Welcome to the Provider Insight newsletter. Here, you’ll find medical, dental, and pharmacy information as well as updates to our plans:

> Commercial
> SelectHealth Advantage® (Medicare)
> SelectHealth Community Care® (Medicaid)
> Federal Employee Health Benefits (FEHB) plans

We encourage you to read Provider Insight to stay up to date on policies affecting our members and your patients.

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SelectHealth News

HEDIS Measurement: Breast Cancer Screening

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

Breast cancer screening rates are one of the HEDIS measurements intended to help increase public awareness and healthcare quality.

Breast cancer is the second-leading cause of cancer death in women, exceeded only by lung cancer. Death rates from breast cancer dropped 40% between 1989 and 2016. This decrease is attributed to better screening rates and methods and improved cancer treatments.¹

The United States Preventive Services Task Force (USPSTF) suggests that, "...screening is most beneficial for women ages 50 to 74" and recommends a screening mammogram every two years for this age group.²

Figure 1 below compares the percentage of breast cancer screenings among Utah and Idaho members (commercial product lines) with 2017 regional and national averages. In addition, 2018 goals for each state are indicated.

Figure 1. Commercial Product Lines – Rates of Breast Cancer Screening (Utah and Idaho)

The Breast Cancer Screening HEDIS measure calculates the percentage of women in this age group who had at least one mammogram within the past 27 months.¹

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Figure 1 below compares the percentage of breast cancer screenings among Utah and Idaho members (commercial product lines) with 2017 regional and national averages. In addition, 2018 goals for each state are indicated.
To support the HEDIS measure objectives, we conduct both member and provider outreach as outlined in figure 2 below.

**Figure 2. Outreach Steps to Support HEDIS Measure Objectives**

<table>
<thead>
<tr>
<th>Member Outreach</th>
<th>Provider Outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Make outbound scheduling calls</strong> to members due for a screening mammogram (in collaboration with Intermountain Healthcare and Symphony RM).</td>
<td><strong>Offer a comprehensive dashboard</strong> developed by the Medical Home department for participating clinics. This dashboard identifies patients needing mammograms for providers conducting targeted outreach.</td>
</tr>
<tr>
<td><strong>Mail informational brochures</strong> to members in need of breast cancer screening. These brochures include mammography center phone numbers and offer reasons and data to support regular breast cancer screenings.</td>
<td><strong>Send monthly cancer screening reports</strong> to OB/GYN providers indicating patients due for women’s health services.</td>
</tr>
</tbody>
</table>

To learn more about our Quality Improvement programs, call **801-442-7425**.


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**Meet Chad Jasperson, New SelectHealth Director of Network Development**

Chad joined SelectHealth in March and will be leading network development efforts in new growth markets.

He has served in clinical and various leadership positions with Intermountain Healthcare for 29 years. He most recently worked in the TeleHealth department where he played a key role in developing a partnership and implementation model for contracting with external hospitals throughout the western region. Using this model, he worked to bring Intermountain specialty services, such as oncology, stroke, and newborn resuscitation, to diverse communities.

Chad has extensive experience in the healthcare industry, relationship and business development, implementation, planning, strategic initiatives, leading multidisciplinary teams, and physician collaboration. He is deeply committed to personal excellence with a strong business and relationship acumen.

He is driven by our mission, vision, and values: “I have been fortunate in my career to have multiple opportunities from direct patient care to leadership roles. I have enjoyed having a positive impact on the lives of the people we serve. I love the direction we are moving—keeping people out of hospitals and helping them adopt healthier habits. This direction is driven by our mission of **Helping People Live the Healthiest Lives Possible**.”

Chad is a fellow of the American College of Healthcare Executives. He holds an MPA from Brigham Young University and a BS in Advanced Radiological Sciences from Weber State University.

Chad lives in Salem, Utah with his wife Shantele and has three children and one grandson. He enjoys spending time with his family, college football, mountain biking, and other outdoor activities.
Shared Risk Networks:
Measuring Persistency for Appropriate Documentation and Coding

Participating providers in the Shared Risk networks (SelectHealth Advantage, SelectHealth Community Care, and SelectHealth Share) agree to support the 18 Shared Commitments, a value-based healthcare delivery model, for the members attributed to their practices. These commitments promote:

> Clinical excellence, integration, and improvement
> Patient access
> Accountability, operational commitment, and mutual respect

The focus for 2019 will be on three watch metrics related to these commitments:

1. Accurate and complete documentation and coding (persistency).
2. Patient satisfaction.
3. Quality.

For the first of these watch metrics, SelectHealth will be focusing on minimum persistency targets for appropriate documentation and coding. More details will be coming soon on the other two watch metrics, patient satisfaction and quality, as well as online dashboards for providers to track their progress.

