Welcome to the Provider Insight® newsletter. This newsletter includes medical, dental, and pharmacy information; as well as updates that pertain to our commercial, SelectHealth Advantage® (Medicare), SelectHealth Community Care® (Medicaid), and Federal Employee Health Benefits. Please encourage each provider and member of your staff to review the newsletter for important information that affects those covered by a SelectHealth policy.

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Preauthorization Requirements Reminder

Like you, SelectHealth is dedicated to promoting the use of evidence-based care process models and the appropriate utilization of services. Accordingly, we implemented the following changes effective January 1, 2018:

> Payment will be made for procedures that require preauthorization only if preauthorization is obtained prior to the service being rendered. Claims for services requiring preauthorization that are not preauthorized will be denied.

> The following surgical procedures were added to the preauthorization list: spine fusions (lumbar and cervical), joint replacements (hip and knee), tonsillectomy, adenoidectomy, and hysterectomy. These are in addition to procedures previously requiring preauthorization.

Medial Branch Blocks (MBB) will require preauthorization beginning June 1, 2018, for all our benefit plans. Previously, only SelectHealth Advantage® (Medicare) required preauthorization for MBB.

Criteria are currently being established for shoulder and ankle procedures. We will notify you separately when these criteria are available, at which time, preauthorization for these procedures will also be required.

Payment will be made only for procedures meeting the clinical criteria established in collaboration between SelectHealth, local Idaho specialists, St. Luke’s Health Partners, and Intermountain Healthcare® Clinical Programs. Any denials will apply to professional and facility claims. Providers are responsible for obtaining preauthorization, and members cannot be billed if the provider fails to obtain the required preauthorization. Ancillary claims (e.g., anesthesia, radiology, labs) will not be affected if preauthorization is not obtained.

The preauthorization requirement applies to all product lines in Idaho except Federal Employees Health Benefits (FEHB).

Regarding emergency services: For procedures requiring preauthorization that are performed due to an emergent clinical issue, submit the preauthorization request with all pertinent documentation once the condition has been stabilized, or as soon as reasonably possible.

> When using CareAffiliate® to submit documentation online post procedure, it must be submitted within 72 hours. If outside of that time frame, a Request for Medical Preauthorization Form must be submitted to SelectHealth as instructed on the form (email is preferred).

> Documentation must clearly demonstrate the emergent circumstances necessitating the procedure.

> Claims denied for failure to obtain preauthorization may be reviewed post service through the SelectHealth Medical Review department.

- If documentation supports the medical necessity/clinical appropriateness of the procedure, provider and facility payments will be reduced 25% for failure to preauthorize the services.
- The SelectHealth member (the patient) will continue to be responsible for paying their normal cost-sharing amounts, but will not be responsible for payment of provider penalties.
- Ancillary claims (e.g., anesthesia, radiology, labs) will not be reduced.

View a list of procedures that require preauthorization.
Preauthorization criteria are available in the medical policy for each procedure. Medical policies are available on selecthealthphysician.org. Click on “Policies & Procedures,” then log in with your secure username and password. Enter the procedure name in the “Search” field and open the associated medical policy. Clinical criteria used to evaluate medical necessity and clinical appropriateness of the specified procedures are developed by SelectHealth with local Idaho specialists, St. Luke’s Health Partners, and Intermountain Healthcare.

To request preauthorization:

> To submit your request online, use our new CareAffiliate tool. Request access to CareAffiliate by completing and submitting an Online Login Application form with the box checked to “Add: CareAffiliate.” Online training is available through the CareAffiliate tool.

> Alternatively, providers can download a Request for Medical Preauthorization Form. Submit the completed form as instructed.

Note: There is currently a 30- to 45-day delay to receive access to CareAffiliate. Until your access is ready, please use the Request for Medical Preauthorization Form.

Questions? Please contact your Provider Relations representative.

Use CareAffiliate for Online Preauthorizations

Use CareAffiliate® to submit preauthorization requests efficiently.

> Submit your preauthorization request and supporting documentation online rather than through fax or email.

> The online functionality improves the accuracy, security, and speed with which requests are reviewed.

> For certain services, requests can be automatically evaluated through CareAffiliate to determine if the request meets established criteria (e.g., place of service, treatment history, clinical findings, procedure/service being requested).

