# PROVIDER CONNECTION

**University of Utah Health Plans**
**Provider Publication**
**Fall 2018**

## DEMONSTRATING OUR COMMITMENT TO THE ENVIRONMENT

To limit our environmental impact, *Provider Connection* will be available online and via email only. You'll continue receiving important information in the newsletter, including announcements, updates to medical policies, helpful tips, and more. If you currently receive the newsletter in the mail, we will send a postcard to your office when new editions are available. The postcard will provide a link to the online location.

In addition to being the environmentally responsible solution, having the newsletter online makes it easier to share with everyone in your office. If you would like a paper copy of the newsletter, call your Provider Relations representative, and we'll be happy to email a copy for you to print.

To ensure you receive the latest newsletter as soon as it's available, subscribe to our email list. We promise we won't spam you, and we'll never share your information. Subscribe today to stay in the know.

## INSIDE THIS EDITION



uhealthplan.utah.edu

HEALTH PLANS
UNIVERSITY OF UTAH

## AT YOUR FINGERTIPS: "WHAT'S NEW"

Did you know there's an easy way to stay caught up with the latest provider news for University of Utah Health Plans? Visit uhealthplan.utah.edu/for-providers and click on the "What's New" tab to view recent coding updates, education opportunities, product information, and other helpful tips. Bookmark our provider website in your favorites for quick access to the most up-to-date information about U of U Health Plans. And watch for more web tips in future editions of Provider Connection.

## IMPROVED DIRECTORY SEARCH FEATURES

To make it faster for members to find a participating provider—or for you to make referrals, we've added a new field to our Provider and Facility Search tool. "Provider Type" lets you choose to see All types of providers or only Medical or Behavioral Health specialties. Looking for a specific type of facility? Click the "Facility" button and then the dropdown arrow next to "Facility Type."

While you're in our directory, look up your own name to ensure all of your information is correct. Need to change anything? Complete and submit a Provider Information Update Form online. Review the fields available in the form—like languages spoken or handicap accessible—to make your information as complete as possible with one update.

## ADDRESSING URGENT BEHAVIORAL HEALTH CRISES

Behavioral health crises don't make appointments and members of our community should never feel they must face a challenge alone. To this end, U of U Health Plans and the University Neuropsychiatric Institute (UNI) have teamed up to organize crisis response programs to provide immediate behavioral therapy access when a member's therapist is not available, or if they have not yet established a relationship.

Whether you're a primary care provider worried about a patient or a therapist looking for crisis support, we have programs to support the full range of needs. From a fast-acting Mobile Crisis Outreach Team to the WarmLine, which offers a compassionate voice on the other end of the line, U of U Health Plan members have access to a safety net when they need it most.

Please be aware of the following resources, and share them with your patients:

For any mental health crisis
**UNI CrisisLine – 801-213-0816**

- Licensed clinicians provide services 24/7
- Crisis intervention and suicide prevention

For prompt, face-to-face crisis response

UNI Mobile Crisis Outreach Team

- Triaged through the UNI CrisisLine – **801-213-0816**
- Youth and adult services teams are available 24/7
- Consultation and support to individuals and families within Salt Lake County and Davis County

For secure evaluation and stabilization

UNI Receiving Center

- Triaged through the UNI CrisisLine – **801-213-0816**
- Short-term stay (up to 23 hours)
- Therapeutic crisis management, assessment and discharge planning

For non-crisis support

UNI WarmLine – **801-213-0816**

- Certified Peer Specialists offer support, engagement and a sense of hope and self-respect

For outpatient appointments

Downtown Behavioral Health Clinic – **801-585-1575**

Farmington Behavioral Health Clinic – **801-213-3770**

- Services for children, adolescents and adults
- Provides psychiatric evaluation and diagnosis, consultation, therapy services, medication management
- Providers specializing in geriatric psychiatry services (at Farmington Clinic only)

Recovery Clinic – **801-585-1575**

- Services for adults seeking outpatient support for addiction recovery
- Alcohol and drug treatment and dual diagnosis treatment
- Outpatient detoxification, if medically appropriate

***Coming Soon...***

An outpatient, stabilization clinic including rapid access, outpatient medication and therapy management, high-acuity management, same-day appointments, virtual visits, and transition care exclusive to U of U Health Plans members.