What is persistency, and how does it impact patient outcomes?

A chronic Hierarchal Condition Category (HCC) must be accepted by the Centers for Medicare and Medicaid Services (CMS) both in 2018 and 2019 to fit the definition of persistency.

HCC corresponds to a patient with a documented and accepted chronic illness in 2018 as well as the same documented chronic illness in 2019. To fall within the persistency metric, the chronic illness must be documented and accepted by CMS on a claim in 2018 and in 2019.

CMS stresses that complete and accurate medical records foster more timely and appropriate care, which leads to improved patient outcomes. Additionally, persistency is key to our ability to identify and deploy appropriate resources to best meet individual SelectHealth Advantage (Medicare) members’ needs. These 2019 targets are:

> 40% by July 1
> 60% by September 1
> 70% by December 1

How is data gathered for this watch metric?

To start meeting these persistency targets, providers will need to submit information on SelectHealth Advantage patients with chronic conditions using the SelectHealth Advantage Value-based Care Form available at the Intermountain Reports Center (log in required). Review the Quick Guide: SelectHealth Advantage Value-Based Care Form (as shown in figure 3 on page 5) for help using this form.

Continued on page 5...
How can a provider track progress?

View progress reports by following these seven steps:

1. Go to the Intermountain Reports Center.
2. Log in.
3. Click on “View Report.”
4. Select your clinic.
5. Select “ALL” your providers.
6. Select “ALL” patients’ names.
7. Click “Run Report,” and print.

Questions? Contact Mitchell Davies at 801-442-7969 or via email at mitchell.davies@selecthealth.org.

Social determinants of health play a significant role in your patients’ well-being and their ability to follow recommended treatment plans.

Our care managers, both Registered Nurses (RNs) and Licensed Clinical Social Workers (LCSWs), work one-on-one with patients to recognize and address these social factors. Many of our care management successes include connecting members with:

> Financial assistance (for medications or medical bills)
> Housing and utilities assistance
> Transportation to and from medical appointments
> Healthy food options
> Social support systems

Learn more about care management at SelectHealth by visiting selecthealth.org or calling 801-442-5305.

Please consider referring your SelectHealth patients who might benefit from these services. When calling, please select the appropriate SelectHealth option:

> **Option 1**: Advantage (Medicare)
> **Option 2**: Community Care (Medicaid)
> **Option 3**: Commercial Small Employer/Individual
> **Option 4**: Commercial Large Employer/Self-funded/FEHB
Intermountain Healthcare News

Immunization Update and ACIP Highlights

The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) met on February 27–28 to provide guidance on vaccines as well as considerations and evidence surrounding anticipated future recommendations. These recommendations will be voted on in the June 2019 ACIP meeting.

Figure 4 below summarizes the key guidance from the meeting in February. Figure 5, on the next page, provides an overview of future vaccine recommendations likely to be voted on in June 2019.

Figure 4: Key Vaccine Guidance Highlights from February 2019 ACIP Meeting

<table>
<thead>
<tr>
<th>Influenza</th>
<th>2018-2019 influenza season vaccine effectiveness (VE): Interim VE is 47% during this moderate-severity year, which was predominated by H1N1 with increasing levels of H3N2 as the season progressed.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2019-2020 influenza vaccine candidate strain components: Three of the four determined components are two Influenza B types that will be the same as last season’s vaccine and two new Influenza A types. The A/H3N2 type determination was delayed until March 21, which hopefully does not cause production and delivery delays in the fall.</td>
</tr>
<tr>
<td></td>
<td>Statistics on diseases averted: The <a href="https://www.cdc.gov/flu">CDC influenza website</a> reports that, in the 2017-2018 season, 7 million illnesses, 109,000 hospitalizations, and 8,000 deaths were averted due to the influenza vaccine.</td>
</tr>
<tr>
<td></td>
<td>Expanded Vaccine Safety Database (VSD) study supports influenza vaccine safety in early pregnancy: An October 2017 study indicated an association with spontaneous abortion (SAB) in the first 28 days after vaccination with an influenza vaccine when an H1N1pmd09-containing vaccine had also been received in the previous season. An expanded VSD study was presented that added data from three more influenza seasons with a much larger study population. This study found no significant association between influenza vaccine receipt and SAB, regardless of prior season vaccination status.</td>
</tr>
</tbody>
</table>