  • If all required criteria are met, CareAffiliate can approve the request and assign an authorization number.

  • If the preauthorization request does not meet criteria, the request will be referred for a manual review for a determination.

Visit selecthealthphysician.org to enroll in CareAffiliate.

> If you don’t currently have access to secure information, choose “Click here to get started” and submit a SelectHealth Information Technology Services Agreement (ITSA) and an Online Login Application.

> If you already have access to secure information, submit an Online Login Application to add CareAffiliate to your Provider Benefit Tools.

We are striving to make the preauthorization process as seamless for our providers as possible. Implementing improvements such as CareAffiliate for online requests and auto reviews helps us meet this goal.

Questions about accessing CareAffiliate? Email providerwebservices@selecthealth.org.
Explore the Provider Benefit Tool

In March, we launched our redesigned Provider Benefit Tool. The secure website features enhanced capabilities to improve the efficiency with which your office interacts with SelectHealth and make it even easier to use.

Use the Provider Benefit Tool to review member information, claims, remittance advices, and much more.

Take a tour of the new Provider Benefit Tool today!

Please share this information with coworkers in your office who have access to the Provider Benefit Tool. To obtain access for additional users, submit an Online Login Application.

New Care Process Models

These days, there are so many advances in medicine, it can be difficult to keep up. And with advancing technology, it is not always clear what options are available, not to mention the best path for a particular diagnosis or disease process.

Intermountain Care Process Models (CPM) and Clinical Guidelines provide clarity with current, evidence-based information on a variety of disorders.

As an example, consider the recently published CPM for Concussion, which includes:

- Background information on an algorithm for diagnosis with physical exam tips, red flags, and expected symptoms.
- Tips to help direct management, including reasonable expectations, individual treatments, when to refer to a specialist, and what type of specialist is appropriate.
- Details on specific, symptom-based management and medications.
- An algorithm for follow-up management, a symptom scale, and return-to-activities recommendations.

There are similar CPMs and Clinical Guidelines for many topics, such as:

- Mild cognitive impairment and dementia
- The management of low back pain for primary care providers, specialists and Emergency Department providers
- Hospital care and rehabilitation for acute ischemic stroke and transient ischemic attack (TIA) patients
- Prescribing opioids for chronic noncancer pain
- A multitude of mental health issues, appropriate imaging, issues around bariatric surgery—even one about issues associated with outdoor air quality

Familiarize yourself with these process models, which are the same guidelines SelectHealth follows when establishing clinical criteria for specific procedures. View Intermountain CPMs or type “Intermountain CPM for (insert topic)” in your search engine.
Timely Responses

“Are we there yet?” No matter how many times your kids ask, the trip just doesn’t get any quicker. The same principle applies with receiving responses from healthcare payers. Sometimes a little patience is all it takes!

Here are some Dos and Don’ts regarding expected response times for common transactions, tips to make the process faster, and common missteps that slow responses.

Claims Processing
It can take up to 30 days to process a claim.

Do:
> File electronically with an Electronic Data Interchange (EDI) Transaction 837 Healthcare Claim. A “clean” claim can be processed almost immediately without intervention from an adjudicator.
> Report all information, including the appropriate NPI number(s), date(s) of service, location of service, and any appropriate modifiers.
> Ensure every provider caring for SelectHealth members is fully credentialed, contracted, and/or added to a group roster BEFORE they render services to members.
> Check claim status online, either through an EDI Transaction 276/277 Claim Status Request/Response or through our secure Provider Benefit Tool for an immediate update at your convenience.

Do not:
> File multiple claims for the same service.

Preauthorization Requests
It can take up to 14 days for SelectHealth to make a determination on your preauthorization request. Please allow for this time when scheduling a surgery. For emergency surgeries that require preauthorization, submit the request within 72 hours of the procedure.

Note: If SelectHealth requests additional information for your preauthorization request, you have limited time to submit the needed documentation. Once the information is received, SelectHealth has up to 14 days (for Medicare and Medicaid plans) or 15 days (for commercial plans) to complete the review and make a determination. Avoid delays by submitting all necessary documentation with your original request.

