended services, please contact your SelectHealth Provider Relations representative.
Because of our 4.5 Star Rating in 2015, we received additional money from Medicare that we’ve put into more benefits for our members. As an example, we moved hundreds of medications from a Tier 2 copay ($15) to a Tier 1 copay ($3) for 2016, as shown in Table 1. This provides better access to needed medications at a lower cost for our members.

We regularly examine our processes to identify ways to improve our Star Rating and continue to provide benefits like low medication copays. One area we’ve identified is in the prescribing of high-risk medications. Evidence-based reviews of high-risk medications (e.g., the Beers List) show that many are unsafe for ages 65 and older. Our formulary includes alternatives to these medications, and most are covered as generics with Tier 1 or Tier 2 copays.

We want our members to get their medications and take them safely. By using alternatives to high-risk medications, not only are we more assured of members’ safety, but we are able to provide lower costs for the medications they need.

Visit the Pharmacy Tools section of the SelectHealth Advantage Provider Reference Manual for more information on our pharmacy programs.

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**Table 1**

<table>
<thead>
<tr>
<th>Medications Added to Tier 1</th>
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<tbody>
<tr>
<td>Acyclovir 200 mg Cap</td>
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<tr>
<td>Allopurinol</td>
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<tr>
<td>Amlodipine</td>
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<tr>
<td>Brimonidine 0.15%</td>
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<tr>
<td>Bupropion 100 mg</td>
</tr>
<tr>
<td>Bupropion 200 mg SR</td>
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<tr>
<td>Carbamazepine 200 mg IR</td>
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<tr>
<td>Clonazepam</td>
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<tr>
<td>Diazepam</td>
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<tr>
<td>Donepezil</td>
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<tr>
<td>Famotidine</td>
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<tr>
<td>Fluticasone Nasal</td>
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<tr>
<td>Gentamicin Ointment Ophthalmic</td>
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<tr>
<td>Hydrocortisone Ointment</td>
</tr>
<tr>
<td>Hydrocodone/APAP 10-325 mg</td>
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<tr>
<td>Hydrochloroquine</td>
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<tr>
<td>Isosorbide</td>
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<tr>
<td>Levothyroxine</td>
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<tr>
<td>Meclizine</td>
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<tr>
<td>Metformin ER</td>
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<tr>
<td>Metronidazole Tab</td>
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<tr>
<td>Neomycin/Polyoxin/Dexamethasone Ointment</td>
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<tr>
<td>Nystatin Cream</td>
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<tr>
<td>Pantoprazole</td>
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<tr>
<td>Polymoxin B/Trimethoprim</td>
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<tr>
<td>Pramipexole</td>
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<tr>
<td>Propranolol Tab</td>
</tr>
<tr>
<td>Risperidone</td>
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<tr>
<td>Sotalol</td>
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<tr>
<td>Temazepam</td>
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<tr>
<td>Timolol Ophthalmic</td>
</tr>
<tr>
<td>Torsemide</td>
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<tr>
<td>Triamterene/HCTZ</td>
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</tbody>
</table>

2015 Star Rating Yields Low Copays on More Prescription Medications
Marketing to Medicare Members

With the Medicare Annual Election Period in full swing, remember these important CMS requirements about displaying plan marketing materials in your office areas:

> Medicare Advantage materials may only be displayed in common (non-treatment) areas of your office.

> Providers are allowed to display marketing materials, but are not allowed to limit or discourage any insurance carrier requesting to also display materials (e.g., if SelectHealth Advantage materials are on display and United wants to display materials, you must also display the United materials, or remove the SelectHealth materials).

SELECTHEALTH COMMUNITY CARE

Help Us Coordinate Benefits

Claims for SelectHealth Community Care members who have an additional SelectHealth plan must be submitted separately once the primary payment is received. Because coding requirements often vary among Medicaid and other plans, we cannot automatically cross over a claim from one line of business to another when Medicaid is involved.

For SelectHealth Community Care members with another SelectHealth plan, we do not clone (copy) the claim, meaning that providers need to bill both plans because coding requirements often differ among Medicaid, commercial, and Medicare.

Verify Eligibility and Accept Members Using Only State-issued Medicaid Member ID Cards

SelectHealth ID Cards offer valuable information to our providers and members, including our contact information and the Subscriber ID. While this information is important, only the state-issued ID card is required for Community Care members to access services. Eligibility may vary from month to month, so be sure to verify each time a member requests care. The state’s eligibility lookup tool provides not only the member’s eligibility status, but also indicates the member’s plan enrollment, whether any copays apply, and if there are any provider restrictions.