| Hexavalent* | VAXELIS™ hexavalent vaccine (HV), a Merck/Sanofi joint venture, on the market in 2020: HV was licensed 12/21/18 for 3 primary series doses, ages 2, 4, and 6 months, and is approved up to age 4 years. The vaccine contains the same DtaP5 as Sanofi’s DAPTACEL®. It also contains IPOL®, adult dose RECOMBIVAX HB®, and Hib PRP-OMP (but at only 3 mcg of Hib PRP rather than the 7.5 mcg that is contained in PedvaxHIB®). |
|            | Anticipated vote to approve HV use for the [Vaccines for Children (VFC) program](https://www.cdc.gov/vaccines/vfc/index.html) in June 2019: Noninferiority was demonstrated for all antigens with the exception of geometric mean concentration (GMC) for a pertussis antigen post dose 3 and for a pneumococcal antigen post dose 3 when given concomitantly with PCV13. Safety of the vaccine was demonstrated with some increased rates of pyrexia compared to control but no febrile convulsions. |
|            | Hib PRP-OMP reduced amount: The amount of Hib PRP-OMP was reduced to avoid reactogenicity. Because of this reduced level of antigen, ACIP will not give a preferential recommendation for its use in the American Indian/Alaska Native (AI/AN) population unless more evidence is provided on post-first dose immunogenicity. |

| Japanese Encephalitis (JE) | ACIP approves accelerated dosing schedule: Approved accelerated dosing schedule is for adults who may receive the second dose anytime 7 to 28 days after the first dose. Booster dose approval expanded: ACIP voted to expand the recommendation of a booster dose of JE vaccine down to age 14 months through 65 years for those at continued risk with at least 12 months separation from a previous dose. |

* DtaP5, IPV, Hep B, Hib PRP-OMP reduced amount

Questions?
Contact Tamara Sheffield, MD, MPA, MPH, Medical Director, Community Health and Prevention, Intermountain Healthcare, at 801-442-3946.

Continued on page 7...
Figure 5: Future Vaccine Recommendations (Vote anticipated June 2019)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Recommendation Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV</td>
<td>The FDA has approved HPV vaccinations for all adults up to age 45 years. The ACIP will most likely harmonize gender by recommending catch-up vaccination for both males and females up to either age 26 or 30 years, anticipating a recommendation of informed decision making (formerly known as a category B recommendation) rather than a full recommendation for ages 30 to 45 years.</td>
</tr>
<tr>
<td>PCV13</td>
<td>The majority of the work group favors either removing or revising the PCV13 recommendation for average-risk adults age 65 and older due to the indirect beneficial herd effects of vaccinating children. However, there are enough dissenting opinions that it is uncertain how the ACIP will vote, possibly in June 2019. In addition, the advent of new PCV15 and PCV20 vaccines looming on the horizon adds to this uncertainty.</td>
</tr>
<tr>
<td>Meningococcal B</td>
<td>The Meningococcal work group recommended to the ACIP a booster dose of Meningococcal B vaccine for those at high-risk age ≥10 years, such as persons with asplenia, complement component deficiency, using a complement inhibitor medication, and microbiologists, or during an outbreak. Booster to be given 1 year after primary series followed by repeat doses every 2–3 years while risk continues.</td>
</tr>
<tr>
<td>HEP A</td>
<td>The Hepatitis work group recommended to the ACIP adding adult persons with HIV as a risk group for receiving 2 doses of Hep A vaccine.</td>
</tr>
<tr>
<td>Tdap</td>
<td>Tdap was approved by FDA in January 2019 as a repeat tetanus dose in ages 10 through 64 years as long as there has been an 8-year separation between doses or at least 5 years between doses for wound management. In its October 2018 meeting, the ACIP said it would discuss the removal of “single use” language for Tdap, allowing it to be given for tetanus boosters or wound management, during its February 2019 meeting, but that discussion did not occur.</td>
</tr>
</tbody>
</table>

