The Inside Story

Scott & White Health Plan
Now part of Baylor Scott & White Health

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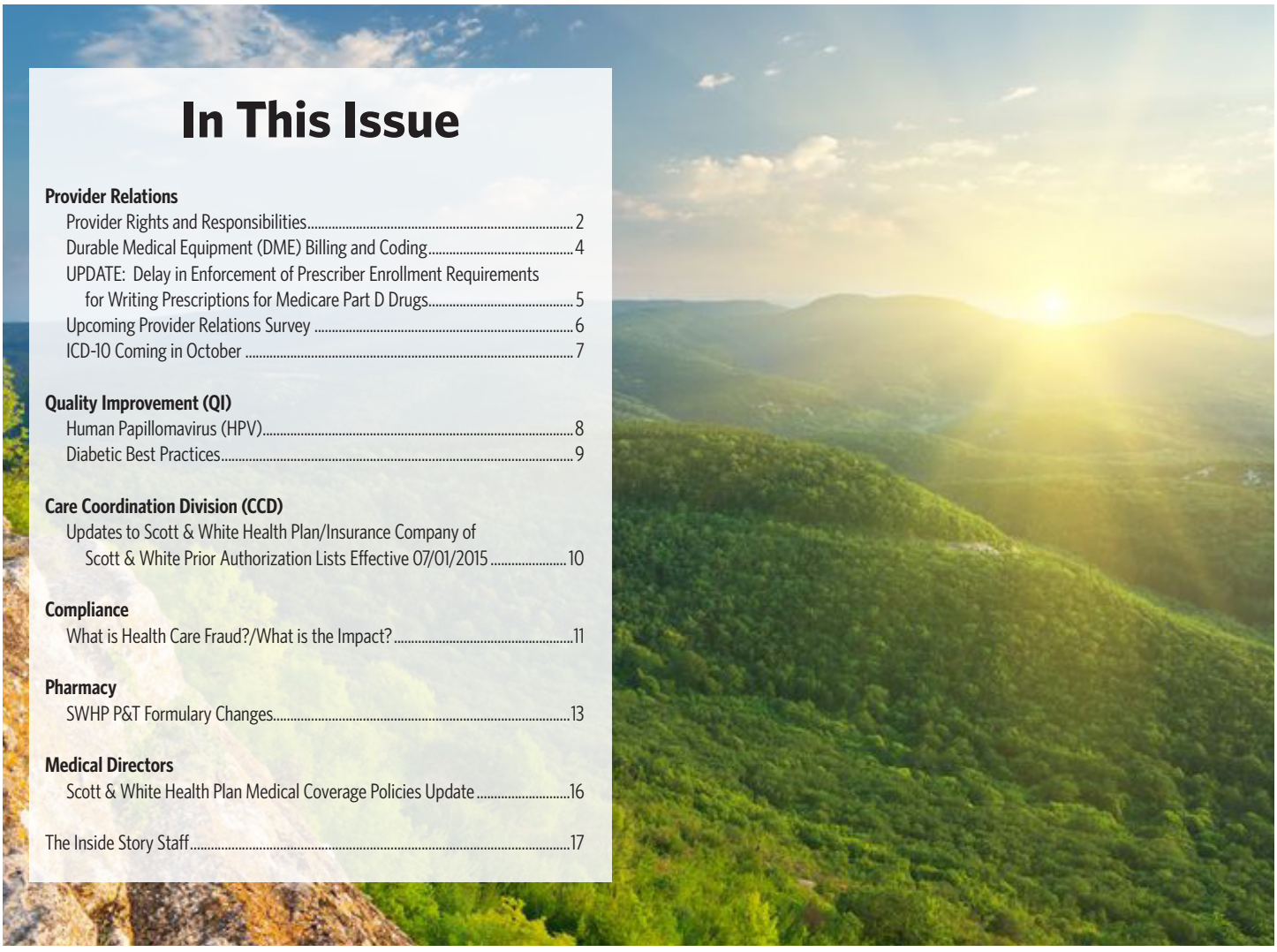
Scott & White Health Plan (SWHP) works throughout the year to better serve our valued providers. We do this in many different ways, such as looking for ways to improve processes and implement programs that will positively impact your interaction with SWHP members. In our newsletter this quarter, we are highlighting two programs that work towards that goal. On page 8, you will find information on Human Papillomavirus (HPV). On page 10, we have information on SWHP's updated Prior Authorization Lists. SWHP strives to ensure sufficient resources are available to meet the needs of our providers. In addition, during the coming year expect to see more face-to-face visits from the Provider Relations Representatives as SWHP ensures that the lines of communication are open and available for you, our valued providers.



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PROVIDER RIGHTS AND RESPONSIBILITIES

Scott & White Health Plan (SWHP) contracted providers are responsible for providing and managing health care services for SWHP members until services are no longer medically necessary.