Verify eligibility online or by phone:
Medicaid eligibility lookup tool: medicaid.utah.gov/eligibility-lookup-tool
Eligibility phone line (AccessNow): 801-538-6155
If you have questions about benefits or claims, contact SelectHealth Member Services at 855-442-3234.
SELECTHEALTH DENTAL
Reminder: Fraud, Waste, and Abuse Training and Attestation Due

Have you completed your annual general compliance and Fraud, Waste, and Abuse (FWA) training and attestation? CMS requires all medical and dental providers and their employees who render services to Medicare beneficiaries to complete the training within 90 days of employment/contracting and annually thereafter.

We have posted links to the approved training and to the attestation document on our SelectHealth Advantage website. You may complete the training offered by CMS or other insurers that meet the CMS requirements. Employees can take the training individually or as a group of employees.

Please note that practices are required to maintain training records for themselves and their employees for no fewer than ten years. SelectHealth and/or CMS may request evidence of completion of these courses.

Evidence may include training logs with dates and certificates of completion, sign-in sheets, attestations, or other methods to demonstrate fulfillment of the obligation.

If you have questions about the FWA training or attestation, contact your Provider Relations representative at 800-538-5054 or provider.relations@selecthealth.org.

Clarification on CMS Enrollment Requirement for Dental Providers to Prescribe to Medicare Members

CMS has released additional guidance on the rule that all providers, including dentists, must either enroll in or opt out of Medicare to be eligible to prescribe medications for Medicare beneficiaries such as SelectHealth Advantage members with the supplemental dental benefit. However, you must be enrolled in Medicare to participate on the SelectHealth Advantage network and be paid for dental services provided to these members.

Time frame delayed – Dentists are encouraged to take action by January 1, 2016, to enroll in or opt out of Medicare to be eligible to prescribe medications for Medicare beneficiaries. If dentists do not enroll or opt out, claims for medications will be denied effective June 1, 2016.

> View more information for providers at: go.cms.gov/PrescriberEnrollment
> ProviderEnrollment@cms.hhs.gov

We appreciate your participation on the SelectHealth Dental Advantage network and the quality care you provide our members. If you have questions, contact Kim Robinson at 801-442-7943 or kim.robinson@selecthealth.org.
# MEDICAL POLICY AND NEW TECHNOLOGY ASSESSMENT

## Medical Policy Update Bulletin

We created this quarterly bulletin for you to review recently approved or revised medical policies. The bulletin contains a summary of each new or revised medical policy and a link to the full text on our provider website.