Care Process Model Updates

Care Process Models (CPMs) are developed by multidisciplinary clinical experts from Intermountain Healthcare and are based on national and other guidelines as part of a comprehensive care management system. Find all Intermountain CPMs at one of these locations:

- m.intermountain.net/clinical/Pages/All-Care-Process-Models-(CPMs).aspx
- intermountainphysician.org/clinical/Pages/Care-Process-Models-%28CPMs%29.aspx

CPMs are updated by the clinical programs every two years to reflect the most current, evidence-based standards.

Recently updated versions include:

- Pediatric Acute Otitis Media
- Urinary Tract Infection in Adults
- Streptococcal Pharyngitis
- Management of Vaginal Birth After Cesarean (VBAC)
- Assessment for Elective Labor Induction
- Emergency Management of Acute Ischemic Stroke
- Opioid Use in Pregnancy
SelectHealth Advantage (Medicare) News

CMS Quality Measures and Star Ratings: Clarification and Targeted Tips

Centers for Medicare & Medicaid Services (CMS) uses the Medicare Star Rating system to monitor performance of Medicare Advantage plans. This program consists of measures related to quality, process, and patient experience. Providers on SelectHealth networks have great impact on the performance measures and, as such, have significant opportunities to bolster these measures while continuing to provide high-quality care to members.

The February edition of Provider Insight featured an article focused on the Consumer Assessment of Healthcare Providers Survey (CAHPS) and Health Outcomes Survey (HOS), which make up the patient experience portion of the Star Rating. Quality measures are also very important to the CMS Star Rating. Two quality measures, medication adherence and statins for those with diabetes, are highlighted below along with tips for making sure your practice is on track.

Medication Adherence

There are three medication adherence measures included in the Stars program, including measures focused on medications frequently used to treat diabetes, cholesterol, and hypertension. Specifically, CMS evaluates prescription fill data to identify:

- Members who have received at least two prescriptions for medications that fall within these drug treatment classes
- If the member has enough medication on hand to cover at least 80% of the days from the first prescription received in the year through the end of the year

Because this evaluation only uses pharmacy claims, off-label medication use (e.g., metformin for weight loss or prediabetes) will be included.

Tips for improving the medication adherence measure include:
- Using the 100-day prescription benefit for Medicare Advantage members
- Ensuring patient understanding of the importance of taking the medication as prescribed
- Encouraging patient to use refill reminder programs offered by the pharmacy where they fill their medication
- Considering mail-order prescriptions if the patient has difficulty getting to the pharmacy to pick up refills

Statin Therapy for Patients with Diabetes

For this measure, CMS evaluates if patients with diabetes between the ages of 40 and 75 have had at least one statin medication fill at any intensity (low, moderate, or high) during the calendar year.

Tips for improving the statins for diabetes measure include:
- Reviewing patients with diabetes to see if statin therapy has been prescribed
- Ensuring patient understanding of the importance of the medication
- Conducting a statin re-challenge with a lower dose and/or lower intensity statin in patients who historically may not have tolerated a statin well

Note: Excluded from this evaluation are members with end-stage renal disease (based on claims during the calendar year) and those who were enrolled in hospice at any point during the calendar year.
New Quality Report for Medical Home Providers

For providers participating in the SelectHealth Advanced Primary Care (Medical Home) program, SelectHealth has developed and published an on-demand provider reporting tool for nine, high-priority Medicare Star measures. This tool can be accessed from the Medical Home dashboard and will help providers understand and track their performance.

What do the data on the report represent?
The data displayed on the new reporting tool represent nine aggregate performance measures for Medicare Advantage patients only (see figure 6 below). Collectively, these measures contribute approximately 20% of the overall Stars rating awarded to SelectHealth each year. The data are retrospective and reflect the provider's historical performance with Medicare Advantage members over a specified time frame. Importantly, there is a two-year lag between the data measurement period and the Star year. For example, the 2020 Stars award rating is based on performance from January 1 through December 31, 2018.

