July 2025: 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; coding updates begin on page 6.**

Questions? Contact Marcus.Call@selecthealth.org for information on content of a medical policy, Brandi.Luna@selecthealth.org for questions about coding and reimbursement policies, or your Provider Relations representative for any other questions.

Select Health Policy Updates

This update includes **two new medical policies** (see **Table 1** below) and **13 revised medical policies** (see **Table 2** below and subsequent pages).

This month, there is only **one archived policy: Computed Tomography Colonography (CTC) Virtual Colonoscopy (399)**, which was archived on **07/21/2025** because applicable codes are already configured to be covered (CPTs **74261** and **74262**) or denied (CPT **74263**) without review.

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 Medical Policies

Policy Title (Number)	Revision Date: Summary of Change (applies ONLY to Commercial plan policy unless summary text appears in BOLD)
Myoelectric Limb Prostheses (695), see page 110 in the **Orthopedic booklet**.	**06/26/2025**: Covered with criteria.
Intrauterine Fetal Surgery (696), see page 10 in the **Pediatric booklet**.	**06/26/2025**: Covered with criteria.

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)
Applied Behavior Analysis (ABA) (630), see page 2 in the **Behavioral Health booklet**.	**07/01/2025**: Comprehensively updated criteria for coverage and included language regarding exceptions for members on FEHB plans.
Artificial Spinal Disc Replacement (243), see page 8 in the **Orthopedic booklet**.	**07/14/2025**: Modified contraindication #B in Lumbar Contraindications section to now read, "Severe lumbar spinal stenosis," instead of "Significant bony lumbar spinal stenosis."

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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)
Bone Growth Stimulators: Ultrasound (201), see page 2 in the **Durable Medical Equipment booklet**.	**07/10/2025**: Included scapular bones as part of bones excluded from this treatment: "Select Health covers ultrasound bone growth stimulators for traumatic fractures and surgical nonunions of all bones, excluding skull, vertebrae, and scapular …"
Cervical, Lumbar, and Thoracic Spinal Fusion with or without Spinal Decompression (622), see page 2 in the **Neurology/ Neurosurgery booklet**.	**06/23/2025**: Added language to clarify the type of procedure eligible for coverage described in criterion #7: "Pediatric scoliosis surgery, age ≤ 21, with progressive deformity with cobb angle > 50 degrees or rapidly progressive curve and > 40 degrees."
Chelation Therapy (296), see page 2 in the **Hematology/ Oncology booklet**.	**07/10/2025:** Added the following four conditions as qualifying options to coverage criteria: "8. Aceruloplasminemia (hereditary ceruloplasmin deficiency); 9. Biliary cirrhosis; 10. Diamond-Blackfan anemia; 11. Secondary hemochromatosis (i.e., due to iron overload from multiple transfusions including persons with IPSS Low- or Intermediate-1-risk myelodysplastic syndrome.)"
Cognitive Rehabilitation (405), see page 19 in the **Physical Medicine booklet**.	**06/16/2025**: Changed qualifying condition for this therapy of traumatic brain injury (TBI) to acquired brain injury (ABI), which allows inclusion of non-traumatic brain injuries as well.
Diagnostic and Therapeutic Interventions for Spinal Pain (626), see page 34 in the **Physical Medicine booklet**.	**07/17/2025**: Modified formatting of overall coverage criteria, and updated requirements in section C. "C. THERAPEUTIC FACET JOINT CRITERIA (CHRONIC PAIN) 1. Select Health covers the first therapeutic steroid facet joint injections when ALL the following criteria are met: a) The above criteria in section A (1–5) have been initially met; and b) The patient has had two diagnostic anesthetic facet joint injections (without steroids) at the same level(s); and c) The medical record confirms each diagnostic injection provided ≥ 80% pain relief (with the duration of relief being consistent with the agent used); and d) Documentation explains why radiofrequency neurotomy is not a treatment option (such as established spinal pseudarthrosis or implanted electrical device). *Continued on page 3…*