For more information about the Crisis Interventional and Hospital Diversion programs, call UNI at **801-583-2500** or visit healthcare.utah.edu/uni.

**Remember:** U of U Health Plans has partnered with UNI to offer a web-based system for PCPs to consult with a psychiatrist about behavioral health concerns through GATE (Giving Access to Everyone) Utah. Visit gateutah.org for more information or email your Provider Relations consultant at provider.relations@hsc.utah.edu.

# INTRODUCING: CREDENTIALING MANAGER, CHARLENE FRAIL-MCGEEVER

As engagement with the provider community expands, we're very pleased to announce the appointment of Charlene Frail-McGeever to manage our Provider Credentialing team. She brings more than twenty years of health insurance experience with her, particularly in the regulatory and credentialing space.

Ms. Frail-McGeever comes to U of U Health Plans Provider Relations department from Molina, where she was the Credentialing and Provider Network Administration director and previous to that, QI Compliance manager. Prior to these positions, she was the assistant bureau director for CHIP and Medicaid programs. She also managed a NCQA-certified credentialing verification organization, served as a Medical Staff Services director for one of Utah's largest medical staffing agencies, and worked in the medical staff office of University Hospital.

# NONDISCRIMINATION IN CREDENTIALING

U of U Health Plans does not make contracting or credentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type in which the applicant specializes. Additionally, we do not prohibit or restrict providers from acting within their lawful scope of practice or discriminate against health care professionals who serve high-risk populations or specialize in the treatment of costly conditions.

We follow these steps to prevent discrimination:

1. Each January, the credentialing status of all provider applicants is reviewed by the Credentialing Committee according to the Minutes from the prior calendar year, and/or reports from our provider application database will be reviewed for patterns of acceptance/nonacceptance that indicate possible discrimination.
2. A typed and signed report summarizing the findings and reviewed by the Provider Network Director annually will be placed with a printout of the log sheets in the Discrimination Monitoring binder.
3. If discrimination based on one of the characteristics or situations listed above is suspected, the following steps will be taken:
    - A more detailed review of the affected provider's applications will be conducted by the Medical Director and Provider Network Director.
    - If discrimination is substantiated:
        - A corrective action plan will be developed and implemented
        - An additional audit of the current year's applicants will be reviewed six months later

## REFER PATIENTS TO OUR CARE MANAGER NURSES

Care manager nurses help people with their health care and community service needs—at the right time, in the right setting, and for the best value. We strive to be respectful of the cultural and linguistic preferences of our members and their supports.

Our Care Management program offers members individual attention to help meet their health care goals. Services include education, advocacy, and coordination of needed services. This program is provided with no out-of-pocket costs to our members who want care management nursing services.

For more information or to request care management services for one of our members, call the Care Management team at **801-587-6480** option 2.

# PHARMACY

## CARISOPRODOL (SOMA®) REMOVED FROM U OF U HEALTH PLANS FORMULARIES

In alignment with strategies to reduce the abuse of opioids, the U Of U Health Plans Pharmacy and Therapeutics (P&T) Committee has removed carisoprodol (Soma®) from all commercial formularies and the Healthy U Medicaid Preferred Drug List.

When consumed orally, carisoprodol is hepatically metabolized to its active metabolite meprobamate, a controlled substance. Research suggests that patients who use carisoprodol long term display abuse-potential characteristics more frequently than long-term users of other skeletal muscle relaxants. Additionally, carisoprodol has reportedly been used to enhance the effects of other drugs, including opioids. Considering the availability of several other skeletal muscle relaxants with safer pharmacologic profiles and the risks associated with this drug, the Committee felt it was appropriate to remove carisoprodol as a treatment option for our members.

The P&T Committee will continue evaluating other drugs with abuse potential to limit or eliminate their availability to our members. Visit U of U Health Plans Pharmacy for a list of medical drugs that require prior authorization and/or have other limits.

