October 2024: Medical Policies, Coding/Reimbursement

Select Health publishes the *Policy Update Bulletin* monthly with new, revised, and archived policy information as well as policy developments and related practice management tips. **Policy updates are featured below and on subsequent pages.**

Coding updates begin on page 4.

Questions? Please contact:

- Marcus.Call@selecthealth.org for information on content of a medical policy
- Brandi.Luna@selecthealth.org for questions about coding and reimbursement policies
- Your Provider Relations representative for any other questions.

Select Health Policy Updates

There are no new policies this month; however, there are **12 revised policies** (see **Table 1** below and on the next pages) and **4 archived policies** (see **Table 2** on page 3).

Policies listed in this bulletin are arranged alphabetically by title, with a link to the online specialty-based booklet (see booklet page number listed where the policy can be found). Coding/reimbursement policy names link directly to the relevant policy.

Policies are also available on the current **Select Health Provider Portal** (secure login required).

Table 1. Revised Medical Policies

Policy Title (Number)	Revision Date: Summary of Change (applies ONLY to Commercial plan policy UNLESS summary text appears in BOLD)
Genetic Testing: Myeloid Neoplasms (185), see page 185 in the **Genetic Testing booklet.**	**9/30/2024**: • Added new criterion #5 to criteria section #A (Myeloproliferative Neoplasms), “A limited panel that only includes JAK2, CALR, and MPL, while not preferred, is considered acceptable.” • Added new criterion #1-b to criteria section #F (Acute Myeloid Leukemia), “Rapid NGS panels will be covered only at diagnosis to facilitate immediate management of newly diagnosed AML patients. Rapid NGS panels are typically more limited in scope to facilitate a rapid return of results. Therefore, more comprehensive myeloid-specific NGS panels will also be covered at diagnosis to allow for further risk stratification at diagnosis. A rapid AML NGS panel should, at a minimum, include the following set of genes: CEBPA, FLT3, IDH1, IDH2, KIT, KRAS, NPM1, NRAS, and TP53.”
High Frequency Chest Wall Compression (128), see page 17 in the **Pulmonary booklet**.	**10/02/2024**: Added new criterion #2 (immotile cilia syndrome) to list of conditions that would qualify for coverage of this therapy.
Intracept (648), see page 57 in the **Physical Medicine booklet**.	**10/01/2024**: Modified requirements in criterion #3: “Exam findings and history exclude other sources of low back pain, and specifically, radiofrequency of the facet joints is either not indicated, contraindicated, or have failed to relieve the lower back pain.”

Continued on page 2...

Select Health

... Continued from page 1

Table 1. Revised Medical Policies, Continued

Policy Title (Number)	Revision Date: Summary of Change (applies ONLY to Commercial plan policy UNLESS summary text appears in BOLD)
CODING & REIMBURSEMENT POLICY **Intraoperative Neurophysiological Monitoring (IONM) (56)**	**10/03/2024**: Added the following guidelines: • "The monitoring technologist may bill separately from the facility." • "If the technician is credentialed by ABNM, they do not have to be licensed in the specific state the surgery is taking place, as the IONM tech is normally providing the monitoring services out of state."
Lipedema Treatment (683), see page 60 in the **General Surgery booklet**.	**10/17/2024**: • Added clarification to section B: "Excessive skin removal is covered for functional problems associated after liposuction for lipedema involving the trunk and legs, or to provide pneumatic or magnetic compressive therapy post-liposuction." • Added an exclusion to section C: "Excessive skin removal involving the arms is considered not medically necessary."
Liver Transplant (Cadaveric) (142), see page 63 in the **General Surgery booklet**.	**10/18/2024**: • Modified overall coverage criteria to align with current clinical standards. • Included guidelines for Oslo protocol for transplantation for colorectal carcinoma to help in evaluating that aspect of eligibility.
Partial Knee Replacement/ Resurfacing (Unicompartmental and Bicompartmental) (431), see page 106 in the **Orthopedic booklet**.	**10/18/2024:** Incorporated the same criteria as listed in medical policy **#598 (Total Knee Arthroplasty)**, to align the requirements for unicompartmental knee resurfacing/replacement procedures.
Pulsed Dye Laser Treatment for Dermatological Conditions (168), see page 31 in the **Dermatology booklet**.	**10/17/2024**: • **Modified title of policy (was previously titled, "Pulsed Dye Laser Treatment of Congenital Hemangiomas and Rosacea").** • Updated terminology from port-wine stains (PWS) to port-wine birthmarks (PWB) to align with current clinical standards.
Simultaneous Liver and Kidney Transplantation (SLK) (144), see page 133 in the **General Surgery booklet**.	**10/18/2024**: Aligned requirements in this policy with those of policy **Liver Transplant (Cadaveric) (142)** as follows: • Modified overall coverage criteria to align with current clinical standards • Included guidelines for Oslo protocol for transplantation for colorectal carcinoma to help in evaluating that aspect of eligibility.

Continued on page 3...