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)
Diagnostic and Therapeutic Interventions for Spinal Pain, CONTINUED	2. Subsequent therapeutic steroid facet joint injections performed at the same level(s) are covered when ALL the following criteria are met: a) The medical record confirms the previous therapeutic steroid facet joint injections resulted in ≥ 50% reduction of facet-related pain OR improvement in ability to perform previously painful movements or ADLs; and b The benefit lasted for at least 3 months; and c) Documentation explains why radiofrequency neurotomy is not a treatment option (such as established spinal pseudarthrosis or implanted electrical device). A maximum of 4 therapeutic steroid facet joint injections is allowed per rolling 12 months."
Gene Expression Profiling: Cutaneous Melanomas (667), see page 9 of the Genetic Testing booklet.	**07/01/2025**: Clarified requirements pertaining to what would be considered high-risk for a T1a melanoma: "High-risk (HR) for T1a melanoma should include at least one of: 1. Mitotic rate ≥ 2/mm², OR 2. Age ≤ 55 years, OR 3. Presence of any of the following pathology features: - Ulceration - Lymphovascular or perineural invasion - Tumor regression - Transected/ base-cut specimen - Limited sampling of larger lesion."
Genetic Testing: Breast, Ovarian, Pancreatic, and Prostate Cancer (664), see page 56 in the **Genetic Testing booklet**.	**06/30/2025**: Updated minimum required genes necessary to qualify for panel testing for each cancer type in criterion #3: • "Breast cancer gene panels must include at a minimum: BRCA1, BRCA2, CDH1, PALB2, PEN, STK11, and TP53; • Ovarian cancer gene panels must include at a minimum: ATM, BRCA1, BRCA2, BRIP1, MLH1, MSH2, MSH6, EPCAM, PALB2, RAD51C, and RAD51D; • Prostate cancer gene panels must include at a minimum: ATM, BRCA1, BRCA2, CHEK2, HOXB13 and TP53; • Pancreatic cancer gene panels must include at a minimum: ATM, BRCA1, BRCA2, CDKN2A, MLH1, MSH2, MSH6, EPCAM, PALB2, STK11, and TP53."
Genetic Testing: Cell-Free Fetal DNA Testing (679), see page 70 in the **Genetic Testing booklet**.	**07/11/2025**: Added criteria for this testing including "Paternal carrier screening" and CPT **0489U** as an exclusion/not covered for this testing.

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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)
Hereditary Peripheral Neuropathy (134), see page 78 in the **Genetic Testing booklet**.	**07/11/2025**: • **Retitled policy as "Genetic Testing: Inherited Peripheral Neuropathy" (was previously titled as, "Genetic Testing: Charcot-Marie-Tooth Syndrome (Hereditary Motor Sensory Neuropathy)";** • **Revised policy to include coverage criteria for this testing.**
Hypoglossal Neurostimulation (Inspire Upper Airway Stimulation) (608), see page 32 in the **Pulmonary booklet**.	**06/23/2025**: Modified requirements in both criterion #A-5 and #B-6: "Documentation which demonstrates CPAP failure (defined as AHI greater than 15 despite CPAP usage) or CPAP intolerance (defined as less than 4 hours per night, 5 nights per week); or documentation supports non-compliance for at least 6 months."
Hysterectomy/Oophorectomy (620), see page 12 in the **Obstetrics/Gynecology booklet**.	**07/07/2025**: Clarified requirements in criteria section #I-H: "Endometriosis by laparoscopy with uterine involvement, and has failed any of the following therapies for > 12 weeks within the last 5 years: i. GnRH (Gonadotropin-releasing hormone) agonist; or ii. GnRH antagonist; or iii. Danocrine (Danazol); or iv. LNG-IUS (Levonorgestrel-containing Intrauterine system); or v. Hormone therapy."
Oral Appliances for Sleep Apnea (492), see page 32 in the **Durable Medical Equipment booklet**.	**07/03/2025**: clarified requirements pertaining to definition of a qualified sleep specialist: "The physician performing the test is a diplomat of the American Board of Sleep Medicine (ABSM) or is sleep medicine certified through one of the following: • American Board of Internal Medicine (ABIM) • American Board of Family Medicine (ABFM) • American Board of Pediatrics (ABP) • American Board of Psychiatry and Neurology (ABPN) • American Board of Otolaryngology – Head and Neck Surgery (ABOHNS) • American Osteopathic Board of Neurology and Psychiatry (AOBNP) • American Osteopathic Board of Family Medicine, (AOBFP) • American Osteopathic Board of Internal Medicine, (AOBIM) • American Osteopathic Board of Ophthalmology and Otorhinolaryngology (AOBOO) • American Board of Anesthesia (ABA) [ABA certification not recognized by CMS]"

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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)
Posterior Tibial Nerve Stimulation (PTNS) (473), see page 18 in the **Genitourinary booklet**.	**06/24/2025:** • Modified requirements in section B (Treatment Limitations): "1. Initial PTNS treatments are covered weekly for 12 weeks. The patient must show a 50% improvement of OAB symptoms for treatment to be covered for every one to two months for the remainder of one year. 2. Continued treatment after the initial 12 months is not covered unless it has been 24 months since the completion of the initial PTNS treatment, and the patient has returning symptoms of OAB. In these instances, a new PTNS trial (weekly for 12 weeks) is required." • Moved previous criterion #B-4 to section C (Exclusions) under the header "Contraindications."
Radiation Therapy for Basal and Squamous Cell Carcinoma (661), see page 52 in the **Dermatology Booklet**.	**07/14/2025:** • Revised to include coverage criteria for these procedures; • Added the following exclusions: "Select Health does not cover use of high-resolution ultrasound to guide SRT delivery and to assess lesion reduction during the superficial radiation treatment protocol as this is not supported by literature (this meets the plan's definition of experimental/ investigational). • Select Health does not cover superficial radiation therapy for keloids as it is considered not medically necessary."
Sleep Disorder Evaluation and Treatment (625), see page 50 in the **Pulmonary booklet**.	06/30/2025: Clarified requirements pertaining to definition of a qualified sleep specialist: "The physician performing the test is a diplomat of the American Board of Sleep Medicine (ABSM) or is sleep medicine certified through one of the following: • American Board of Internal Medicine (ABIM) • American Board of Family Medicine (ABFM) • American Board of Pediatrics (ABP) • American Board of Psychiatry and Neurology (ABPN) • American Board of Otolaryngology – Head and Neck Surgery (ABOHNS) • American Osteopathic Board of Neurology and Psychiatry (AOBNP) • American Osteopathic Board of Family Medicine, (AOBFP) • American Osteopathic Board of Internal Medicine, (AOBIM) • American Osteopathic Board of Ophthalmology and Otorhinolaryngology (AOBOO) • American Board of Anesthesia (ABA) [ABA certification not recognized by CMS]"