# CODING CORNER

## PRIOR AUTHORIZATION TIPS FOR ORTHOPEDIC/ SPINAL PROCEDURES

To ensure appropriate evidence-based care for members, most health plans require prior authorization on certain services. Different plans may have differing requirements, making prior authorizations an often cumbersome reality for offices. To make the approval process more efficient, reduce time and staff burden, and improve the experience for you and our members, follow these tips when requesting prior authorizations:

### Urgent Requests

Some provider offices feel as if marking every request as urgent will speed the determination turnaround time. It can actually slow the review process. U of U Health Plans receives many requests for conditions present for months or years with a request for an "urgent" review. All urgent requests are triaged by physicians who determine if the "urgent" request actually meets the mandates set by regulatory bodies for urgent determination. These requirements stipulate that for a request to be urgent a determination requires immediate action; although it may not be a life-threatening circumstance, an urgent situation could seriously jeopardize the life or health of the covered member, the ability of the member to regain maximum function or—in the opinion of a physician with knowledge of the claimant's condition—would subject the member to severe pain. An urgent care condition is a situation that has the potential to become an emergency in the absence of treatment.

Many offices and patients consider every situation may be interpreted to be "urgent" but realistically, chronic conditions in which a turnaround time for a decision of 14 days or less is appropriate are best marked as routine. Our standards require a determination (as long as we have adequate information) in not more than 14 calendar days.

### Scheduling procedures/diagnostic studies requiring review too soon

As noted above, if an urgent request is reclassified as routine and a procedure is scheduled for three days later, the authorization may not have been completed. Routine review time frames are 14 calendar days, though we strive to complete reviews as quickly as possible. Given the volume of prior authorization requests we receive, it is not always possible to get routine reviews on elective procedures or testing completed in less than 10 to 14 days. Scheduling the requested procedure 14 or more days after the request will avoid the need to reschedule the patient.

Though U of U Health Plans works hard to meet members and providers' desired schedule, scheduling alone does not meet the definition of urgent. Cases submitted as urgent for this reason will be reclassified as "routine."

## Sending all necessary documentation with your prior authorization request

The most common reason for an initial denial of service is the lack of necessary documentation to approve the request. Sending only the most recent progress note often times leaves important information out of the consideration process. Though it may take some additional effort upfront to acquire notes from referring providers or physical therapists, providing documentation of previous conservative therapy can help ensure your prior authorization request is reviewed appropriately the first time.

## Including detailed information on conservative therapy

Though not all orthopedic procedures or diagnostic testing require conservative therapy, many do. For musculoskeletal services, many criteria require evidence that conservative therapy has failed.

**Conservative therapy guidelines require a minimum of the following therapies:**

- Three weeks of NSAID medications
- At least six weeks of physical therapy
- At least six weeks of activity modification

**Documentation must be specific** – Without the necessary detail, the request may be denied for lack of conservative therapy when this therapy indeed may have occurred. Too often, the only conservative therapy noted is that the patient has been sent to physical therapy but no outcomes are reported. Providing either physical therapy notes or a summary of the outcome and duration of physical therapy enables us to more accurately review the request the first time.

**Conservative therapy needs to be temporally appropriate** – Make sure notes reflect the timeliness of the conservative therapy in relation to the request (e.g., therapy performed two years ago may not be relevant to the current request).

**NSAID use needs to be routine and prescription strength** – Documentation should not simply note that the patient has been "taking ibuprofen", taking "Aleve," or taking a product "prn." The requirement for NSAIDs is not for pain relief as much as for anti-inflammatory effect. This requires routine use of a prescription-strength medication to achieve. Patients may use over-the-counter NSAIDs, but the dose should be equivalent to a prescription strength (e.g., 500 mg of naproxen or 800 mg of ibuprofen).

**Provide documentation of physical therapy outcomes** – The most commonly missed documentation are notes documenting the character, frequency, duration, and outcomes from physical therapy specific to the request. Including these notes in the initial request greatly expedites the review. In lieu of physical therapy notes, duration of physical therapy and a summary of the outcome will assist us in making the most appropriate determination.

The cost of health care in the United States continues to rise and many patients simply cannot afford the care they need. Prior authorization to ensure appropriate utilization is a valuable tool to help contain those costs and keep necessary care available to all members of our community. We appreciate the opportunity to partner with you to provide quality care to our members, your patients.