Provider Rights

Providers have the right to:

- Be treated courteously and respectfully by SWHP staff at all times.
- Request information about SWHP's utilization management, case management, and disease guidance programs, services, and staff qualifications and contractual relationships.
- Upon request, be provided with copies of evidence-based clinical practice guidelines and clinical decision support tools used by SWHP.
- Be supported by SWHP to make decisions interactively with members regarding their health care.
- Consult with SWHP Medical Directors at any point in a member's participation in utilization management, case management, or disease guidance programs.
- Provide input into the development of SWHP's Case Management and Disease Guidance Programs.
- File a complaint on own behalf of a SWHP member, without fear of retaliation, and to have those complaints resolved.
- Receive a written decision regarding an application to participate with SWHP within 90 days of providing the complete application.
- Communicate openly with patients about all diagnostic testing and treatment options.
- The right to appeal claims payment issues.
- The right to 90 days prior written notice of termination of the contract.
- The right to request a written reason for the termination, if one is not provided with the notice of termination.

Provider Responsibilities

Primary Care Physicians (PCPs):

- Provide primary health care services not requiring specialized care. (i.e., routine preventive health screening and physical examinations, routine immunizations, routine office visits for illnesses or injuries, and medical management of chronic conditions not requiring a specialist)
- Obtain all required pre-authorizations as outlined in the Provider Manual.
- Refer SWHP members to SWHP contracted (in-network) specialists, facilities, and ancillary providers when necessary.
- Assure SWHP members understand the scope of specialty and/or ancillary services that have been authorized and how or where the member should access the care.

- Communicate a SWHP member's medical condition, treatment plans, and approved authorizations for services to appropriate specialists and other providers.
- Keep panel open to SWHP members until it contains at least 100 SWHP members on average per individual PCP.
- Will give SWHP at least 7 days advance written notice of intent to close panel and may not close panel to SWHP unless closing panel to all payors.

Specialists:

- Deliver all authorized medical health care services related to the SWHP member's medical condition as it pertains to specialty.
- Deliver all medical health care services available to SWHP members though self-referral benefits.
- Determine when the SWHP member may require the services of other specialists or ancillary providers for further diagnosis or specialized treatment, as well as, if the member requires admission to a hospital, rehabilitation facility, skilled nursing facility, or etc.
- Provide verbal or written consult reports to the SWHP member's PCP for review and inclusion in the member's primary care medical record.

All Providers:

- Follow SWHP's administrative policies and procedures and clinical guidelines when providing or managing health care services within the scope of a SWHP member's benefit plan.
- Uphold all applicable responsibilities outlined in the SWHP Member Rights & Responsibilities Statement.
- Maintain open communications with SWHP members to discuss treatment needs and recommended alternatives, regardless of benefit limitations or SWHP administrative policies and procedures.
- Provide timely transfer of SWHP member medical records if a member selects a new primary care practitioner, or if the practitioner's participation with SWHP terminates.
- Participate in SWHP Quality Improvement Programs, which are designed to identify opportunities for improving health care provided to SWHP members and the related outcomes.
- Comply with all utilization management decisions rendered by SWHP.
- Respond to SWHP Provider Satisfaction Surveys.
- Provide SWHP with any SWHP member's written complaints or grievances against provider or practice immediately (within 24 hours). *The process for resolving complaints should be posted in the provider's office or facility and should include the Texas Department of Insurance's toll free number.*

Providers should notify SWHP when there are changes to their practice, such as:

- Change of ownership and tax identification number (TIN).
- Change of address (service/mailing/billing), phone number, or fax number.
- New provider added to group or practice.
- Provider terminations from group or practice.
- Adverse actions impacting practitioner's ability to provide services.
- Termination from or opt out of participation in Medicare or Medicaid.

All changes reported should include an effective date.

Durable Medical Equipment (DME) Billing and Coding

Scott & White Health Plan (SWHP) is in the process of updating our systems to incorporate recent changes based on industry standards and changes with the Centers for Medicare and Medicaid Services (CMS) guidelines. These updates will enable SWHP to verify appropriate durable medical equipment (DME) coding and frequencies. ***The updates will be effective July 1, 2015.***

Currently, some SWHP DME providers may be receiving claim denials for claims with incorrect place of service (POS) codes. CMS requires that DME providers bill using the place of service where the equipment can reasonably be expected to be used (home, assisted living facility, etc.), rather than where the equipment is purchased or rented. SWHP will utilize the CMS DMEPOS rental list as a verification tool to ensure claims are billed with the correct rental modifiers.

We greatly appreciate the partnership that we have with you to provide our members with the healthcare services that they need. It is important to us to continue these partnerships.

We encourage you to please contact the SWHP Provider Relations Department at 800-321-7947, ext. 203064 or 254-298-3064, if you have any questions or need additional information.

We look forward to our continued partnership with you to bring the highest quality of care to all our SWHP members.

