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May 1, 2024

The Bulletin

This monthly bulletin includes recent changes to our medical 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 April 1, 2024
Durable Medical Equipment

- Definitive Lower Limb Prostheses (#18)
    - Updated policy to include new HCPCS codes for:
        - A pneumatic prosthetic knee (L5841) and
        - The RevoFit System for socket volume adjustment (L5783)
- Powered Exoskeleton for Ambulation and Rehabilitation (#89)
    - Changed policy title; policy was previously titled *Powered Exoskeleton for Ambulation*
    - Expanded policy scope to include powered exoskeleton devices for robot-assisted physical therapy
- Upper Extremity Rehabilitation System with Brain-Computer Interface (#94)
    - New medical policy includes investigational criteria

Medicine

- Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (#170)
    - Added to criteria for non-healing diabetic lower-extremity ulcers three products that may be medically necessary

Surgery

- Pectus Excavatum and Carinatum Treatment (#12.02)
    - Changed policy title; policy was previously titled *Pectus Excavatum and Carinatum Treatment*
    - Added non-coverage criteria for the use of orthotics in the treatment of pectus carinatum

Changes effective May 1, 2024
Surgery

- Endometrial Ablation (#01)
    - Updated criteria to allow documentation requirements to be met using clinical documentation without requiring pathology/procedure reports

Transplant

- Placental and Umbilical Cord Blood as a Source of Stem Cells (#45.16)
    - Updated policy to include medical necessity criteria for omisirge (omidubicel)

Changes effective August 1, 2024
Surgery

- Knee Surgeries (#229)
  - Clarified language in criterion to specify patellofemoral pain

View our Medical Policy Manual

Join our medical policy discussion

We encourage input as policies are developed, but we also have a formal process that allows you to submit additional information—such as well-designed, published clinical trials—that may warrant a policy review. To share your feedback about our medical policies, join our reviewer list.

Recent updates and archived medical policies

We encourage you to review recent updates and archived medical policies, which may also include revisions that will be published in the next issue of *The Bulletin*.

Reimbursement policies

Changes effective August 1, 2024
Administrative

- Global Days (#101)
  - Adding that suture removal is not eligible for separate reimbursement regardless of the surgical global period
- Virtual Care (#132)
  - Adding definition of modifier FR
  - Clarifying that services billed with both an audio-only and an audio/video modifier are not reimbursable; correct coding states that services should be either audio-only or audio/video, not both
  - Only audio-only services included on the Centers for Medicare & Medicaid Services' (CMS's) telehealth list will be reimbursed when billed with the appropriate audio-only modifier
  - Adding that we will not reimburse for telehealth/telemedicine services not included in the CMS telehealth list
  - Revising eligible telehealth providers list to use CMS general terminology of mental health counselors and marriage and family therapists rather than listing state-specific licensure
  - Adding back reimbursement rate for professional telehealth services
    - **For providers in Idaho and Utah**: In line with a January 1, 2024, CMS rule change, place of service (POS) 10 will be reimbursed using non-facility rates and POS 02 will continue to be reimbursed using facility rates.
  - Revising language to clarify that if the wrong modifier is used, the claim will be denied—rather than rejected—and the provider can submit a corrected claim for reconsideration
  - Adding that expanded telehealth will be reimbursed through December 31, 2024

Anesthesia

- Anesthesia Reimbursement and Services Reporting (#102)
  - Reducing allowable for AD modifier to 50%

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 it's a requirement for the Affordable Care Act (ACA).

Validating provider directory content

Practice information, including rosters, must be reviewed and validated in its entirety at least once every 90 days. Follow these steps to review the information about your practice.

- Respond timely to our requests for verification of your directory data.
- If your clinic or facility submits provider rosters to us, please send changes, corrections, additions or terminations immediately so we can update our directories as soon as possible.

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

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