... Continued from page 2

Table 1. Revised Medical Policies, Continued

Policy Title (Number)	Revision Date: Summary of Change (applies ONLY to Commercial plan policy UNLESS summary text appears in BOLD)
Speech Therapy Guidelines (178), see page 61 in the Ear, Nose, & Throat booklet.	**10/18/2024**: Added the following exclusion: "Speech therapy for idiopathic delays in speech development for infants and children younger than 18 months of age is considered experimental/investigational because idiopathic delays in speech development cannot be reliably diagnosed or treated in the prelingual developmental stage."
Transcatheter Edge-to-Edge Repair (464), see page 51 in the Cardiovascular booklet.	**10/17/2024:** • Modified criterion #B-1 for Tricuspid Valve: "Select Health will cover tricuspid TEER with primary or secondary tricuspid regurgitation that is severe or greater." • Added coverage for CPT codes 0545T, 0569T, and 0570T, with criteria.
Tricuspid Valve Implantation (684), see page 97 in the Cardiovascular booklet.	**10/17/2024:** • Incorporated coverage criteria for both prior failed tricuspid valve implantation and native tricuspid valve: — "1. For prior failed tricuspid valve replacement, patients with severe symptomatic tricuspid regurgitation despite guideline directed medical therapy; or — 2. For native tricuspid valve, patients with primary or secondary tricuspid regurgitation that is moderate-to-severe or severe." • Added coverage for CPT code 0545T with criteria.

Table 2. Archived Policies

Policy Title (Number)	Revision Date: Summary of Change
Pediatric: Hypothermia for Treatment of Neonatal Hypoxic-Ischemic Encephalopathy (536)	**10/07/2024:** Archived policy; **CPT 99184** is covered without review.
Coding & Reimbursement: Insertion, Non-Biodegradable Drug Delivery Implant to Report Joint or Ophthalmologic Spacers or Prosthesis (71)	**10/03/2024:** Archived policy; this coding/ reimbursement policy is no longer valid or needed due to changes in coding guidelines **[Effective 10/03/24].**
Neurology/Neurosurgery: Treatments for Trigeminal Neuralgia (184)	**10/11/2024:** Archived policy; these claims are now reviewed with medical policy **Stereotactic Radiation Therapy (#336).**
Cardiovascular: Genetic Testing: Vectra DA Blood Test for Rheumatoid Arthritis (561)	**10/07/2024:** Archived policy; Avalon policy **Vectra DA Blood Test for Rheumatoid Arthritis (#AHS-G2127)** lists non-coverage of this test.

Select Health Coding Updates

Telehealth Place of Service (POS) 10 now reimbursed at the higher, non-facility rate.

The *Telehealth and Telemedicine Coding and Reimbursement Policy* has been recently updated. The biggest change is that **place of service (POS) 10** is now reimbursed at the non-facility rate, which is higher than the facility rate.

Telehealth/telemedicine services claims are required to be submitted with place of service 02 or 10. Effective **January 1, 2024**, telehealth services billed with the:

- **Place of service 02** will be reimbursed at the facility site of service differential and according to the Medicaid or Medicare fee schedules as appropriate.
- **Place of service 10** will be reimbursed at the non-facility site of service differential and according to the Medicaid or Medicare fee schedules as appropriate.

Modifiers 95, GT, GQ, G0, FQ, and FR can also be appended as appropriate but are not required if the correct place of service is used.

Learn more. Access the full Telehealth and Telemedicine policy.

NOTE: Telehealth coverage and reimbursement will vary by plan and geography based on certificates of coverage and state and federal regulations. Services are covered in accordance with the ***Select Health Telehealth and Telemedicine Coding and Reimbursement Policy***. Providers will be required to follow all state regulations related to state certifications and providing telehealth services to members outside of the state where the provider is licensed.

HEDIS Measures (Claims Coding): Controlling Blood Pressure (CBP) and Blood Pressure Control in People with Diabetes (BPD)

Each year Select Health participates in the HEDIS audit with some HEDIS measures also impacting our STARS rating. CBP and BPD are two of these measures.

In our efforts to improve the rating of these measures along with the health of our members, we are looking to simplify the way we collect information for us and for clinics to comply with this measure.

CBP and BPD measures require nurse reviewers from Select Health to request and review patient charts to abstract blood pressure readings. This is time-consuming for reviewers and requires clinics to take time to provide access to the required charts.

HOW HAS THIS WORKED IN THE PAST?

In the past, we have used many ways to request patient charts, including direct access to clinic EMRs, asking clinics to pull and send charts, and having our reviewers come to the clinic to gather needed charts. This current process requires a great deal of time for clinic staff as well as Select Health nurse reviewers.

HOW CAN WE SIMPLIFY THIS PROCESS?

When a claim is submitted with CPT II codes for blood pressure, there is no need for either the clinic to send a chart or for the Select Health nurse auditor to review the chart. The CPT II codes are captured administratively, and no further action is needed. This applies to both **claim-captured** and **patient-reported** blood pressure readings.

Please submit CPT II codes (see Table 3 on the following page) for both types of readings.

Continued on page 5...

... Continued from page 4

HOW CAN YOU HELP?