# GENERAL CRITERIA FOR MRI

U of U Health Plans uses InterQual® criteria when making medical-necessity determinations. These criteria are evidence-based and designed to ensure appropriate utilization of medical procedures. MRIs are costly and, because many patients have high deductible health plans and will pay the entire cost of testing, we appreciate your efforts toward only ordering imaging that is medically necessary.

## General guidelines to support medical-necessity criteria:

These are decision-making guidelines to help you evaluate whether an MRI is the best option.

- Clinically appropriate? Ordering an MRI because "the patient requests MRI of XXX" will likely result in a denial.
- Evaluate suspected progression? Ordering an MRI for a chronic problem with no changes in signs or symptoms will often result in a denial of coverage. Chronic back pain, neck pain, and headaches with no new symptoms are classic examples.
- Diagnostic need? Many criteria require that a plain film of the area be done with results available before proceeding to an MRI. If the plain film has findings that explain the complaint, the MRI will be denied. Osteoarthritis of the knee is a common example: Pain in the knee – OA on plain film – No other issue – MRI of knee ordered. This will be denied because there is no diagnostic need for advanced imaging.
- Film results support need? Ordering the plain film and MRI at the same time, meaning the plain film results are not available, will usually end up with a denial of coverage.
- Required for treatment decision? Make it clear in your assessment how the MRI result will alter your treatment decision.
- Required for referral? If an MRI is a requirement for getting an appointment with a specialist, but the clinical scenario does not meet criteria, the MRI will not be approved. Talk to the specialist if they have this as a "referral rule," or consider using a different specialist.
- Supported by lab results? Many criteria require that a lab diagnostic evaluation has been undertaken first (e.g., MRI of the pituitary). The pertinent lab results need to be available.

## General criteria for some of the most commonly ordered MRIs:

**Lumbar Spine**

- **Suspected lumbar disk herniation or foraminal stenosis**
  Requires radiculopathy plus either of the following:
  - Motor Deficit – Must have either severe motor weakness documented (scale 1-5) or less severe motor deficit which does not improve on reevaluation
  - Sensory Deficit – must have one of the following:
    - Severe pain (documented on scale of 1-10) which does not improve with conservative treatment for ≥ 3 days
    - Less severe pain refractory to NSAIDs, six-week physical therapy, and activity modification
    - Paresthesia in a nerve root distribution, worsening on reevaluation
- **Suspected cauda equina** – Document suspicion of, and symptoms consistent with, cauda equina (e.g., bilateral lower extremity weakness/numbness, bowel/bladder involvement, saddle anesthesia, sphincter tone)
- **Suspected Spinal Stenosis** – Document suspicion of spinal stenosis. Document: Is pain worse with walking? Improved with forward flexion? Failure of conservative treatment?
- **Nonspecific back pain with no neurologic deficits** – Evidence does not support imaging.

**Knee**

- **Suspected unstable meniscus** – Document suspicion of unstable meniscus tear, locking, and positive McMurray
- **Suspected stable meniscus tear** – Document effusion, joint tenderness, knee giving way, pain with flexion and rotation, AND failure of conservative therapy
- **Suspected ACL tear** – Document knee giving way by history, as well as degree of instability on physical exam
- **Collateral ligament MCL/LCL** – Document degree of instability on physical exam
- **Chronic knee pain of undetermined etiology –** Document locking, giving way, joint tenderness, effusion, crepitus, AND both of the following:
    - Findings of plain films
    - Failure of conservative therapy

**Shoulder**

- Suspected acute rotator cuff tear – Document traumatic event, pain, weakness, active and passive ROM findings, AND findings on plain film
- Suspected chronic rotator cuff tear – Same as for an acute tear PLUS failure of conservative therapy
- Suspected labral tear – Document injury, pain interfering with ADLs, popping, catching, clicking, crank test, compression test, anterior slide test, AND both of the following:
    - Findings on plain film
    - Failure of conservative therapy
- Chronic shoulder complaints – Document if applicable: joint pain, locking, pain with ROM, limited ROM, crepitus, AND both of the following:
    - Plain film findings
    - Failure of conservative therapy

**Hip**

- Suspected femoroacetabular impingement or acetabular labral tear – Document joint pain, giving way, locking, clicking, pain with ROM, limited ROM, weakness, AND findings on plain films
- Chronic hip pain – Document joint pain, giving way, locking, clicking, pain with ROM, limited ROM, weakness, AND both of the following:
    - Findings on plain films
    - Failure of conservative therapy

**Remember:**

- Time for authorization of services can be up to 14 calendar days. Marking a request as urgent will not change the processing time unless urgency is for a medical reason (not scheduling).
- Include documentation of required criteria with your initial request to optimize the review time.