If a medical policy appears in this bulletin, it means we have recently adopted or revised it. It does not indicate whether we provide coverage for a service on a particular member’s plan. If an inconsistency or conflict arises between the information in this bulletin and the posted medical policy, the conditions in 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>570</td>
<td>Genetic Testing: Molecular Profiling for Determining Therapy of Molecular Tumors (NEW)</td>
<td>7/28/2015</td>
<td>We developed a new policy for molecular profiling for determining therapy of molecular tumors. SelectHealth Commercial does NOT cover molecular profiling for determining therapy of molecular tumors as it is considered investigational and not medically necessary. SelectHealth Advantage covers molecular and genetic testing consistent with Medicare Local Coverage Determination (LCD) L24308 and Noridian guidelines on specific covered and excluded molecular tests. Where Medicare policy does not explicitly outline coverage and there are no InterQual guidelines, commercial plan policy will apply. SelectHealth Community Care covers selected genetic testing covered by Medicaid when Utah Medicaid criteria are met, as outlined in the Utah Medicaid Laboratory Services Manual. Utah Department of Health (UDOH) Medicaid Coverage and Reimbursement Lookup Tool. UDOH Medicaid Lookup Tool.</td>
</tr>
<tr>
<td>571</td>
<td>Anterolateral Ligament Reconstruction as Part of Knee Reconstruction Surgery (NEW)</td>
<td>7/28/2015</td>
<td>We developed a new policy for Anterolateral Ligament Reconstruction as Part of Knee Reconstruction Surgery. SelectHealth Commercial does NOT cover anterolateral ligament reconstruction as part of knee reconstruction surgery as it is unproven. SelectHealth Advantage does NOT cover anterolateral ligament reconstruction as part of knee reconstruction surgery. Since there are no Medicare or InterQual guidelines for medical necessity that specifically address these services, SelectHealth commercial policy will apply. SelectHealth Community Care does NOT cover anterolateral ligament reconstruction as part of knee reconstruction surgery. Since there are no Medicaid or InterQual guidelines for medical necessity that specifically address these services, SelectHealth commercial policy will apply.</td>
</tr>
<tr>
<td>567</td>
<td>Blepharoplasty, Brow Ptosis Repair, and Reconstructive Eyelid Surgery (NEW)</td>
<td>7/15/2015</td>
<td>We developed a new policy for blepharoplasty, brow ptosis repair, and reconstructive eyelid surgery. SelectHealth Commercial covers blepharoplasty and reconstructive eyelid surgery including brow ptosis when criteria are met. SelectHealth Advantage covers blepharoplasty, blepharoptosis, and brow ptosis repair consistent with CMS Local Coverage Determination (LCD) L35536, L35534 and (LCA) A54173 and A47276. SelectHealth Community Care covers codes associated with blepharoplasty, blepharoptosis, and brow ptosis repair consistent with the coverage status of the codes as specified in the State of Utah Medicaid Lookup Tool.</td>
</tr>
<tr>
<td>Policy Number</td>
<td>Policy Name</td>
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<td>Summary of Change</td>
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<tr>
<td>572</td>
<td>Non-medically Indicated (Elective) Induction of Labor Before 39 Weeks Gestational Age (NEW)</td>
<td>8/24/2015</td>
<td>We developed a new policy for elective induction of labor prior to 39 weeks.</td>
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<td><strong>SelectHealth Commercial</strong> covers elective induction of labor prior to 39 weeks in limited circumstances when criteria are met that define the services being medically necessary.</td>
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<td></td>
<td><strong>SelectHealth Advantage</strong> covers induction of labor prior to 39 weeks for medically indicated reasons. Since there are no specific Medicare or InterQual guidelines for medical necessity that specifically address these services, SelectHealth Commercial policy will apply.</td>
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<td></td>
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<td></td>
<td><strong>SelectHealth Community Care</strong> covers maternity care and deliveries consistent with the State of Utah Medicaid Provider Manual, section 2-33, Maternity Care including induction of labor. Since there are no specific Medicaid or InterQual guidelines for medical necessity that address induction of labor prior to 39 weeks, SelectHealth Commercial policy will apply.</td>
</tr>
</tbody>
</table>