What quality measures are included in this report?
Of the nine measures reported, five are drawn from the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), for which members are assigned to physicians based on PCP attribution. The other four measures are related to CMS Medicare Part D and are drawn from Pharmacy Quality Alliance (PQA) Measure specifications, for which members are assigned to physicians based on the first prescriber in the measurement period.

Figure 6. Stars Provider Reporting Tool - Sample Report
The HEDIS measures are:
1. Breast Cancer Screening
2. Colorectal Cancer Screening
3. Diabetes Care – Eye Exam
4. Diabetes Care – Kidney Disease Monitoring
5. Diabetes Care – Blood Sugar Controlled

The PQA measures are:
1. Medication Adherence for Diabetes
2. Medication Adherence for Hypertension (RAS antagonists)
3. Medication Adherence for Cholesterol (Statins)
4. Statin Use in Person with Diabetes (SUPD) — (different than the HEDIS measure)

How are Star Ratings determined?
The cut points (or performance thresholds) for determining your Star Ratings (e.g., four, three, or two stars) are based on the Star year’s thresholds. The report includes detailed information about cut points for each measure.

What are the limits of this tool?
Keep in mind, you cannot drill down to identify individual members/patients that contribute to the rating. The SelectHealth Medical Home Report and other reports that include prospective measurement can be used for patient (member) level gaps in care intervention.

How do I access these reports?
If you have an account, you can access this new reporting tool by navigating to the SelectHealth Medical Home Report Hub (“Links” tab) located at: SelectHealth Medical Home Report Hub. Figure 7 below indicates where to find the report on the report hub.

If you don’t have an account, set one up by contacting your SelectHealth Medical Home representative.

Questions?
Set up an account, get additional training, or learn more by contacting your SelectHealth Medical Home representative.
CMS Requirement Changes for Fraud, Waste, and Abuse (FWA) Compliance

Recently, CMS removed certain compliance training requirements previously applicable to First Tier, Downstream, and Related Entities (FDRs) of Medicare Advantage Plans, such that SelectHealth is no longer required to:

> Provide CMS-issued training to healthcare providers and business partners on general compliance and FWA
> Confirm completion of those trainings

However, SelectHealth providers and business partners (FDRs) are still required to comply with these three, key tasks:

1. **Implement** a compliance program.
2. **Annually train** employees and contractors supporting SelectHealth Medicare Advantage plans on compliance policies and FWA.
3. **Complete the online training attestation** here. Attestation records may be reviewed by CMS during compliance audit proceedings.

Learn more about these requirements and find links to helpful resources here.

The Weigh to Health Program: Diabetes Prevention Services for Medicare Patients

The Weigh to Health program, developed by Intermountain Healthcare, helps participants lose 5–7% of their starting body weight and increase moderate physical activity to 150 minutes per week. In 2017, the program updated curriculum and requirements to become a Centers for Disease Control (CDC)-accredited National Diabetes Prevention Program. Along with that process, The Weigh to Health program has been working to become a Medicare Diabetes Prevention Program provider. By the end of 2019, the 12-month program will be offered to those insured by Medicare.

**How will members use this benefit?**

Currently, most SelectHealth plans cover the up-front cost of The Weigh to Health program for patients who **either** have a BMI ≥30 or have been diagnosed with weight-related comorbidity such as prediabetes, high cholesterol, hypertension, and cardiovascular disease.

Medicare participants will need a blood test confirming prediabetes to use this one-time benefit.

**What does the program include?**

The program includes 18 group sessions facilitated by a Registered Dietitian Nutritionist (RDN) and four, one-on-one RDN appointments over 12 months. The program’s focus on facilitating healthy lifestyle changes is the best option for patients who have screened at-risk for prediabetes, had a blood test confirming prediabetes, or don’t have prediabetes but want to lose weight. Regularly scheduled orientations are held at different facilities, giving patients a number of convenient options.

**Where can members learn more?**

For more information and a list of facilities offering The Weigh to Health program, visit The Weigh to Health website.
SelectHealth Community Care (Medicaid) News

Enhance Patient Interactions with SelectHealth-contracted Language Interpreters

We contract with language interpreters to help you provide the best care for our SelectHealth Community Care* members who speak little or no English as well as for those who use sign language.

Contracted language interpreters are listed in figure 8 below based on where the member is receiving care.