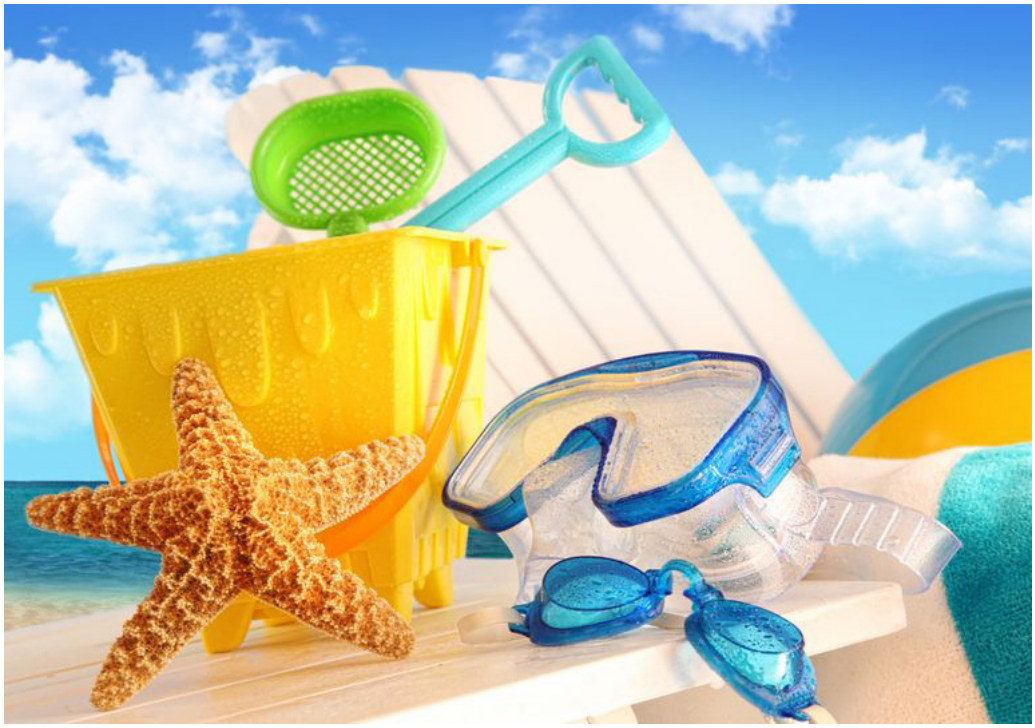
UPDATE: Delay in Enforcement of Prescriber Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs

The Centers for Medicare and Medicaid Services (CMS) finalized rule CMS-4159-F on May 23, 2014, which requires physicians and other eligible professionals who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be covered under Medicare Part D. CMS originally planned to enforce this requirement beginning December 1, 2015. However, CMS made revisions to rule CMS-4159-F on May 6, 2015. The revised rule is published as CMS-6107-IFC, which went into effect on June 1, 2015.

Under the revised rule CMS-6107-IFC, CMS is delaying enforcement of the prescriber enrollment requirements until June 1, 2016. The revised rule also encourages Part D sponsors and pharmacy benefit managers (PBMs) to begin outreach activities to Medicare Part D prescribers no later than January 1, 2016. Therefore, prescribers may be contacted multiple times from the various Part D sponsors and PBMs with whom they participate.

CMS strongly encourages prescribers of Part D drugs to submit their Medicare enrollment applications or opt-out affidavits to their Medicare Administrative Contractors (MACs) before January 1, 2016. This will provide the MACs with sufficient time to process the prescribers' applications or opt-out affidavits and avoid prescription drug claims from being denied by the Part D plans, beginning June 1, 2016.

For more information, please visit the CMS Part D Prescriber Enrollment website at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Prescriber-Enrollment-Information.html.