Do:
> Refer to the requirements in the procedure’s online Medical Policy to ensure all necessary documentation is included with your request.
> For emergency procedures, documentation must clearly demonstrate the clinically emergent need.
> Submit preauthorization requests via our secure online preauthorization tool, CareAffiliate. Many procedures can be automatically evaluated to determine if they meet clinical criteria.
  • **Note**: For emergency procedures only, when using CareAffiliate to submit documentation post procedure, documentation must be submitted within 72 hours.

Do not:
> Submit requests or documentation for the same surgery multiple times or to multiple places (e.g., don’t email and fax a request, or submit via CareAffiliate and fax). We must review all documentation every time it is received, thus slowing down the response time.
> Submit requests for procedures that do not require preauthorization. This creates unnecessary delays for the review team. Call Member Services at 800-538-5038 if you’re unsure whether preauthorization is required.
> Call multiple times or multiple people for the status of your preauthorization request. This also creates unnecessary delays for the review team. Check our secure Provider Benefit Tool or CareAffiliate for status updates.

Secure Website Access
View patient claims and eligibility information, medical policies, and clinical reports; or submit and monitor preauthorization requests through our secure web tools. Secure access is available only to participating providers. There is currently a 30- to 45-day turnaround time to receive access to our secure portal.
Do:

> Include information for each user and each online tool requested on one Online Login Application.
> Submit a new Online Login Application to add users or tools to your clinic’s secure access.
> Only request access for authorized users in your clinic—and notify us immediately if a user leaves your clinic so we can disable their access.

Do not:

> Send multiple applications for identical requests.
> Call to check on your access request sooner than 30 days after the request was submitted.
> Share your secure login information with anyone. Each authorized person must log in with their own User ID and password. Sharing your login information with unauthorized users is a violation of federal HIPAA regulations.

Thank you for helping us streamline the preauthorization and request process so we can serve you better!

Transition of Care

Life changes—we offer resources to help. Whether you have a patient who recently moved or they need a new doctor, we can help.

Member Advocates can:

> Find an in-network doctor in their new area
> Make an appointment
> Switch from a pediatrician to an adult provider

Call SelectHealth Member Advocates® at 800-515-2220 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturday, from 9:00 a.m. to 2:00 p.m.

Member Services can:

> Find a new health insurance plan
> Explore options for coverage
> Explain benefits

Call SelectHealth Member Services at 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturday, from 9:00 a.m. to 2:00 p.m.

Breast Cancer Screening Tools

Breast cancer screenings save lives and are important to public health. But Idaho has one of the lowest breast cancer screening rates in the country.

> According to healthandwelfare.idaho.gov, Idaho ranks 50th in the nation for breast cancer screenings. The Idaho public health goal is to have 81% of women screened by 2020.
> Breast cancer is usually treatable when it is found early. Mammograms are the best way to find cancer in its early stages, even before symptoms are present.

According to the healthandwelfare.idaho.gov.

Program Overview

In 2016, SelectHealth partnered with Genentech to discover why women aren’t being screened for breast cancer and to develop motivational messages to be used across the state.

In October 2016, Utah focus groups discussed what barriers exist in our communities and to test the effectiveness of new messages. Focus group participants identified several barriers:

> Perception that no family history means low/no risk of breast cancer
> Inconvenience
> Fear of pain
> Confusion around mammogram guidelines
> Idea that it’s okay to wait until symptoms present
> No clear benefit to getting a mammogram/no confidence in mammogram accuracy
> Out-of-pocket cost or lack of insurance coverage
> Prefer to ignore risk of breast cancer
> Physicians not proactively communicating the need for/benefit of screening

After months of collaboration, four new marketing pieces were developed and tested in a pilot program from September to December 2017. Breast cancer screening rates increased in the pilot clinics by an
average of 10.88%, compared with a 7.69% increase in the control groups.

Based on feedback from the pilot clinics, the materials were revised and are now available for public use to help increase awareness of the importance of breast cancer screenings and to motivate women to schedule a mammogram.

**Materials for your office**

All program materials are located in the Genentech Forum, **What’s Your Reason For a Mammogram**. These helpful tools can be downloaded and customized by each clinic or program. They are designed to:

- Challenge women to reflect on their priorities
- Change perceptions about the risks of breast cancer and the benefits of screening
- Decrease and overcome barriers to screening
- Drive women to schedule a mammogram

A tent card, navigation script, and postcard are available for you to print. We send each eligible member who hasn’t received her mammogram a health brochure that outlines the benefits of this screening. The materials are specific to the demographics, culture, and barriers in Utah communities.

