October 1, 2023

The Bulletin

This monthly bulletin includes recent changes to our medical policies and reimbursement policies. It is a supplement to our bimonthly provider newsletter, *Provider News*. **Note**: Medication policy updates are published in *Provider News*.

Medical policies

Changes effective October 1, 2023
Genetic Testing

- BRAF Genetic Testing to Select Melanoma or Glioma Patients for Targeted Therapy (#41)
    - Updated criteria for BRAF testing for targeted treatment for all glioma as it now may be considered medically necessary

Laboratory

- Investigational Gene Expression, Biomarker, and Multianalyte Testing (#77)
    - Added six new investigational tests and removed two tests that are no longer available

Changes effective January 1, 2024
Surgery

- Hypoglossal Nerve Stimulation (#215)
    - Updating criteria to align with recent U.S. Food and Drug Administration (FDA) approval for the Inspire™ II system
    - Clarifying continuous positive airway pressure (CPAP) intolerance
    - Changing age requirement from 22 to 18
- Radiofrequency Ablation and Injection of Sacroiliac Joint Nerves (#231)
    - New policy with always investigational criteria for radio frequency ablation and injections for the nerves of the sacroiliac joint

Utilization Management

- Surgical Site of Service – Hospital Outpatient (#19)
    - Updating and clarifying policy criteria

View our Medical Policy Manual

Join our medical policy discussion

We welcome your input and feedback as we draft our medical policies. Join our email reviewer list. While we prefer to receive input as policies are developed, we also have a formal process that allows you to submit additional information, such as clinical trial results, that may warrant a policy review.

Recent updates and archived medical policies

Recent updates and archived medical policies may include revisions that will be published in the next issue of *The Bulletin*.

Reimbursement policies

Administrative

- Virtual Care (#132)
    - Clarification added that virtual check-ins, audio only and store and forward services are considered not separately payable and will deny as non-reimbursable if originating from a related evaluation & management (E&M) with the previous 7 days or resulting in a related E&M services within 24 hours or soonest available appointment after the virtual service

Changes effective January 1, 2024
Administrative

- Inpatient Hospital Readmissions (#111)
    - Adding a definition for children's hospital
    - Adding children's hospitals and critical access hospitals to the policy exclusion list
    - Removing medical treatment for cancer from the policy exclusion list
    - Correcting reference to Centers for Medicare & Medicaid Services (CMS)

Facility

- Emergency Room Visit: Level of Care (#110)
    - Adding emergency room visits resulting in an inpatient admission are included in facility room and board reimbursement

    - Adding *Reimbursement of Room and Board* (Facility #103) to policy cross references
    - Correcting reference to CMS

- Implants, Implant Components, Medical and Surgical Supplies for All Procedures (#125)
    - Adding documentation requirements
    - Adding that claims should include the manufacturer's invoice amounts of the item(s); any shipping or handling will be denied as content to the implant cost
        - Each implant/device must be billed separately as one line item and one unit
    - Adding that upon review of the medical records, reimbursement will be at 100% cost per unit as outlined in the detail implant description located within the medical record/documentation
    - Adding that billed charges for revenue codes 0270-0279 will require a manufacturer's invoice to support supplies used that correspond to the services rendered
        - These units must be clearly indicated on the manufacturer's invoice submitted with the claim
        - If the units do not match or are not noted, the revenue codes 0270-0279 will be denied
        - If supplies are purchased by the provider in bulk, the units that apply to the claim billed must be noted on the invoice and itemized bill or the revenue codes 0270-0279 will be denied

- Reimbursement of Room and Board (#103)
    - Adding emergency room visits that result in an inpatient admission are considered not separately reimbursable
    - Adding *Emergency Room Visit: Level of Care* (Facility #110) and *Implants, Implant Components, Medical and Surgical Supplies for all Surgical Procedures* (Administrative #125) to policy cross references
    - Removing incremental nursing from definitions
    - Removing durable medical equipment under inpatient claims
    - Updating verbiage, removing duplicate statements and placing definitions in alphabetical order

View our Reimbursement Policy Manual

Verify your provider information

Providing up-to-date and accurate information about the providers in each of our networks is critical for our members to access care and a compliance requirement for the Affordable Care Act (ACA).

Validating provider directory content

Please follow these steps to review the information about your practice every 90 days. **Please respond timely to any requests from us for verification of your directory data**.

If your clinic or facility submits provider rosters to us, please submit changes, corrections, additions or terminations immediately so we can update our directories as soon as possible. **Your roster must be validated and reviewed in its entirety at least once per quarter**.

We appreciate your assistance in keeping information about your practice up to date.