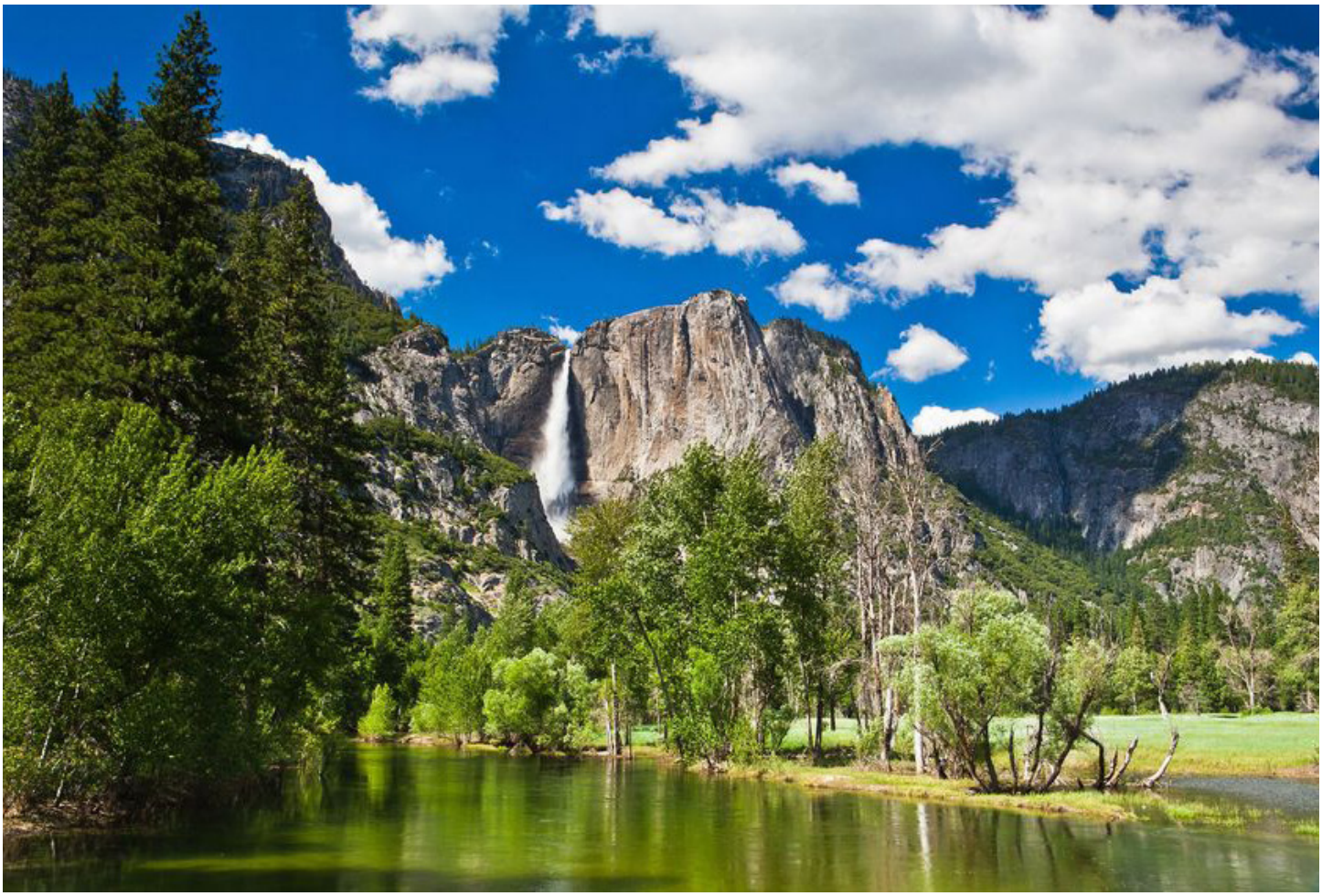


Upcoming Provider Relations Survey

The Scott & White Health Plan (SWHP) Provider Relations Department will be sending out a Provider Relations Survey during the week of July 6, 2015.

The purpose of the survey is to obtain feedback on how we are doing and what we can do better in terms of our SWHP website, claims processing, and communication from Provider Relations Department. Our goal is to identify opportunities for improvement based on your survey responses.

As you continue to provide high quality, cost effective healthcare services to our SWHP members, we want to ensure we are providing you with outstanding service. Thank you in advance for completing the Provider Relations Survey and providing us with your feedback.



ICD-10 Coming in October

Despite many delays, and although October may still seem far off, the US will finally join the rest of the world in using the 10th revision of the International Statistical Classification of Disease, better known as ICD-10 on October 1, 2015.

You may be tempted to delay preparing for the transition, but there is a great deal of work that needs to be completed. Also, advance planning and education are crucial for success. Scott & White Health Plan (SWHP) is here to support you with your ICD-10 preparation. We will have a series of presentations available on our SWHP website that includes links and resources that you can use to answer questions and assist you in the transition.

ICD-10: What's changing?

- ICD-10 codes are more specific. Requiring more specificity in your documentation/clinical practices. For example, acute otitis media has expanded from one code to 16!
- Diagnosis codes have expanded from 13,600 codes in ICD-9 to over 69,000 in ICD-10.
- ICD-10 codes consist of 3-7 characters. ICD-9 codes have 3-5 characters.
- The code book in ICD-10 has 21 chapters. There are 17 chapters in the code book for ICD-9.
- ICD-10 diagnosis codes begin with a letter (except for U). Most ICD-9 codes begin with a number (except for V and E codes).
- ICD-10 groups injuries first by specific site (e.g., head, arm, leg) and then by type of injury (e.g., fracture, open wound). ICD-9 classifies injuries by type.
- Certain diseases have been re-classified/re-assigned to a more appropriate chapter in ICD-10 (e.g., gout re-classified from endocrine chapter in ICD-9 to musculoskeletal chapter in ICD-10).

ICD-10: What stays the same?

- ICD-10 mirrors the ICD-9 process; there is just a lot more choices.
- ICD-10 continues to have the same structure as ICD-9. The first three characters are the category of the code and all codes within the category have similar traits.
- The alphabetic and tabular index remains with minor changes.
    - The alphabetic index is divided into two parts, the Index to Diseases and Injury and the Index to External Causes, which is similar to ICD-9.
    - Within the Index to Diseases and Injury, there is a "Neoplasm Table" and a "Table of Drugs and Chemicals."
    - The alphabetic index has the same formatting in ICD-10 as in ICD-9.

Transition Takeaways:

- All physician encounters MUST be submitted with ICD-10 codes **starting on October 1, 2015.** There is no crossover.
- Claims for dates of service **prior to October 1, 2015** will be submitted with **ICD-9 codes.**
- Inpatient physician encounters will be submitted using the guidelines for the **date of discharge.**
- **Physicians will continue to use CPT codes for any procedures or surgeries, even after October 1, 2015.**

Making the switch from ICD-9 to ICD-10 offers many benefits, including increased specificity and communication, better tracking of diseases and outcomes, improved transparency for reimbursement, and the ability to expand with new technology/discoveries.

Human Papillomavirus (HPV)

HPV is the most common sexually transmitted infection (STI). According to the Centers for Disease Control and Prevention (CDC), 79 million Americans are currently infected with HPV and about 14 million will become infected each year. HPV is so common that almost all sexually active men and women have acquired HPV at some point during their life. Because there are no signs or symptoms, many people are not even aware that they have acquired HPV. Sometimes it takes several years for symptoms to appear.

