February 2026: 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 the following pages. Coding and reimbursement 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 **4 new policies** this month (see **Table 1** below) and **10 revised medical policies** (see **Table 2** on page 2). Additionally, a new medical policy for **Non-coverage of Low-Dose Radiation Therapy for Osteoarthritis (700)** will be published and effective on **April 2, 2026**. There are **no archived policies this month**.

Policies listed in the tables below are arranged alphabetically by title, with a link to the online specialty-based book and page number where the policy can be found (or to the policy itself if coding/reimbursement). Policies are also available on the Select Health website.

Table 1. New Policies

Policy Title (Number)	Revision Date: Summary of Change (applies ONLY to Commercial plan policy UNLESS summary text appears in BOLD)
CODING/REIMBURSEMENT POLICY Breast Cancer Screening Requirements When Additional Follow-Up is Needed (CR-102)	**01/01/2026**: Created and published this new coding/reimbursement policy.
CODING/REIMBURSEMENT POLICY Disposable Endoscope (CR-104)	**01/01/2026**: Created and published this new coding/reimbursement policy.
MEDICAL POLICY **Genetic Testing: Monogenic Diabetes (699)**, see page 169 in the **Genetic Testing booklet.**	**01/23/2026**: Created and published this new medical policy
CODING/REIMBURSEMENT POLICY Insertable Retrieval Device (CR-103)	**01/01/2026**: Created and published this new coding/reimbursement policy.

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Table 2. Revised Medical Policies

Policy Title (Number)	Revision Date: Summary of Change (applies ONLY to Commercial plan policy UNLESS summary text appears in BOLD)
Acute Inpatient Rehabilitation (443), see page 3 in the **Physical Medicine booklet**.	**02/11/2026**: Removed portion of requirement pertaining to stroke in criterion #1-a: "Rehabilitation therapy must begin within 60 days from the onset of the stroke."
Genetic Testing for Prostate Cancer Prognosis (544), see page 28 in the **Genetic Testing booklet**.	**02/06/2026**: • Removed exclusion of the ArteraAI test and included this with other similar tests as qualifying for coverage when criteria are met. • Added exclusion of Decipher Prostate Metastatic Genomic Classifier test.
Genetic Testing: Hereditary Peripheral Neuropathy (134), see page 76 in the **Genetic Testing booklet**.	**02/19/2026**: Modified requirements in criteria section #3 header: "Select Health covers panel testing for an inherited peripheral neuropathy, which must include at least 5 of the following genes: PMP22, GJB1, MFN2, BSCL2, MPZ, REEP1, SPAST, SPG11, SPTLC1 and TTR, when the following criteria are met: ..."
Hyperbaric Oxygen Therapy (HBO2/HBOT) (129), see page 21 in the **Pulmonary booklet**.	**02/04/2026**: Modified treatment allowances in section on "Radionecrosis, soft tissue" to be: "40 treatments; up to an additional 20 treatments may be indicated, but requires MD review."
Hysterectomy/Oophorectomy (620), see page 12 in the **Obstetrics/Gynecology booklet**.	**02/04/2026**: Modified requirements in criterion #F-v (a–d) for clarification.
Infusion Pumps (External or Implantable) (609), see page 59 in the **Physical Medicine booklet**.	**02/19/2026**: Added the following clarification to criteria #B-2: "For the management of chronic pain**, when the following criteria are met: a. Treatment decisions are managed by a certified, physician pain specialist b. More conservative methods have failed; including (1–4): 1) Over-the-counter drugs (e.g., NSAIDS). 2) Physical therapy: Minimum of 12 visits within a 6-week period; must have been performed within the previous year. (It is recommended that at least four of the visits be performed in-person.) 3) Psychological/behavioral therapies. 4) Pain interventions are either contraindicated or have failed. **Requirements outlined in criteria #2-b (1–4) do not apply to cancer patients."

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Table 2. Revised Medical Policies, continued

Policy Title (Number)	Revision Date: Summary of Change (applies ONLY to Commercial plan policy UNLESS summary text appears in BOLD)
Liver Transplant — Living Donor Liver Transplantation (143), see page 75 in the **General Surgery booklet.**	**02/16/2026**: Added qualifying factors for donors that may be considered for coverage to both criterion #B-1 ("The prospective donor is age > 18 and < 60 (selected patients over 60 years of age can be considered for donation)" and criterion #B-3d ("The prospective donor has a demonstrable, significant long-term relationship with the recipient [carefully selected Good Samaritan or non-directed donors are appropriate for donors].")
Office-Based Anesthesia (641), see page 2 in the **Anesthesia booklet.**	**02/16/2026**: • Added Anesthesia Assistant to list of eligible providers in criteria section #1: "Select Health covers Monitored Anesthesia Care (MAC), when administered by an Anesthesiologist, Anesthesia Assistant, or a Nurse Anesthetist." • Removed "restoration" from criterion #1-Aiv: "Lengthy restoration procedures for pediatric patients."
Small Bowel Transplant (640), see page 149 in the **General Surgery booklet.**	**02/19/2026**: Added new criterion #7 as a qualifying factor for coverage: "Non-reconstructable gastrointestinal tract."
Transcranial Magnetic Stimulation [TMS] for Psychiatric Disorders and Navigational Tool for Neurosurgery (241), see page 28 in the **Behavioral Health booklet**.	**01/20/2026**: Changed age requirement from "Patient is ≥ 18 years of age" to "Patient is ≥ 15 years of age" for qualification of TMS.

Select Health Coding Updates

USE CORRECT CODING FOR FASTER CLAIMS PAYMENT

To support accurate and timely claims payment, it is essential to follow correct coding practices. This includes:

- Selecting the appropriate modifiers
- Reporting the correct number of units
- Mapping each diagnosis code to the correct corresponding procedure code

The new editing system coming in 2026 will adhere to CMS requirements and established coding guidelines. Failure to comply with these standards may result in claim denials. By consistently applying these practices, we help ensure accurate claim processing and reduce the likelihood of denials or rework.

REMINDER: UPDATED GUIDELINES FOR VITAMIN D SERUM 25-HYDROXYVITAMIN D (25(OH)D) LABORATORY TESTS

Please be aware that the guidelines for **Vitamin D Serum 25-hydroxyvitamin D (25(OH)D) testing** and **Free Triiodothyronine (T3) testing** have recently been updated.

To ensure accurate billing and appropriate use of laboratory services, make sure to review the current medical policy guidelines related to these tests and other applicable laboratory services.

You can access the updated medical policies in the **Laboratory Utilization Policies booklet** on the Select Health website.

NEW CODING EDITING SYSTEM COMING IN Q2 2026

Select Health will be transitioning to a new system that will better align our editing processes with standard coding practices and Select Health policies, ultimately improving edit consistency and accuracy. The new platform is expected to launch early in the second quarter of 2026.

BILLING BEST PRACTICES FOR LABORATORY SERVICES

When billing for laboratory services, always ensure that you are selecting the most appropriate procedure code. Correct code selection supports accurate claims processing and helps prevent denials or payment delays.

Key Guideline:

When a **multianalyte test** is performed using a **single wet-lab procedure** and **no specific panel code** is available, the service should be billed using:

One (1) unit of CPT® 81479 (Unlisted molecular pathology procedure)

This approach ensures proper reporting when established panel codes do not exist for the performed testing.

For detailed guidance, refer to: **Coding and Reimbursement Policy: Diagnostic Laboratory and Genetic Test [#CR-100]**

Questions? Contact your Provider Relations representative.

Select Health