**REVISED POLICIES**

<table>
<thead>
<tr>
<th>Policy Number</th>
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</tr>
</thead>
<tbody>
<tr>
<td>129</td>
<td>Hyperbaric Oxygen Therapy (Revised)</td>
<td>6/2/2015</td>
<td>Raynaud’s Phenomenon added as a noncovered indication.</td>
</tr>
<tr>
<td>150</td>
<td>Mohs Surgical Guidelines (Revised)</td>
<td>5/25/2015</td>
<td>Addition under <strong>Commercial Policy</strong>:</td>
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<td></td>
<td>Change criteria to clarify amount of tissue required to be removed and anatomical location to read:</td>
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<td>• In cosmetically sensitive areas where preservation of as much normal tissue as possible is important to maintain normal appearance and optimize the potential for cure and to minimize the potential for recurrent surgery, <strong>if &gt;2 cm diameter tissue must be removed</strong></td>
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<tr>
<td></td>
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<td>• Skin cancers &gt;4.0 cm in diameter on any location</td>
</tr>
<tr>
<td>172</td>
<td>Reduction Mammoplasty (Breast Reduction) (Revised)</td>
<td>5/8/2015</td>
<td>Addition of “Documentation of signs and symptoms provided by a practitioner independent of the requesting surgeon’s practice” under criteria for coverage.</td>
</tr>
<tr>
<td>223</td>
<td>Continuous Glucose Monitoring (CGM) Systems with and without Real-time Monitoring (Revised)</td>
<td>5/4/2015</td>
<td>Revision under “Replacements will only be allowed when ALL of the following criteria are met”:</td>
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<td>#2 – Documentation is provided demonstrating the member has used the device at least 50% of the time for a 30-day period within the past 90 days.</td>
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<td>#3d. – The member demonstrates stability or improvement in the A1C level.</td>
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<tr>
<td>492</td>
<td>Oral Appliances for Sleep Apnea (Revised)</td>
<td>5/7/2015</td>
<td>Under criteria for coverage:</td>
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<td></td>
<td></td>
<td></td>
<td>#6 – Addition of “Temporal Mandibular Joint Syndrome or other TMJ-related pathological processes insufficient dentition to support device stability”</td>
</tr>
<tr>
<td>559</td>
<td>Sphenopalatine Ganglion (SPG) Injection in the Management of Headaches (Revised)</td>
<td>5/15/2015</td>
<td>Addition of new LCDs L34775 and L34779 under <strong>SelectHealth Advantage</strong>, Since these LCDs do not list headaches as a covered diagnosis for these procedures, this procedure is not covered for this diagnosis.</td>
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<td></td>
<td><strong>SelectHealth Community Care</strong> language was added:</td>
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<td>“SelectHealth Community Care does NOT cover sphenopalatine ganglion (SPG) block for acute and chronic headaches because SelectHealth has found this procedure to be not medically reasonable and necessary since current evidence is insufficient to determine the efficacy and safety. As there are no other Utah State Medicaid-specific guidelines or InterQual guidelines for sphenopalatine ganglion (SPG) block for acute and chronic headaches, Commercial policy will apply.</td>
</tr>
<tr>
<td>265</td>
<td>Radiofrequency Ablation (RFA) for Back or Neck Pain (Radiofrequency Neurolysis, Facet Joint Rhizotomy) (Revised)</td>
<td>5/15/2015</td>
<td>Addition under <strong>SelectHealth Advantage</strong>:</td>
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<td>SelectHealth Advantage covers non-pulsed radiofrequency ablation (RFA) of the lumbar, thoracic, and cervical facet joints consistent with Medicare Local Coverage Determination (LCD) L34127, L33842, L34775, and L34779.</td>
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<td>Addition under <strong>SelectHealth Community Care</strong>:</td>
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<td>SelectHealth Community Care covers non-pulsed radiofrequency rhizotomy of the cervical and lumbar spine when all of the medical necessity criteria are met according to the special note on UDOH Medicaid Lookup Tool, also available on the State of Utah Medicaid Program Medicaid Information Bulletin (January 2014, page 21 14-34) and State of Utah Medicaid Provider Manual, Section 2, page 35.</td>
</tr>
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<td>518</td>
<td>Physical Therapy (PT) Occupational Therapy (OT) (Revised)</td>
<td>6/10/2015</td>
<td>Addition under <strong>SelectHealth Commercial</strong>: SelectHealth covers physical therapy (PT) and occupational therapy (OT) for habilitative services on non-grandmothered (transition relief) Small Employer and Individual commercial plans. SelectHealth does NOT cover physical therapy (PT) and occupational therapy (OT) for habilitation for any other indications not mentioned above.</td>
</tr>
<tr>
<td>357</td>
<td>Gene Expression Profiling for Monitoring Acute Rejection in Cardiac Transplant (Allomap®) (Revised)</td>
<td>7/17/2015</td>
<td>Addition under <strong>SelectHealth Commercial Plan</strong>: Exclusion Criteria: The addition of &gt;5 years after heart transplantation</td>
</tr>
<tr>
<td>386</td>
<td>Gender Reassignment Surgery (Revised)</td>
<td>6/17/2015</td>
<td>This policy was specifically for American Express members and now the wording has been changed to include “only for plans with the gender reassignment supplemental coverage and SelectHealth Advantage members.” Also, the term “gender dysphoria” has replaced “gender identity disorder” throughout the policy.</td>
</tr>
<tr>
<td>444</td>
<td>Transcatheter Aortic Valve Implant (TAVI) Transcatheter Aortic Valve Replacement (TAVR) (Revised)</td>
<td>7/10/2015</td>
<td>Addition to the description section of the policy: “In June 2015, the first repositionable transcatheter valve, the CoreValve Evolut R received FDA approval. This is the first valve that can be repositioned after initial deployment so as to reduce valve leakage or other issues.”</td>
</tr>
<tr>
<td>334</td>
<td>Neuropsychological Testing (Revised)</td>
<td>7/10/2015</td>
<td>We clarified language to include: <strong>SelectHealth</strong> does NOT cover computerized or standard neuropsychological testing when performed to establish a baseline (prior to injury) assessment for individuals participating in sporting activities or similar scenarios as the validity of this testing has not been proven in the published literature.</td>
</tr>
<tr>
<td>185</td>
<td>Negative Pressure Wound Therapy (Revised)</td>
<td>7/16/2015</td>
<td>Change made under <strong>Indications for initial approval</strong> from “three-week trial of therapy will be authorized” to “30-day trial of therapy will be authorized if all of the following conditions are met.”</td>
</tr>
<tr>
<td>509</td>
<td>Fetal Cell Free SNA (cfDNA) Testing for Down Syndrome (Revised)</td>
<td>7/16/2015</td>
<td><strong>Added exclusion for SelectHealth Commercial</strong>: SelectHealth does NOT cover fetal cell-free DNA (cfDNA) in multiple gestation pregnancies or any other indication.</td>
</tr>
<tr>
<td>430</td>
<td>Left Atrial Appendage Closure (LAAC) devices (Watchman®) (Revised)</td>
<td>8/6/2015</td>
<td><strong>Removed the following requirement for SelectHealth Commercial under criteria for coverage as it no longer applies</strong>: “The device is being used as part of the required post-approval registry of approximately 2,000 newly enrolled patients, followed to at least two years to evaluate acute procedural and longer term outcomes, similar to those from the pivotal study, with FDA to make the final recommendations with respect to study size. In addition, that the patients enrolled in the premarket trial (PROTECT-AF), both arms, be followed for five years.”</td>
</tr>
<tr>
<td>545</td>
<td>Propel® Implant for the Treatment of Chronic Rhinosinusitis (Revised)</td>
<td>7/28/2015</td>
<td>Updated policy to reflect recent evidence from technology assessment completed 7/28/15. Noncoverage of this technology not modified.</td>
</tr>
<tr>
<td>302</td>
<td>Cochlear Implantation (Revised)</td>
<td>8/6/2015</td>
<td>Change made to include coverage and link updates: <strong>SelectHealth Community Care</strong> covers cochlear implants only for children younger than age 21 and pregnant adults on a case-by-case basis, consistent with codes covered in the UDOH Medicaid Lookup Tool and Utah State Medicaid Policy. As Utah State Medicaid does not have specific coverage criteria, InterQual procedure criteria for cochlear implants are used to determine coverage for these devices. Audiology services and related devices are not covered for non-pregnant adults.</td>
</tr>
</tbody>
</table>
### REVISED POLICIES