# MEDICAL POLICY

University of Utah Health Plans uses medical policies as guidelines for coverage determinations in accordance with the member's benefits. Quarterly notice of recently approved and revised medical policies is provided in ***Provider Connection*** for your convenience. The Medical Policy Updates section of this newsletter does not indicate that coverage is provided for the procedures listed.

| NEW POLICIES | | |
|---|---|---|
| Policy Number | Policy Name | Effective Date |
| **MP-006 (New)** | **DNA Analysis of Stool for Colon Cancer Screening (Cologuard®)** | **6/10/18** |

**Commercial Plan:**

U of U Health Plans **does NOT** cover Cologuard for stool colon cancer screening as it is considered not medically necessary.

U of U Health Plans **does NOT** cover any other method of DNA analysis of stool testing for colon cancer screening. Use of this testing is considered investigational/ experimental.

| | | |
|---|---|---|
| **MP-007 (New)** | **Ambulatory Insulin Pump and Closed-Loop Insulin Delivery Systems** | **6/21/18** |

**Commercial Plan:**

U of U Health Plans covers insulin pumps for all Type 1 diabetics, regardless of the adequacy of their current insulin regimen. **(Criterion "C" addresses pump renewals)**

U of U Health Plans covers ambulatory insulin pumps for Type 2 diabetics if the following criteria are met:

A. **Insulin pump criteria:**

   i. Request is from a treating endocrinologist or diabetes specialist.

   ii. Diabetes members with at least one year of subcutaneous insulin therapy.

   iii. Documentation through log books of treatment regimen consisting of three or more injections of insulin per day including both long-acting insulin analogs (insulin glargine, insulin determir or insulin degludec) plus a short-acting insulin analog (insulin aspart, insulin lispro or insulin glulisine) for at least two months prior to initiation of insulin pump. Must have at least 80% compliance over two months.

   iv. Has documented logs of glucose self-testing at least four times per day for two months prior to initiation of the insulin pump. Must have 80% compliance over two months.

   v. Documentation of member or caregiver's ability to perform carbohydrate counting and insulin dose calculation.

   vi. Documentation of diabetes specialist's assessment of clinical therapeutic value of an insulin pump and ability to train member on appropriate use of insulin pump.

   vii. Documentation of at least two visits with a diabetes specialist during the six months prior to initiation.

| NEW POLICIES *(Continued)* | | |
|---|---|---|
| Policy Number | Policy Name | Effective Date |
| **MP-007 (New)** *(continued)* | **Ambulatory Insulin Pump and Closed-Loop Insulin Delivery Systems** | **6/21/18** |

viii. Meets one or more of the following criteria while on a multiple-daily injection insulin:
   a. Glycosylated hemoglobin levels (HbA1c) greater than 8%;
   b. Recent history (within the last six months) of significant, recurring hypoglycemia (less than 60mg per deciliter or requiring assistance);
   c. Wide fluctuations (well above and below set glycemic targets) in blood glucose before and after meal times despite appropriate adjustment of doses;
   d. At least one documented incidence of hyperglycemic hyperosmotic syndrome or diabetic ketoacidosis within the previous six months;
   e. Type 1 diabetes mellitus.

**B. Covered Products:**

i. Medtronic®
   a. Minimed™ 530G
   b. Minimed 630G
   c. Minimed 670G Hybrid closed-loop insulin delivery system

ii. Omnipod® and Ominpod DASH™

iii. Tandem® Diabetes
   a. t:flex®
   b. t:slim X2™

**iv. Pump systems eligible for <u>supplies only</u>, NOT new service**
   a. Animas Vibe™
   b. Animas One Touch® Ping®
   c. Roche Accu-Chek® Combo

**C. Renewals:**

i. Patients must have had at least two visits with a diabetes specialist within the previous 12 months.

ii. Documentation must show that the member is adhering to the treatment plan outlined by a diabetes specialist.

iii. Patients who are continuing insulin pump therapy and requesting a new insulin pump must provide documentation that current pump's warranty has expired.