Implement this change: If your clinic is not already submitting CPT II codes for blood pressure readings, please consider implementing this change to decrease workload for clinics and for Select Health.

Share with your vendor: If your clinic works with a vendor to do claims coding, please share this message with them and ask that they use the CPT II codes in **Table 3** at right when submitting claims.

This change in workflow will allow us to target education and resources to those members most in need.

Questions? Contact Kirstin Johnson at **801-442-8224** or via email at: kirstin.johnson@selecthealth.org.

Table 3. Claims Coding for Blood Pressure

CPT II Code	Blood Pressure Reading
Systolic	
3074F	Less than 130
3075F	130–139
3077F	Equal to or greater than 140
Diastolic	
3078F	Less than 80
3079F	80–89
3080F	Equal to or greater than 90

Coding for HEDIS Measure Glycemic Status Assessment for Patients with Diabetes (GSD)

The National Committee for Quality Assurance (NCQA) revised the name of the HEDIS measure **Hemoglobin A1c Control for Patients With Diabetes (HBD)** to **Glycemic Status Assessment for Patients With Diabetes (GSD)** starting in 2024.

This change was made to reflect the addition of a glucose management indicator (GMI). The GMI is calculated based on continuous glucose monitoring (CGM) data using average glucose levels.

Key coding updates for this measure:

- **LOINC code 97506-0** is used to identify GMI values.
- Remember to include **CPT II HbA1c codes** to help reduce the burden of HEDIS medical record chart review. Use these codes on the date of service the HbA1c was drawn. (See **Table 4** at right).

If using an EMR system, please consider electronic data sharing with Select Health to help us capture the glycemic status values. This will help reduce HEDIS chart requests and improve the quality of care we are able to provide our members. If interested, please email us at qualityimprovement@selecthealth.org.

Questions? Please contact Stacey Merrill, Select Health Quality Consultant RN at stacey.merrill@selecthealth.org.

Table 4. GSD Claims Coding

CPT II Codes	HbA1c Test Result
3044F	Hemoglobin A1c level less than 7.0%
3051F	Hemoglobin A1c level greater than or equal to 7% and less than 8.0%
3052F	Hemoglobin A1c level greater than or equal to 8.0% and less than or equal to 9.0%
3046F	Hemoglobin A1c level greater than 9.0%

Coding for HEDIS Measure: Appropriate Imaging for Low Back Pain (LBP)

This HEDIS measure is important for primary care providers (PCPs) as well as urgent care, orthopedics, and pain and spine providers. Use imaging only when needed to help keep healthcare costs down and use our resources wisely.

Tables 5 and 6 (below) provide ICD-10-CM codes that either **trigger** members into or **remove** members from the HEDIS LBP measure. These lists are not all-inclusive. This information is **NOT** about a change in policy but a reference to quality improvement activities.

Table 5. Common ICD-10-CM Codes that TRIGGER members into the HEDIS Measure

ICD-10 Code	Description
M47.816	Spondylosis without myelopathy or radiculopathy lumbar region
M54.16, M54.17	Radiculopathy, lumbar region
M54.30 - M54.32 **M54.40 – M54.42**	Sciatica Lumbago with Sciatica
M99.03, M99.04	Segmental & Somatic Dysfunction of lumbar region/sacral region
M99.83	Other Biomechanical Lesions of Lumbar Region
S33.5XXA, **S33.6XXA**	Sprain of ligaments of lumbar spine Sprain of sacroiliac joint,
S39.012A (D,S)	Strain of muscle, fascia, & tendon of lower back
S39.92XS	Unspecified Injury of lower back, sequela
NOTE: This is a list of commonly used codes. Other codes not listed here related to low back pain may trigger member to qualify for the HEDIS measures.	

Table 6. ICD-10 Codes that will REMOVE the member from the LBP HEDIS Measure (If imaging is done within 28 days of the diagnosis for medical necessity)

ICD-10 Code	Description	ICD-10 Code	Description
G89.11	Acute pain due to trauma	**M45.6**	Spondylopathy lumbar region
B20; Z21	HIV	**R26.2**	Difficulty in walking, not elsewhere classified
CPT & ICD PCS Codes (as applicable)	Lumbar Surgery	**G83.4**	Cauda equina syndrome
R29.2	Abnormal Reflex	**M46.36**	Infection of intervertebral disc (pyogenic), lumbar region
M46.46	Discitis, unspecified, lumbar region	**Z85.9**	Personal history of malignant neoplasm, unspecified (ANY CANCER)
A17.81; G06.1; M46.25 – M46.28	Spinal Infection; Osteomyelitis; discitis	**Z85.3**	Personal history of malignant neoplasm of breast
Z86.03	Personal history of neoplasm of uncertain behavior (ANY CANCER)	**Z85.45**	Personal history of malignant neoplasm of unspecified male genital organ (prostate, testicular, etc.)
Z85.40	Personal history of malignant neoplasm of unspecified female genital organ (cervix, uterus, ovary, etc)	**Z94.0**	History of Kidney Transplant
Z85.820	Personal history of malignant melanoma of skin		

Select Health

© 2024 Select Health. All rights reserved. 2988402 10/24