**Suggested workflow**

- Display tent cards in the waiting room, exam rooms, and at the front desk.
- Mail postcards to patients who haven’t received their recommended breast cancer screening and then call them 2-3 weeks later to follow up. A second mailing can be done later in the year to women who still have not received their screening.
- Use the navigation script to guide conversations with women and discuss any concerns they may have.
- Help patients schedule a mammogram while they are in the office if possible—don’t just give them the phone number to call on their own.
- Become familiar with the materials and the different reasons for having a mammogram. If it seems appropriate, share one or more of the reasons with the patient and offer to help her schedule a mammogram.
- Speak confidently. If you are passionate about the need for a mammogram, that will help put the patient at ease. If you are hesitant or unconvinced yourself, that may come across in the conversation.

Help improve the health of the women we serve by educating your patients and helping them schedule a mammogram.

**Diabetes Prevention Program**

The Treasure Valley Family YMCA® offers a year-long program for those at risk for developing diabetes. The program is available
in the following communities: Treasure Valley, McCall, Mountain Home, Twin Falls, and Wood River Valley.

The Program Includes

- Attending 16 weekly core sessions with a group of 8 to 15 participants followed by biweekly and monthly maintenance sessions for the remainder of the year
- Interacting with a lifestyle coach who can help facilitate behavior change using motivational interviewing
- Participating in weekly discussions on healthy eating and physical activity, and hearing from guest speakers such as dietitians and personal trainers

Criteria To Participate

- Must be at least 18 years old AND
- Must have a BMI of ≥ 25. Asian individual(s) BMI > 23 and one of the blood values OR
- Must have a BMI of ≥ 25. Asian individual(s) BMI > 23 and score 9 or greater on the CDC prediabetes risk assessment

Blood Value/Diagnosis Qualifications

1. A1c test between 5.7 and 6.4 percent
2. Fasting plasma glucose between 100 to 125 mg/dL
3. Two-hour (75 gm glucola) plasma glucose between 140 to 199 mg/dL
4. Prediabetes determined by Gestational Diabetes Mellitus (GDM) clinical diagnosis during previous pregnancy

Cost

- The full cost of the program will be covered by SelectHealth upon completion for members on a commercial plan. Members with SelectHealth Advantage qualify for up to $240 in reimbursement under their wellness benefit.

The most effective outcomes involve a collaboration between members, providers, and the program sponsors. If you have a patient who might benefit from the Diabetes Prevention Program offered through Treasure Valley Family YMCA, please direct them to the program website to learn more.

Patient referrals can be securely faxed directly to the Treasure Valley Family YMCA at 888-965-4924 or for EPIC users, a referral can be sent directly through the EMR.

If you have questions about these benefits, please call Member Services at 800-538-5038

Coding Reminders

To receive appropriate reimbursement for bilateral procedures, remember to report the procedure with Modifier LT on one line and Modifier RT on another line instead of reporting it only once with Modifier 50.

For more information about modifiers, please refer to our online Medical Policies. Type “Modifiers” in the search box. Policy #17 Modifiers provides a table of all modifiers with billing tips including explanations of how each one affects adjudication.

SELECTHEALTH ADVANTAGE

New Medicare Cards Are on Their Way
Starting April 2018, the Centers for Medicare & Medicaid Services (CMS) began mailing new Medicare (red, white, and blue) cards that replace Social Security numbers with a unique Medicare number. This will help keep Medicare member information more secure and protect against identity theft.

SelectHealth Advantage® (HMO) members should continue to use their SelectHealth Advantage ID cards each time they receive care or fill a prescription. The new Medicare card won’t change coverage or benefits.

For more information, view this fact sheet or visit the CMS provider support page.

**Time to Schedule Preventive Visits**

Did you know Annual Wellness Visits (AWVs) are underutilized? You may find that you can get reimbursed for services you thought may not be covered by SelectHealth Advantage. There are many services included under the AWV umbrella (resulting in a more complete picture of the patient’s health), and the challenge is how to increase the convenience of AWVs for patients and providers. Each clinic develops their own workflow for scheduling and performing these visits, but the important thing is getting them done. Sometimes part of the process can be completed prior to the patient arriving, including the health survey, medication and supplement list, and the care provider and supplier list. When this works well, it is truly a team approach within the clinic.