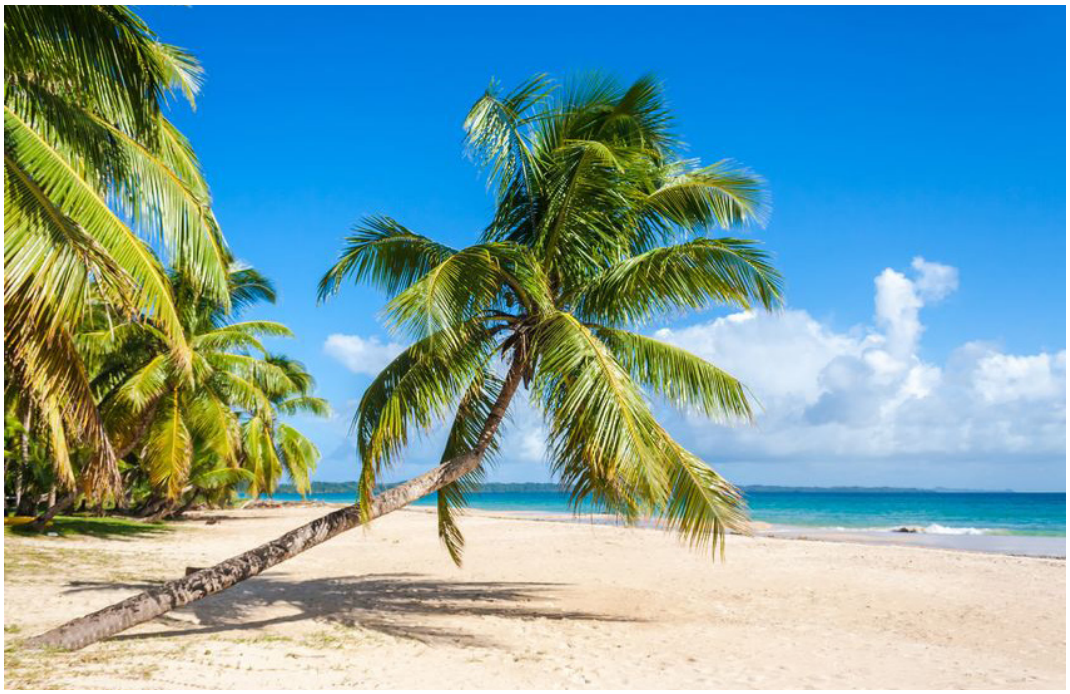
Most of the time, HPV does not cause any serious health problems and will disappear on its own. However, if it does not, genital warts and even cancer may develop. People with weak immune systems may be more susceptible to developing serious health conditions.

The CDC recommends that all boys and girls ages 11 and 12 should get vaccinated against HPV. There are several things that providers can do:

1. Encourage patients to maintain monogamous relationships.
2. Get screened for cervical cancer.
3. Encourage patients to get vaccinated.

Parents and children may be reluctant to discuss the need for the HPV vaccine. For the brochure, "Tips for Talking to Parents about HPV Vaccine", please go to http://www.cdc.gov/vaccines/who/teens/for-hcp-tipsheet-hpv.pdf.

SOURCE: Centers for Disease Control and Prevention, 2015.



Diabetic Best Practices

As another school year comes to an end, many of our pediatric patients and their families are preparing for the transition from living at home to college or into the workforce. This leaves them with a lot of questions. Not the least of which is, 'who is responsible for care?' While this may be a simple inconvenience for some, for those with chronic conditions such as diabetes, this is a very real and pressing concern. That said, current research published in JAMA, Endocrinology Today, and by the American Diabetic Association (ADA) as well as formal policy statements from the Federal Government and the NCQA all address this issue.

In the April 2015 issue of JAMA, it mentions that the Patient-Centered Medical Home (PCMH) is the focus for innovation regarding the US healthcare system. In fact, according to the AMA, the ANA, American Academy of Family Medicine, American Academy of Pediatrics, American College of Physicians, the American Osteopathic Association, the NCQA, and the Affordable Care Act, to name but a few, it is the new standard of care. Instead of the focus being on the face to face visit, "the PCMH model calls for practices to work within systems that are not restricted by organizational boundaries... but are coordinated across all elements of the health care system, patients' day-to-day lives, and their communities..." (Markovitz, A.R., Alexandar, J.A., Lantz, P.M., & Paustian, M.L., 2015, para. 2) Baylor Scott & White Health has adopted this concept because diabetes touches every part of a patient's life. The standards of care monitoring for diabetes are blood pressure, kidney function, and checking for neuropathy and retinopathy. The problem is that this standard monitors the disease and not the patient. The PCMH answers this problem. How are we coordinating the care? Does the patient understand? How does the care affect the patient's day-to-day life? Is this care realistic given the community resources? This in turn brings us to the second part of the solution, the structured transition of care. With the concept of the PCMH, there should be a seamless transfer of information. The patient knows exactly who is providing what care and why. Not only does the primary care team get the necessary information, but they incorporate the patient into the decisions and information process. In the case of our pediatric patients, this includes joint provider (pediatrician and adult provider) visits as we enter this transition. Further research by the ADA has proven that utilizing a staff member, such as the nurse, as a transition coordinator is effective in reducing the anxiety and increasing patient compliance.

In closing, the use of structured transitions as part of a PCMH have been shown to be the best practice for diabetic patients preparing to go off to college or into the workforce. By insuring continuity of care and reducing patient anxiety regarding the transition, we can increase patient satisfaction and subsequently compliance with the standards of care that will lead to the best patient outcomes.