**D. Exemptions:**

i. Patients with gestational diabetes or diabetes during pregnancy are exempted from previous management provisions of this policy.

U of U Health Plans **may cover** closed-loop insulin delivery systems when the following criteria are met **(A, B, and C):**

**A.** Member is age 8 and over.

B. Member falls into one of the following categories:

i. Patient has Type 1 diabetes; or

ii. Insulin pump therapy is being used as an adjunct to kidney transplant; or

iii. Member is pregnant whether Type 1 or Type 2.

| NEW POLICIES *(Continued)* | | |
|---|---|---|
| Policy Number | Policy Name | Effective Date |
| **MP-007 (New)** *(continued)* | **Ambulatory Insulin Pump and Closed-Loop Insulin Delivery Systems** | **6/21/18** |

C. Type 1 diabetic patients who have performed self-monitored blood glucose (SMBG) testing averaging ≥ 4 readings with 80% compliance for 30 consecutive days within a previous three-month period and **has ONE** of the following:
   i. Hemoglobin A1C ≥ 7.5; or
   ii. Recurrent hypoglycemic events as listed below*; or
   iii. Wide glucose excursions (daily fluctuations of 200mg/dL or more).

***For recurrent hypoglycemic events:***

*The Member has demonstrated significant hypoglycemic unawareness as manifested by any* ***ONE of the following within the 6 months prior to the request:***

*1) At least one ER visit specifically for a hypoglycemic conditions.*
*2) At least one hospitalization for hypoglycemic complications.*
*3) Clinical documentation supporting significant or frequent hypoglycemic issues.*

U of U Health Plans **will only cover replacements if ALL** of the following criteria are met:

A. The device is out of warranty and the device is malfunctioning; and
B. Malfunction or damage was not due to patient neglect or abuse; and
C. Member must have attended two diabetic medical provider visits within the last 12 months at least one of which must be with a prescribing provider, and demonstrated compliance with therapeutic regimen.

U of U Health Plans considers use of a hybrid closed-loop insulin delivery system **as an artificial pancreas device system investigational.**

| | | |
|---|---|---|
| **MP-008 (New)** | **Continuous Glucose Monitor (CGM)** | **6/21/18** |

**Commercial Plan:**

U of U Health Plans may cover nonimplantable continuous glucose monitors (CGM) when the following criteria are met:

**A. Previous management criteria:**
   i. Request is from a treating endocrinologist or diabetes specialist.
   ii. Diabetes members with at least one year of subcutaneous insulin therapy.
   iii. Documentation through log books of treatment regimen consisting of three or more injections of insulin per day including both long-acting insulin analogs (insulin glargine, insulin determir, or insulin degludec) plus a short-acting insulin analog (insulin aspart, insulin lispro or insulin glulisine), for at least two months prior to initiation of continuous glucose monitor. Must have at least 80% compliance over two months.
   iv. Has downloaded logs of glucose self-testing at least four times per day for 60 consecutive days in the three months prior to request for approval.
   v. Documentation of diabetes specialist's assessment of clinical therapeutic value of an insulin pump and ability to train member on appropriate use of continuous glucose monitor.
   vi. Documentation of at least two visits with a diabetes specialist during the six months prior to initiation.
   vii. Meets one or more of the following criteria while on a multiple daily injection insulin:
      a. Glycosylated hemoglobin levels (HbA1c) greater than 7%.
      b. Recent history (within the last six months) of significant, recurring hypoglycemia (less than 60mg per deciliter or requiring assistance).

| NEW POLICIES *(Continued)* | | |
|---|---|---|
| Policy Number | Policy Name | Effective Date |
| **MP-008 (New)** *(continued)* | **Continuous Glucose Monitor (CGM)** | **6/21/18** |

c. Wide fluctuations (well above and below set glycemic targets) in blood glucose before and after meal times, despite appropriate adjustment of doses.

d. At least one documented incidence of hyperglycemic hyperosmotic syndrome or diabetic ketoacidosis within the previous six months.

e. Type 1 diabetes mellitus.