These visits are valuable to patients, providers, and health plans. AWVs help patients by determining other resources necessary for the patient, strengthening patient-to-provider relationships, and providing an opportunity to clarify a plan of care. The clinical advantages of an AVW include:

- Reviewing the medical and family history
- Developing or updating a list of current providers and medications
- Recording height, weight, blood pressure, and other routine measurements
- Detecting any cognitive impairment
- Providing personalized health advice based on a health risk assessment
- Getting to discuss individualized risk factors and treatment options
- Creating a screening schedule (like a checklist) for appropriate preventive services
- Discussing advance care planning

Many tests can be included with the AWV and are considered preventive as well, though they may require special coding. These include screenings for prostate cancer, diabetes, cholesterol, cervical cancer, HPV, HIV, syphilis, hepatitis B infection, and a hepatitis C antibody, and may be covered as preventive depending on the member’s plan benefits. Please review the full list of preventive services.

**CMS Stars Program—Keep Up the Good Work!**

CMS annually performs a comprehensive review of
all health plans contracted to offer Advantage plans to Medicare beneficiaries. SelectHealth received a 4-Star rating for 2018. Achieving high ratings in the Stars program is the result of a combined effort between SelectHealth and the provider network. One of the things that makes this program so challenging is that the bar is always rising. Each year, based on how participating plans perform in the program’s measures, the thresholds for achieving high ratings are adjusted. Because of this, we need to maintain focus on improving health outcomes for the SelectHealth Advantage membership. We appreciate all the efforts within the provider network to engage patients in their care and close care gaps.

The following high-priority measures will continue to be included in the CMS Stars rating evaluation:

- Breast cancer screening
- Colorectal cancer screening
- Diabetes care (A1c in control, diabetic eye exam, nephropathy monitoring)
- Controlled blood pressure
- Medication adherence for diabetes, hypertension, and cholesterol

Each year, CMS can choose to add new measures to the program. Below are new measures for 2019 health plan evaluation and Stars ratings:

- Medication reconciliation within 30 days of inpatient discharge (note must indicate reconciliation was performed because of a recent discharge)
- Statin therapy for diabetic and cardiovascular patients

Thank you for your continued efforts in closing care gaps and incorporating processes to address the new measures within your practice.

FEDERAL EMPLOYEE HEALTH BENEFITS

Reminder: FEHB Service Area Reduction

As noted in the November 2017 Provider Insight newsletter, the SelectHealth Federal Employees Health Benefits (FEHB) service area will no longer extend into the state of Idaho. This means, all services must be received in Utah by an in-network provider on the Select Med® network. Services received in Idaho will only be covered for urgent or emergency care.

Please consult with any patients who continue to be enrolled on an Idaho FEHB plan with SelectHealth about continuing treatment. Services for preventive, routine, or elective care will not be covered outside of the service area for federal employees who reside in Idaho.

Letters were recently sent to all remaining SelectHealth FEHB subscribers reminding them of this network change.

PHARMACY

Pharmacy News

Please take a few minutes to read the latest Pharmacy & Therapeutics newsletter along with Formulary Updates. These contain information about recent formulary decisions, specific therapeutic class updates, and industry news.

CODING AND REIMBURSEMENT, MEDICAL POLICIES, AND NEW TECHNOLOGY ASSESSMENT
Coding and Reimbursement Policy Bulletin

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

Medical Policy Bulletin

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

### REVISED POLICIES

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Name</th>
<th>Policy Effective Date</th>
<th>Summary of Change</th>
</tr>
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<tbody>
<tr>
<td>06</td>
<td>Preventive Care and Screening Guidelines (Revised)</td>
<td>01/01/2018</td>
<td>SelectHealth Commercial: The age range for herpes zoster immunization, CPT 90750 (for Shingrix), has been changed from 60 and older to 50 and older. The age range for herpes zoster immunization code 90736 remains the same at 60 and older.</td>
</tr>
<tr>
<td>59</td>
<td>Multiple Procedure Reduction for Therapy Service (Revised)</td>
<td>02/26/2018</td>
<td>SelectHealth Commercial and SelectHealth Advantage: Removed speech therapy codes 92506, 58990, and 59152. Replaced physical/occupational therapy codes 97001-97004 with 97161-97168. Added CPT 97763, Orthotic(s)/prosthetic(s) management.</td>
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### NEW POLICIES