Updates to Scott & White Health Plan/ Insurance Company of Scott & White Prior Authorization Lists

Effective 07/01/2015

Scott & White Health Plan (SWHP) and Insurance Company of Scott & White (ICSW) would like to thank you for providing the outstanding care that you do to our members. SWHP/ICSW is providing this courtesy notice to you regarding upcoming changes to the SWHP/ICSW Prior Authorization (PA) lists. ***These changes are effective July 1, 2015.***

You can access a copy of the new PA lists using one of the following methods:

1. Using the My*Benefits* Portal located at https://swhpah.swhp.org/. Enter your user name and password to login. Once you are logged in, look for the section titled "My Health Tools/Resources" on the home page. The PA lists are located under this section. If you do not have access to My*Benefits*, please click on the link that says, **"To register as a Provider click here."**

2. Contact the Provider Relations Department at the phone number listed below to request a copy.

Please contact the Provider Relations Department at (254) 298-3064 or (800) 321-7947, ext. 203064 if you have any questions or concerns.

What is Health Care Fraud?/ What is the Impact?

The majority of health care professionals and consumers are honest and act with integrity, but there is a small number who are not honest, and it is important for you to recognize fraud, and its impact and how you can help.

What is Health Care Fraud?

Health care fraud is the intentional act of deceiving, concealing, or misrepresenting information that results in health care benefits being paid to an individual or group. Medical or drug providers, individual members, and employer groups, as well as health insurance employees, can commit health care fraud. What does this mean to you? It means that someone is cheating the system to gain money or benefits that he or she is not entitled to. Individuals convicted of health care fraud can be subject to fines and or imprisonment.

What is the Impact of Health Care Fraud?

Health care fraud results in increased cost of health care benefits. The National Health Care Anti-fraud Association (NHCAA) estimates that conservatively 3% of all health care spending ($68 billion) is lost to health care fraud. How does this affect you?

- Higher premiums
- Higher costs to provide care
- Possible compromise in quality of care

Examples of Provider and Member Fraud

- Provider bills for services, procedures, and/or supplies that were not provided. An actual case involved a skin doctor who regularly billed insurers for acne surgery while only doing facials or no work at all. He had staff beauticians perform surgery. The doctor paid $100,000 to settle the charges.
- Giving money, products, or services as an incentive for providing member referrals. This process is called "kickbacks" and, as you would expect, is illegal. An actual case involved a large drug company that provided free samples of a high profile drug to doctors and encouraged them to bill their patients' insurance. The company believed this would lead to a large increase in future prescriptions.
- Routine waiving of patient copayments or deductibles then over billing the insurance plan. In waiving the patient's copayment, the doctor may compensate for the loss of reimbursement by charging the insurance company a rate higher than normal or over billing to receive a greater than normal reimbursement.
- Using someone else's medical insurance card. This may be a situation involving identity theft. Regardless, the individual is providing a false identity and inflating the future cost of health insurance benefits.
- A member filing for reimbursement on services or medications that were not received or performed.

What is SWHP Doing About This Concern?

Scott & White Health Plan (SWHP) has the Compliance Department and will have a Special Investigative Unit (SIU) Investigator to monitor and investigate suspicious activities within its health plan. The SIU staff will work closely with state and federal law enforcement agencies, other insurance companies, and the provider community to detect and prevent health care fraud. The SIU staff will also work closely with clinical professionals, claims investigators, and will be data mining to detect fraudulent wasteful and abusive activity.

How You Can Help?

- Review your Explanation of Benefits (EOB) and, if available, compare it to your medical bill. If there is any difference between the two, contact Customer Service at the phone number provided on your EOB and insurance card.
- Protect your health insurance information. Do not let anyone else use your health insurance card.
- Do not let anyone use your Social Security Number.
- Be suspicious of free medical services that require your insurance information. Remember, if it is free, there isn't any need to share insurance information.
- Alert your health insurance company of any providers who routinely waive your copayment or deductible.
- Never sign a blank insurance claim form.

SWHP and Baylor Scott & White Health are dedicated to conducting business according to the highest standards of ethical conduct and in compliance with all federal, state, and local laws governing its business. Accordingly, SWHP is committed to the detection, correction, and prevention of fraud, waste, and abuse.

There is a dedicated hotline for reporting fraud, waste, and abuse.

Call the Hotline at (888) 800-1096.

You may remain completely anonymous. You are legally protected from retaliation for raising questions or reporting suspected violations in good faith.

Scott & White Health Plan (SWHP) Pharmacy & Therapeutics (P&T) Formulary Changes

The SWHP P&T Committee meets monthly to review drugs and policies. You can find formulary updates, formularies/preferred drugs lists (PDLs), prior authorization criteria and prior authorization forms at https://swhp.org/providers/pharmacy-services.