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</table>
| 524           | Bone-Anchored Hearing Aids (BAHA) (Revised)                                  | 8/6/2015              | Changes made to include coverage and links updated:  
**SelectHealth Advantage** covers implantable Bone-Anchored Hearing Aids (BAHA), also called osseointegrated implants, subject to Medicare criteria found in Medicare Benefit Policy Manual, Chapter 16-General Exclusions from coverage, Section 100.  
**SelectHealth Community Care** covers implantable Bone-Anchored Hearing Aids (BAHA), also called osseointegrated implants, only for children younger than age 21 and pregnant adults on a case-by-case basis, consistent with codes covered in the UDOH Medicaid Lookup Tool and Utah State Medicaid Policy. As Utah State Medicaid does not have specific coverage criteria, SelectHealth commercial coverage criteria are used to determine coverage for these devices. Audiology services and related devices are not covered for non-pregnant adults. |
| 290           | Spinal Implant Systems for the Treatment of Thoracic Insufficiency Syndrome (TIS) (Revised) | 7/28/2015             | Policy title changed to reflect availability of multiple devices to treat Thoracic Insufficiency Syndrome (TIS). Previous policy was titled: titled, “Vertical Expanding Titanium Rib (VEPTR/VEPTR II) for the Treatment of Thoracic Insufficiency Syndrome (TIS)”  
MAGnetic Expansion Control System (MAGEC®) was added to the policy.  
**SelectHealth Commercial** covers adjustable spinal implantation systems, including the vertically expanding titanium rib (VEPTR/VEPTR II) and the MAGnetic Expansion Control System (MAGEC) systems for the treatment of Thoracic Insufficiency Syndrome (TIS) in skeletally immature patients in situations that meet the FDA indications.  
**SelectHealth Advantage** covers adjustable spinal implantation systems, including the vertically expanding titanium rib (VEPTR/VEPTR II) and the MAGnetic Expansion Control System (MAGEC) for the treatment of Thoracic Insufficiency Syndrome (TIS) consistent with CMS guidelines. Since there are no NCD, LCD, or other specific InterQual guidelines for the vertically expanding titanium rib (VEPTR/VEPTR II) Commercial policy will apply.  
**SelectHealth Community Care** covers adjustable spinal implantation systems including the vertically expanding titanium rib (VEPTR/VEPTR II) and the MAGnetic Expansion Control System (MAGEC) for the treatment of Thoracic Insufficiency Syndrome (TIS) consistent with CMS guidelines. Since there are no NCD, LCD, or other specific InterQual guidelines for the vertically expanding titanium rib (VEPTR/VEPTR II) Commercial policy will apply. |
| 236           | Robot-assisted Surgery (Revised)                                             | 7/28/2015             | Literature was updated to reflect recent M-Tech review on the use of robot-assisted surgery in pancreatectomy and pancreatoduodenectomy. The outcome of that review was to continue to NOT cover robot-assisted pancreatectomy and pancreatoduodenectomy. The policy section that only lists covered indications has not changed. |
| 281           | Genetic Testing: Gene Expression Profiling in the Management of Breast Cancer (Revised) | 9/8/2015              | Prosigna® gene expression profiling test added as a covered test for women with early stage breast cancer who are estrogen receptor-positive and lymph node-negative.  
**SelectHealth Commercial** covers Prosigna gene expression profiling test for patients with breast cancer when criteria are met.  
**SelectHealth Advantage** does not cover Prosigna gene expression profiling test for patients with breast cancer as CMS does not currently include this test as a covered genetic test.  
**SelectHealth Community Care** covers gene expression profiling test for the management of breast cancer treatment when Utah Medicaid criteria are met, as outlined in the Utah Medicaid Laboratory Services Manual. Genetic testing, gene expression profiling, or similar tests not covered by Utah Medicaid and are not covered by SelectHealth Community Care. Please refer to the UDOH Medicaid Lookup Tool for coverage status of associated codes.  
For those codes that are covered by Utah Medicaid but not addressed with criteria in the UDOH Medicaid Lookup Tool, commercial criteria will apply. |
Technology Assessment (M-Tech) News