SelectHealth will pay for interpretation services for Community Care members as follows:

> When provided by a contracted interpreting agency (see table below based on services at different points of care)
> For services covered by Medicaid and SelectHealth (NOTE: Only those members who have Community Care as secondary coverage will be covered for interpretive services under Medicare Advantage or commercial plans.)

The provider will be responsible for the cost of interpretation services when the member:

> Receives services from interpreters other than those contracted (see figure 8 below)
> Was not eligible for Community Care at the time of service
> Accrues costs for appointment change or cancellation by the provider’s office

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The provider will be responsible for the cost of interpretation services when the member:

> Receives services from interpreters other than those contracted (see figure 8 below)
> Was not eligible for Community Care at the time of service
> Accrues costs for appointment change or cancellation by the provider’s office

Effective May 1, 2019, SelectHealth Community Care will cover interpreters making follow-up phone calls for:

> Communicating lab or radiology results
> Scheduling appointments
> Managing medication changes

Continued on page 13...
Preauthorization Criteria for Total Knee Arthroplasty (TKA), Total Hip Arthroplasty (THA), and Spinal Fusion Surgeries

Beginning **May 1, 2019**, preauthorization criteria for TKA/THA/spinal fusion surgeries will be the same for SelectHealth Community Care members as it is currently for the commercial plan members.

These evidence-based changes reflect best practices and expert consensus of the Intermountain Musculoskeletal and Neuroscience Clinical programs.

Please review the appropriate policies for each type of surgery using the links below:

- [Total Knee Arthroplasty](#)
- [Total Hip Arthroplasty](#)
- [Cervical and Lumbar Spinal Fusion and Combined Decompression/Fusion](#)

Each of these policies includes the specific preauthorization criteria as well as:

- Links to key resources from CMS and the State of Utah
- When surgery is NOT covered (e.g., contraindications or relative contraindications, experimental/investigational procedures, or robotic-assisted procedures or custom components without adequate outcomes evidence)
- A summary of medical information
- Billing/coding information
- Key references (evidence base)

**Questions?** Contact your Provider Relations representative at **801-538-5054** or via email at providerrelations@selecthealth.org.

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**How extensive is the need for interpreters?**

The American Community Survey (ACS) 2017 data, published by the Census Bureau, estimates that more than 66 million people (nearly 22% of U.S. residents) speak a language other than English at home. Of this population, 39% told the Census Bureau that they speak English “less than very well.”

How does this impact patient health outcomes?

Those with Limited English Proficiency (LEP)* struggle with healthcare services because they:

- Tend to not receive adequate preventive care
- Have limited access to regular care
- Are more likely to be dissatisfied with their care
- Are much more likely to experience adverse drug complications
- Struggle to understand diagnoses
- Have low health literacy
- Are at greater risk of being misunderstood by their physicians

Learn more at:

- [Think Cultural Health Resource Library](#)
- [AHRQ Overview of Medical Interpreter Standards of Practice](#)
- [NCIHFAQs for Healthcare Professionals](#)

*“For many individuals with limited English proficiency (LEP), the inability to communicate in English is the primary barrier to accessing health information and services. Health information for people with LEP needs to be communicated plainly in their primary language, using words and examples that make the information understandable.” ([health.gov/communication/literacy/quickguide/factsbasic.htm](https://health.gov/communication/literacy/quickguide/factsbasic.htm))

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Practice Management Resources

Automate SelectHealth Preauthorization: Switch to Care Affiliate

Care Affiliate is our online preauthorization tool. It enables you to submit preauthorization requests and supporting documentation online rather than through fax or email. This electronic functionality improves security and the speed at which requests are reviewed.

Why should I use Care Affiliate?
Compared to faxed and emailed requests, using the Care Affiliate tool offers many benefits, such as:

- Requiring fewer steps overall
- Eliminating duplicative efforts and potential errors when staff enter information from a paper form
- Decreasing response time
- Reducing follow-up calls and decision delays due to missing information
- Eliminating the risk of faxed member information being lost or sent to the wrong fax number
- Enabling automatic review and preauthorization decisions for many procedures

How do I access Care Affiliate?
Request access to the SelectHealth physician portal and Care Affiliate by visiting selecthealthphysician.org (see the area magnified in figure 9 below), and follow these instructions:

1. Download and complete the required documentation for:
   - **A new account**: Submit the SelectHealth Information Technology Services Agreement (ITSA) AND the Online Login Application.
   - **A new user on an existing account**: Submit ONLY the Online Login Application.