SWHP P&T Formulary Changes (March- May 2015)

Medication	Copay	Comments	Indication(s)	SWHP Formulary Alternatives	Effective Date
Pradaxa® (dabigatran)	**SWHP Non-formulary** **ACA Compliant- Tier 3** **MCD- Tier 4**	**SWHP tier change** from Tier 2 to non-formulary status **ACA Compliant tier change** from Tier 2 to Tier 3 status **MCD tier change** from Tier 3 to Tier 4 Addition of step therapy (ST) requiring failure of preferred agents Eliquis® or Xarelto® **All tier and ST changes effective 1/1/2016** Prior authorization required			1/1/2016
Savaysa™ (edoxaban)	**Non-formulary**	Addition of non-formulary prior authorization criteria Addition of step therapy (ST) requiring failure of preferred agents Eliquis® or Xarelto®	Indicated to reduce the risk of stroke and systemic embolism (SE) in patients with nonvalvular atrial fibrillation	Eliquis® Xarelto®	7/1/2015
Cosentyx™ (secukinumab)	**Non-formulary**	Revision of non-formulary prior authorization criteria	Indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy	Enbrel® Humira® Remicade® Stelara®	7/1/2015
Onfi® (clobazam)	**SWHP Tier 3**	Prior authorization required Maintenance Eligible	Indicated for adjunctive treatment of seizures associated with Lennox-Gastaut syndrome (LGS) in patients 2 years of age or older	Klonopin® clonazepam clonazepam ODT Felbatol® Felbamate Lamictal® lamotrigine Topamax® topiramate	6/1/2015

Banzel® (rufinamide)	**SWHP Specialty** **ACA Compliant- Tier 4** **MCD- Tier 5**	Prior authorization required **(SWHP and ACA Compliant Only)** **ACA Compliant tier change** from Tier 3 to Tier 4 (effective 1/1/2016) **MCD tier change** from Tier 4 to Tier 5 (effective 1/1/2016)	Indicated for adjunctive treatment of seizures associated with Lennox-Gastaut Syndrome (LGS) in pediatric patients 1 year of age and older, and in adults	Klonopin® clonazepam clonazepam ODT Felbatol® Felbamate Lamictal® lamotrigine Topamax® topiramate	6/1/2015 (unless noted in comments)
Aptiom® (eslicarbazepine)	**SWHP Tier 3** **ACA Compliant- Tier 3**	Maintenance Eligible	Indicated as adjunctive treatment of partial-onset seizures	Felbatol® felbamate Gabitril ® tiagabine Keppra® levetiracetam Lamictal® lamotrigine Neurontin® gabapentin Topamax® topiramate Trileptal® oxcarbazepine Zonegran® zonisamide	6/1/2015
Fycompa™ (perampanel)	**SWHP Tier 3** **ACA Compliant- Tier 3**	Maintenance Eligible	Indicated as adjunctive therapy for the treatment of partial-onset seizures with or without secondarily generalized seizures in patients with epilepsy aged 12 years and older	Felbatol® felbamate Gabitril ® tiagabine Keppra® levetiracetam Lamictal® lamotrigine Neurontin® gabapentin Topamax® topiramate Trileptal® oxcarbazepine Zonegran® zonisamide	6/1/2015
Trileptal® **oxcarbazepine**	**SWHP Tier 2** **SWHP Tier 1**	**Tier change:** Move Trileptal® from SWHP Tier 3 to Tier 2; Move oxcarbazepine from SWHP Tier 3 to Tier 1 Maintenance Eligible			6/1/2015
Keytruda® (pembrolizumab)	**SWHP Specialty** **ACA Compliant- Tier 4**	Prior authorization required	Indicated for the treatment of patients with unresectable or metastatic melanoma and disease progression following ipilimumab and, if BRAF V600 mutation positive, a BRAF inhibitor	Yervoy® (ipilimumab)	5/1/2015
Vitekta® (elvitegravir)	**ACA Compliant- Tier 4** **MCD- Tier 5**		Indicated for use in combination with an HIV protease inhibitor coadministered with ritonavir and with other antiretroviral drug (s) for the treatment of HIV-1 infection in antiretroviral treatment- experienced adults	Isentress® (raltegravir) Stribild® (elvitegravir/ cobicistat/ emtricitabine/ tenofovir) Tivicay® (dolutegravir) Triumeq® (dolutegravir/ abacavir/ lamivudine)	5/1/2015

Prezcobix™ (darunavir/cobicistat)	**ACA Compliant- Tier 4** **MCD- Tier 5**		Indicated for the treatment of HIV-1 infection in adult patients	Prezista® (darunavir) + Tybost™® (cobicistat) Prezista® (darunavir) + Norvir® (ritonavir)	5/1/2015
Evotaz™ (atazanavir/ cobicistat)	**ACA Compliant- Tier 4** **MCD- Tier 5**				5/1/2015
Lenvima™ (lenvatinib)	**SWHP Specialty** **ACA Compliant- Tier 4** **MCD- Tier 5**	Prior authorization required (SWHP Specialty and ACA Compliant)	Indicated for the treatment of patients with locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer	Nexavar® (sorafenib) Caprelsa® (vandetanib)	5/1/2015
Ibrance® (palbociclib)	**SWHP Specialty** **ACA Compliant- Tier 4** **MCD- Tier 5**	Prior authorization required (SWHP Specialty and ACA Compliant)	Indicated in combination with letrozole as initial endocrine-based therapy for the treatment of postmenopausal women with estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative, advanced metastatic breast cancer	tamoxifen	5/1/2015
Farydak® (panobinostat)	**SWHP Specialty** **ACA Compliant- Tier 4** **MCD- Tier 5**	Prior authorization required (SWHP Specialty and ACA Compliant)	Indicated for the treatment of multiple myeloma in patients who have received at least two prior regimens, including bortezomib and an immunomodulatory agent	Thalomid® (thalidomide) Revlimid ® (lenalidomide) Velcade® (bortezomib)	5/1/2015
Yervoy® (ipilimumab)		Revision of prior authorization criteria			5/1/2015

Scott & White Health Plan Medical Coverage Policies Update

Scott & White Health plan (SWHP) is pleased to announce the release of the Medical Coverage Policies listed below. You can find these policies on our website, https://swhp.org/providers/policies/medical-coverage-policies.