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

Here is a list of recent technologies we reviewed and our M-Tech Committee recommendations:

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Technology</th>
<th>Date Reviewed*</th>
<th>Committee Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>322</td>
<td>Endoscopic Ablation for Low-grade Barrett’s Esophagus</td>
<td>September 8, 2015</td>
<td>Covered. Current evidence has illustrated the clinical utility of RFA for low-grade dysplastic Barrett’s esophagus in carefully selected patients. See Medical Policy #322.</td>
</tr>
<tr>
<td>281</td>
<td>Prosigna for Breast Cancer Recurrence Testing</td>
<td>September 8, 2015</td>
<td>Covered. Current evidence suggests the Prosigna gene expression profile test to have analytic and clinical validity. Evidence regarding the utility of breast cancer recurrence testing has been established in the literature in general. Prosigna gene expression profile test in early stage (stage 1) ER+ node negative breast cancer is covered. See Medical Policy #281.</td>
</tr>
</tbody>
</table>

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

Listed below are other technologies the M-Tech Committee is actively assessing or scheduled to review. As the reviews are completed, we will notify stakeholders to inform them of our coverage determinations:

> Bariatric Surgery  
> Cologuard® for Colorectal Cancer Screening  
> ConfirmMDx® Prostate Cancer Test  
> Decipher® Prostate Cancer Classifier  
> Enterra™ Gastric Pacemaker for Gastroparesis  
> Hemorrhoid RFA Ablation  
> iStent® for Glaucoma  
> Ligament-sparing knee replacement devices (e.g. Biomet Vanguard XP knee)  
> Magnetic Resonance-guided Focused Ultrasound (MRgFUS) for Bone Cancer  
> Magnetic Resonance-guided Focused Ultrasound (MRgFUS) for Prostate Cancer  
> Magnetic Resonance-guided Focused Ultrasound (MRgFUS) for Uterine Fibroids  
> Oncotype DX® Colon  
> Prolaris® for Prostate Cancer  
> Psych Med Genetic Testing  
> Selective Internal Radiation Therapy (SIRT) for Liver Cancer  
> SphenoCath® SPG Block for Migraine Management  
> Sublingual Immunotherapy  
> vBloc® for Weight loss  
> Vermillion OVA1® for Ovarian Cancer

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, contact us at mtech@selecthealth.org or call 801-442-7585.

You can view all SelectHealth medical policies and technology assessments on our website. Go to selecthealth.org, click on the “Provider” tab (upper right corner), enter your login information, and then click on “Policies and Procedures” (left side of page) to be directed to the website.