2. Email completed documentation to providerwebservices@selecthealth.org.

Where can I learn more?
Questions? Email providerwebservices@selecthealth.org, or call 800-538-5054 (option 2).
Population Health On-Demand Physician Performance Metrics

Navigate to intermountainhealthcare.org/phmeasures (see figure 10 below) for a list of 2019 physician performance metrics for our SelectHealth Share, SelectHealth Community Care, and SelectHealth Advantage products.

Information includes:

> Updated 2019 Quality Measures for your specialty
> Updated 2019 Patient Experience thresholds
> Detail on how shared savings will be distributed to your clinic

We appreciate our relationship with you, your participation, and the excellent care you provide our members.

Questions? Contact the Population Health Consultants at Intermountain Healthcare at phconsultants@imail.org.

Reduce Claim Delays with the Provider Benefit Tool

The SelectHealth Provider Benefit Tool will help you check eligibility and benefits before your patients arrive as well as status of claims and remittance advice.

Need access to the Provider Benefit Tool? Follow the instructions on page 10 (the same as for accessing Care Affiliate).

Need help using the Provider Benefit Tool? Once you have access and log in to the Provider Portal, click on the Provider Benefit Tool icon. You will find resources to help you easily navigate the tool, including Quick Search, Patient Lookup, and Browse Claims (see figure 11 at right).

Questions? Email providerwebservices@selecthealth.org, or call 800-538-5054 (option 2).
Medical Policies, Coding & Reimbursement

Medical Policy Update Bulletin

Please review the approved and revised Coding and Reimbursement Policies below. The Medical Policy Update Bulletin gives you access to new and revised medical policies in their entirety, along with an overview or summary of changes.

The appearance of a policy in the Medical Policy Update Bulletin indicates that SelectHealth has recently adopted or revised a Coding and Reimbursement Policy but does not indicate whether or not SelectHealth provides coverage for the procedures listed. For any inconsistency or conflict between the information provided in this bulletin and the posted medical policy, the provisions of the posted policy will prevail.

New Policies Created and Published:
> Sleep Disorder Evaluation and Treatment (625); effective 3/14/2019
> Evaluation and Treatment for Autism Spectrum Disorder (630); effective 3/14/2019
> Venipuncture and/or Collection of Specimens (78); effective 1/1/2010 (created and published retroactively)

Revised Policies:

<table>
<thead>
<tr>
<th>REVISED Policy Title (Number)</th>
<th>Effective Date</th>
<th>Summary of Change (Only applies to commercial plan policy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic Testing: Cystic Fibrosis (CF) (289)</td>
<td>2/25/2019</td>
<td>Revised criterion concerning qualified providers to be in alignment with updated language: “… when ordered or recommended by a medical geneticist, a genetic counselor, or a provider ….”</td>
</tr>
<tr>
<td>Genetic Testing: Notch 3 Testing for Cerebral Autosomal Dominant Arteriopathy With Subcortical Infarcts and Leukoencephalopathy (353)</td>
<td>2/26/2019</td>
<td>Updated lists of eligible failed medications and failed therapies. Modified the required time frame specified in criterion #3d from within last year to within 2 years: “Imaging or diagnostic laparoscopy within 2 years is otherwise non-diagnostic ...”</td>
</tr>
<tr>
<td>Hysterectomy (620)</td>
<td>2/28/2019</td>
<td>Published updated version of policy.</td>
</tr>
<tr>
<td>Medical Record Documentation (35)</td>
<td>1/22/2019</td>
<td>Revised to provide coverage of drug and antibody level monitoring in inflammatory bowel disease when criteria are met; title changed from Infliximab and Adalimumab Testing</td>
</tr>
<tr>
<td>Drug Monitoring in Inflammatory Bowel Disease (532)</td>
<td>3/22/2019</td>
<td>Expanded qualifying factors for oral/tube enteral feedings/supplemental feedings to include severe neurological disorder or severe psychiatric condition. Incorporated criteria for extensively hydrolyzed formulas.</td>
</tr>
<tr>
<td>Formulas and Other Enteral Nutrition (534)</td>
<td>3/22/2019</td>
<td>Modified criteria to include coverage of speech therapy for habilitative services (developmental delay) on plans covering these services.</td>
</tr>
<tr>
<td>Speech Therapy Guidelines (178)</td>
<td>4/5/2019</td>
<td>Continued on page 17...</td>
</tr>
</tbody>
</table>
Medical Policies, Coding & Reimbursement, Continued