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<thead>
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<th>Summary of Change</th>
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<tbody>
<tr>
<td>620</td>
<td>Hysterectomy (New)</td>
<td>01/01/2018</td>
<td>Commercial Plan: SelectHealth covers hysterectomy as medically necessary when certain criteria are met. Please see the policy for criteria. SelectHealth does NOT cover hysterectomy if the criteria are not met, as it is considered not medically necessary.</td>
</tr>
<tr>
<td>621</td>
<td>Tonsillectomy and Adenoidectomy (New)</td>
<td>01/01/2018</td>
<td>Commercial Plan: SelectHealth covers tonsillectomy and adenoidectomy if certain criteria are met. Please see the policy for criteria. SelectHealth does NOT cover tonsillectomy and adenoidectomy for any other indications, as it is considered not medically necessary.</td>
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<tr>
<td>Policy Number</td>
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<td><strong>NEW POLICIES</strong></td>
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| 622 | Cervical and Lumbar Spinal Fusion and Combined Decompression/Fusion *(New)* | 01/01/2018 | **Commercial Plan:** SelectHealth covers cervical/lumbar spinal fusion and combined decompression/fusion if certain criteria are met. Please see the policy for criteria. Note: Separate evaluation is needed if any of the following are being used (hyperlinks to these policies are also available within this policy):  
  > Axial Lumbar Interbody Fusion *(AXIALIF)*  
  > Interspinous Distraction Devices/Spacers  
  > Interspinous Fixation *(Fusion)* Devices  
  > Image Guided Lumbar Decompression *(e.g. Minimally Invasive Lumbar Decompression *(mild)*) |
| 623 | Eustachian Tube Balloon Catheter *(New)* | 02/15/2018 | **Commercial Plan:** SelectHealth covers the eustachian tube balloon catheter procedure if certain criteria are met. Please see the policy for criteria. |
| **REVISED POLICIES** | | | |
| 452 | Genetic Testing: Expanded Carrier Screening *(Revised)* | 01/26/2018 | Title change from Universal Carrier Screening. **Commercial Plan:** SelectHealth now covers Counsyl Foresight for expanded carrier testing **once per lifetime**. SelectHealth does NOT cover any other expanded carrier screening. |
| 475 | Psychiatric Residential Treatment Centers *(Revised)* | 02/15/2018 | **Commercial Plan:** A disclaimer has been added: “Does not apply to Idaho plans as of October 2017.” |
| 509 | Genetic Testing: Fetal Cell-Free DNA *(cfDNA)* Testing for Down Syndrome *(Trisomy 21), Trisomy 13, and Trisomy 18 *(Revised)* | 01/17/2018 | **Commercial Plan:** Removed the following criterion:  
  
  “#3. Family or personal history of aneuploidy; “3. Previously affected pregnancy with a trisomy; or 4. Documented first-degree relative with a translocation specific for a common trisomy;”” |
| 538 | Gene Expression Testing for Indeterminate Thyroid Nodule Biopsy *(Revised)* | 02/28/2018 | **Commercial Plan:** SelectHealth now covers the Thyroseq* test along with the Afirma* test if certain criteria are met. Please see the policy for criteria. |
| 577 | Use of Chromosomal Microarray Analysis *(CMA)* in Pregnancy *(Revised)* | 12/20/2017 | **Commercial Plan:** SelectHealth covers CMA for fetal demise. This change was based on the December 2016 ACOG decision. |
| 598 | Total Knee Arthroplasty *(Revised)* | 02/16/2018 | **Commercial Plan:** Changed language in Criterion 1f:  
  Old - HgbA1c is less than 8  
  New - Hemoglobin A1C (Hgb A1C) is less than 8 in diabetics.  
  Changed language in Criterion 1g:  
  Old - tobacco free  
  New - No tobacco smoking by history or a smoke-free history at least 4 weeks prior to surgery. |
| 599 | Total Hip Arthroplasty *(Revised)* | 02/16/2018 | **Commercial Plan:** Same changes as in “Total Knee Arthroplasty.” |
| **ARCHIVED** | | | None |