**B. Covered Products:**

i. Dexcom® G4®

ii. Dexcom G5®

iii. Dexcom G6®

iv. Medtronic Enlite®

v. Medtronic Guardian®

vi. Freestyle® Libre® systems are not considered continuous glucose monitors and are covered under the pharmacy benefit.

**C. Exemptions:**

i. Patients with gestational diabetes or diabetes during pregnancy are exempted from previous management provisions of this policy.

**D. Renewals:**

i. Patients must have had at least two visits with a diabetes specialist within the previous 12 months.

ii. Hemoglobin A1c levels must have been checked at least every 6 months within the previous year.

iii. Documentation must show that the member is adhering to the treatment plan outlined by a diabetes specialist.

**E. Exclusions:**

i. Members taking medications that would impair cognitive function or ability to appropriately respond to alerts including chronic opioids, benzodiazepines, or sedatives.

ii. Members who require acetaminophen for chronic pain management.

a. Prior use of samples will not be considered in the determination of a member's eligibility for coverage for this medication.

U of U Health Plans does NOT cover implantable continuous glucose monitors (CGM) systems (e.g., Eversense® CGM System) as they are considered investigational.

| | | |
|---|---|---|
| **MP-011 (New)** | **Benign Skin Lesion Removal** | **7/15/18** |

**Commercial Plan:**

This policy was developed to help answer questions of coverage as to when benign skin lesion removal is covered. Key policy language states:

U of U Health Plans covers the removal of lipomas, seborrheic keratoses, melanocytic nevi, acrochordons/skin tags, fibromas, warts, and dermatofibromas in adults when found to be medically necessary based upon documentation of a **functional* impairment**.

Some benign skin conditions present predominantly in children (e.g., congenital hemangiomas, port wine stains, and other vascular lesions) may only be covered under specific conditions identified in policies specific to those conditions.

Specific lesions not shown to have a covered functional* problem are denied based upon the reconstructive and cosmetic limitations present in the plan certificate of coverage.

| NEW POLICIES *(Continued)* | | |
|---|---|---|
| Policy Number | Policy Name | Effective Date |
| **MP-011 (New)** *(continued)* | **Benign Skin Lesion Removal** | **7/15/18** |
| ***Functional impairment** is defined as pain of such a magnitude or location of the lesion(s) that it impairs an individual's ability to perform their activities of daily living (ADL), limit mobility, or otherwise prevent normal function of a body part. | | |
| **MP-014 (New)** | **Treatment of Congenital Hemangiomas (Port Wine Stains)** | **7/24/18** |

**Commercial Plan:**

This policy is intended to further define when congenital hemangioma treatments are covered.

U of U Health Plans covers laser treatment of port wine stains when the purpose of the treatment is to resolve the lesion in a potentially functionally important area in limited circumstances.

Areas considered of functional importance by the plan are as follows:

A. The genitals.
B. The facial triangle enclosed by the ears and the chin.
C. Any port wine stain area to resolve a functional problem associated with pain, discomfort or bleeding.

U of U Health Plans **does NOT** cover laser treatment of port wine stains for cosmetic or psychological reasons. Use for cosmetic or psychological reasons falls under the plan's cosmetic exclusion of coverage.

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|---|---|---|
| **MP-014 (New)** | **Genetic Testing: Cell-Free DNA (cfDNA) Fetal Testing** | **7/24/18** |

**Commercial Plan:**

U of U Health Plans covers testing for fetal aneuploidy when the following criteria are met:

A. Pregnancy is a singleton pregnancy; and
B. ONE of the following are present:
    i. Women with a first or second trimester positive screen; or
    ii. Pregnant women 35 years of age or older at delivery*; or
    iii. Previously affected pregnancy with a trisomy; or
    iv. Documented first degree relative with a translocation specific for a common trisomy; or
    v. Abnormal sonographic findings.

**In cases where the pregnant woman has received a 'donor' egg and is acting as a surrogate, it is the age of the donor that is relevant to the decision process not the age of the surrogate.*

U of U Health Plans **does NOT** cover testing for fetal aneuploidy in multiple-gestation pregnancies or any other indications.

U of U Health Plans **does NOT** cover fetal chromosomal microdeletions syndromes and other chromosomal disorders using circulating cell-free fetal DNA testing.



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