...Continued from page 16

Archived Policies

SelectHealth archives a policy when a certain set of criteria is no longer applicable or necessary such that a code (or codes) is either set to be automatically covered or automatically not covered. This nullifies the need for any clinical criteria and corresponding medical policy. Newly archived policies include:

> **BioPhotonic Scanner (250); effective 3/13/2019** (remains not covered)

> **Helmet Therapy for Cranial Remodeling (212); effective 3/25/2019** (policy/codes were switched from possibly covered to covered)

May 2019 Coding Updates (Note: Documentation changes apply to all plans.)

Updated Preauthorization Requirements

CPAP/BiPAP (Effective **04/01/2019**) will require preauthorization after the first three-month rental if criteria in **Medical Policy #625 - Sleep Disorder Evaluation and Treatment** are not met.

Coding Clarifications

Based on an increase in claims and appeals for claims billing for the following situations, please use the coding guidance provided for each:

> **Code 69210 - Removal impacted cerumen requiring instrumentation, unilateral:** For claims billing for Evaluation and Management (E&M) services (i.e., office visits) with the **code 69210**, SelectHealth will consider payment for both an E&M visit and impacted cerumen removal on the same day if all criteria in the **Coding and Reimbursement Policy #01 - Cerumen Removal** have been met.

> **Code 76942 - Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation:** For claims billing for trigger point injections as well as **code 76942** billed with transrectal ultrasounds:

  • SelectHealth will not separately reimburse for ultrasound guidance (76942) when done with the following unless documentation proves medical necessity:
    - Joint aspiration/injection **codes 20600-20611**
    - Tendon sheath/ligament **codes 20550-20551**
    - Trigger point injection **codes 20552-20553**

  Please refer to **Coding and Reimbursement Policy #55 - Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections** for details.

  • SelectHealth follows CMS guidance and will bundle ultrasound guidance for needle placement (**code 76942**) with a diagnostic ultrasound when done on the same anatomic region. Please refer to the **National Correct Coding Initiative Manual for Medicare Services (chapter 9, section H)**.

> **Code 99152 vs G0500 for gastrointestinal (GI) procedures:** When reporting moderate sedation for GI procedures, please use **code G0500. Code 99152** should not be billed with GI procedures per the **National Correct Coding Initiative (NCCI)**.
Documenting and Coding Secondary Hypercoagulable States

Accuracy of coding and documentation is key for secondary hypercoagulable states.

**What are secondary hypercoagulable states?**

Secondary hypercoagulable states are generally acquired disorders in patients with underlying systemic diseases or clinical conditions known to be associated with an increased risk of thrombosis. Patients with active or metastatic malignancy or a CHAD score of ≥2 are more likely to have a secondary hypercoagulable state.

Chronic oral anticoagulation (lifelong therapy with close follow-up) is recommended for most patients with atrial fibrillation, recurrent deep vein thrombosis (DVT), or recurrent pulmonary embolism (PE) due to high rate of recurrence.

Anticoagulation is not used to treat the underlying condition; but instead, it is used to treat the hypercoagulable state. Patients not taking anticoagulation or only taking aspirin because of bleeding risks can still be diagnosed with secondary hypercoagulable state if at increased risk for blood clots due to an underlying condition.

**What are the documentation and coding requirements for secondary hypercoagulable state?**

Be sure to document:

> The primary condition (atrial fibrillation, history of DVT and PE)
> Current treatment, previous ablations, current rhythm, and specialty providers
> Secondary condition (hypercoagulable state), and link with the causing condition (e.g., hypercoagulable state secondary to atrial fibrillation)
> Current treatment: warfarin, DOAC

Use [ICD-10 code D68.69](https://www.selecthealth.org) (Other thrombophilia) per coding guidelines.

**Questions?**

Contact Tamara Smith in Risk Adjustment Analytics at **801-442-9333**.