Regence

June 1, 2026

The Bulletin

This monthly bulletin includes recent changes to our medical and reimbursement policies.

Notes

- *The Bulletin* is a supplement to our bimonthly provider newsletter, *The Connection*.
  - Medication policy updates are published in *The Connection*.
- Dental policy updates are published in the News section of **regencedental.com/providers**.
- For Blue Cross and Blue Shield Federal Employee Program® (BCBS FEP®) medical policies, please refer to the Blue Cross Blue Shield Service Benefit Plan brochure, the BCBS FEP medical policies or call our Customer Service team.

Medical policies

Commercial

Changes effective June 1, 2026

Genetic Testing

- Genetic Testing for Hereditary Breast, Ovarian, Pancreatic and Prostate Cancer and Li-Fraumeni Syndrome (#02)
  - Updated policy title; policy was previously titled *Genetic Testing for Hereditary Breast and Ovarian Cancer and Li-Fraumeni Syndrome*
  - Updated criteria to more accurately reflect policy scope
- Measurement of Serum Antibodies to Selected Biologic Agents (#65)
  - Added golimumab (Simponi) drug/antibody levels to medically necessary criteria

View our commercial Medical Policy Manual

Medicare Advantage

No recent reimbursement policy updates required notification.

View our Medicare Advantage 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 September 1, 2026

Administrative

- Bundling Edits (#105)—applies to commercial and Medicare Advantage
  - Adding information about our tertiary editor with no change to how edits are applied
- Correct Coding Guidelines (#129)—applies to commercial and Medicare Advantage
  - Defining application of local coverage determination (LCD) Articles to commercial claims
  - Adding billing and revenue coding examples
  - Clarifying that when the modifier indicates a service shouldn't be reimbursed, regardless of correct coding, we will not reimburse
- Global Days (#101)—applies to commercial and Medicare Advantage
  - Adding language that states we will not separately reimburse preventive and/or preventive like visits (99391-99397, G0402, G0438, G0439, G0513, G0514, S0285, S0612, S0621) when billed the same day as a minor surgical procedure (0 day)
- Implants, Implant Components, Medical and Surgical Supplies for All Procedures (#125)—applies to commercial and Medicare Advantage
  - Adding that implant procedure codes billed without an implant device procedure code are not eligible for reimbursement

Facility

- Reimbursement for Outpatient Charges while Inpatient (#117)—applies to commercial and Medicare Advantage
  - New reimbursement policy states outpatient charges billed while a patient is inpatient in the same facility should be included in the inpatient charges
    - **Note:** Policy recognizes that provider exclusions may exist based on several factors.
- Reimbursement of Chest X-Rays and Radiologic Guidance for Facilities (#105)—applies to commercial and Medicare Advantage
  - Adding definitions for contrast agents, diagnostic radiopharmaceuticals and therapeutic radiopharmaceuticals
  - Adding that diagnostic radiopharmaceuticals and certain imaging agent(s) are an integral component to the diagnostic procedure and that unbundling imaging agent(s) from the diagnostic procedure is not separately reimbursable
    - **Note:** Therapeutic radiopharmaceuticals are eligible for reimbursement.
  - Updating the reference to the CMS chest X-ray LCD to the current LCD number and link
- Reimbursement of Facility Room and Board (#103)—applies to commercial and Medicare Advantage
  - Adding new criteria regarding operating room, specialty and intensive care units
  - Adding new respiratory services criteria
  - Adding additional criteria that are within the scope of normal nursing practices
- Reimbursement of Respiratory Therapy Services for Facilities (#108)—applies to commercial and Medicare Advantage
  - Archiving policy

Medicine

- Maternity Care (#107)—applies to commercial and Medicare Advantage
    - Clarifying definitions of antepartum, intrapartum and postpartum periods
    - Updating code examples
    - Adding scenarios in which global delivery codes are not eligible for reimbursement:
        - Different provider billing for antepartum services
        - Delivery-only codes without antepartum care

Modifiers

- Modifier 24; Unrelated Evaluation and Management (#119)—applies to commercial and Medicare Advantage
    - New reimbursement policy that provides information about billing modifier 24
        - Stating that modifier 24 is only allowed to be appended to an evaluation & management (E&M) code rendered during the postoperative period (10- or 90-day) when the service is unrelated to the surgical procedure
        - Stating that we do not separately reimburse an E&M code billed with modifier 24 if the E&M code has a primary diagnosis that is associated with the surgical procedure or if the E&M code has a diagnosis that is a complication of the surgical procedure or an after-care diagnosis
- Modifier 25; Significant, Separately Identifiable Service (#103)—applies to commercial and Medicare Advantage
    - Adding language that states we will not separately reimburse E&M code(s) that are appended with modifier 25, when performed on the same day as a surgical procedure (0- or 10-day global period) if a previous face-to-face E&M code with the same diagnosis was billed within the prior 60 days
- Modifier 78 & 79; Unplanned Return to the Operating/Procedure Room (#112)—applies to commercial and Medicare Advantage
    - Updating policy title; policy was previously titled *Modifier 78; Unplanned Return to the Operating/Procedure Room By the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period*
    - Adding definition of modifier 79 and related information

Changes effective October 1, 2026

Administrative

- Chiropractic and Osteopathic Treatments (#138)—applies to commercial
    - Updating list of reimbursable services to align with the billing provider's scope of license in the location where services are rendered
    - Adding definition of chiropractic manipulative treatment (CMT)
    - Adding list of reimbursable codes
    - Removing HCPCS S8990 from the osteopathic treatment section; this code is not reimbursable by chiropractors
    - Specifying that correct coding guidelines include (but are not limited to) using appropriate modifiers and billing according to scope of practice as defined by the applicable state licensing authority
    - Clarifying that osteopathic care is not reimbursable by chiropractors

- Chiropractic and Osteopathic Treatments (#138)—applies to Medicare Advantage
    - Updating list of reimbursable services to align with the billing provider's scope of license in the location where services are rendered
    - Adding definition of CMT
    - Adding list of reimbursable codes
    - Removing CPT 97140 and 98943 and HCPCS S8990; these codes are not reimbursable by chiropractors and/or for Medicare members
    - Specifying that correct coding guidelines include (but are not limited to) using appropriate modifiers and billing according to scope of practice as defined by the applicable state licensing authority
    - Clarifying that osteopathic care is not reimbursable by chiropractors

View our Reimbursement Policy Manual

Reimbursement policy feedback

We encourage physicians and other health care professionals to share their input using our Reimbursement Policy Feedback Form.

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) and Medicare Advantage plans.

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.