- 001 Acupuncture
- 004 Physical Therapy
- 017 Cochlear Implants & Auditory Brain Stem Implants
- 055 Insulin Pump and CGMS
- 137 Psychologic Evaluation for Med and Surg Procedures
- 203 Proton Beam Radiation Therapy
- 206 Autism Coverage Therapy

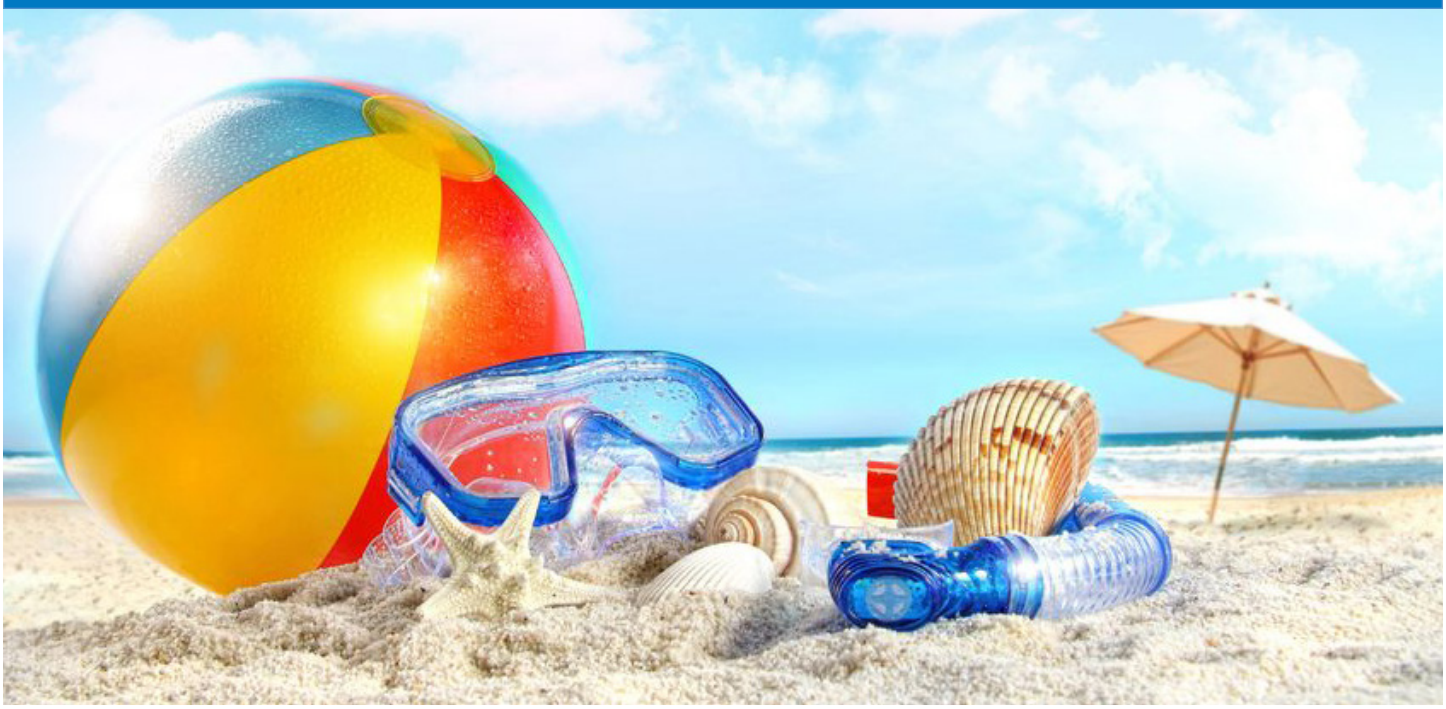
SWHPs Medical Coverage Policies are reviewed on an annual basis to assure continued relevance and to keep them current. This review is conducted by SWHP Medical Directors. Each policy is reviewed using a number of resources such as:

1. Medical literature
2. InterQual® guidelines
3. SW Technology Assessment Determinations
4. Specialty Society or other national guidelines

Once policies have been reviewed by the Medical Directors, they are sent for specialty review. Recommendations from the specialty reviewers are considered at a subsequent Medical Director Committee meeting and a final decision on the content of the policies under consideration is made.

The review process for the above policies has been completed and they have now been published to the website. Your comments and suggestions regarding the Medical Coverage Policies are always welcome and may be forwarded to: SWHPMedicalDirectors@sw.org

Our Friday Focus editions may be found at:
https://swhp.org/about-us/news/newsletters/providers-friday-focus



SCOTT & WHITE HEALTH PLAN

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