Select Health Coding Updates (Quality Gap Closure)

The coding information in this section relates to closing gaps for specific HEDIS measures and does not necessarily reflect current covered codes for claims reimbursement.

Update to Statin Exclusion Coding

The Pharmacy Quality Alliance (PQA) has removed the ICD-10 code of T46.6X5A from the eligible rhabdomyolysis myopathy exclusions. Please refer to **Table 3** below for updated appropriate statin exclusions.

As a reminder, exclusion coding must be submitted in a claim **EACH** year for the patient to be removed from statin measures. Charting a statin intolerance in the EMR does not remove a member from the statin measures.

Use the list of required codes for qualifying statin exclusions; note that a statin allergy diagnosis **does not count** as an exclusion unless a claim for one of the listed codes is submitted.

Table 3. Qualifying Statin Exclusions to be Coded

Diagnosis	Applicable/Non-Applicable Codes
Cirrhosis	
Dialysis	
End-Stage Renal Disease (ESRD)	
Hospice Care	
In-Vitro Fertilization (IVF)	
Lactation	
Myalgia	NOT APPLICABLE: M79 codes for Medicare Diabetes
Myopathy	G72 codes
Myositis	M60 codes
Palliative Care	NOT APPLICABLE: For Medicare Diabetes
Prediabetes	R73.03, R73.09 codes for Medicare Diabetes only
Pregnancy	
Polycystic Ovary Syndrome (PCOS)	E28.2 codes for Medicare Diabetes only
Rhabdomyolysis	M62 codes

Eye Exam Documentation for Members with Diabetes

Diabetic retinopathy, a common complication of diabetes, underscores the importance of regular retinal eye examinations. These exams aid in early detection and timely intervention and are crucial for preventing vision loss. Given the prevalence of diabetes, primary care providers play a pivotal role in encouraging the importance of these exams and meticulous documentation of exam results.

The HEDIS measure, Diabetic Eye Exam (EED) addresses this need.

BEST PRACTICES & TIPS FOR MEETING THE DIABETIC EYE EXAM (EED) MEASURE:

- **Educate patients** on risk of diabetic eye disease and encourage annual retinal eye exams.
- **Use EMR alerts** to flag patients due for a retinal eye exam
- **Consider contacting patients** who haven't had a recent retinal eye exam
- **Document exam details** if a report isn't available - include date, eye care provider's name/type, and results (e.g., "Last retinal eye exam with John Smith, OD, was June 20XX – no retinopathy.")
- **Use fax-back forms** to collect exam results from optometrist/ophthalmologist. Download Select Health's **preferred communication form**.
- Remember that In-office retinal imaging (e.g., RetinaVue) is an option, **BUT images must be read by an optometrist or ophthalmologist**. (AI interpretation will count for 1 year only.)

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Coding Updates, Continued

EYE EXAM DOCUMENTATION AND CODING

Submit claims with either the correct procedural **OR** CPT II codes to reduce work for you and your office staff as indicated below:

- **For a primary care provider (PCP)** billing for retinal imaging performed in their office, USE:
  - Procedure codes **92227** or **92228** to close the gap of a diabetic eye exam without further action (counts for 1 year only).
  - CPT II result codes (e.g., **2023F**, **2025F**, **2033F**, etc.) if you document results from an eye specialist's examination (counts for up to 2 years, depending on the unspecified findings).
- **For an ophthalmologist or optometrist** billing, USE procedure code **92250**. (This code does not count when used by a PCP.)

WHY USE CPT II CODES (SEE TABLE 4 BELOW):

- Streamline administrative processes, which will decrease the need for record abstraction throughout the year.
- Provide more accurate medical data.
- Identify and close gaps in care more accurately and quickly.
- Improve patient outcomes.

Table 4. CPT II Codes for use by Primary Care Providers

CPT II Code	Definition
Eye Exam WITHOUT Evidence of Retinopathy (All options MUST be interpreted by an ophthalmologist or optometrist)	
2023F	Dilated retinal eye exam **without evidence of retinopathy**
2025F	Seven standard field stereoscopic retinal photos **without evidence of retinopathy (Retina Vue/ Aurora/Smartscope in office**)
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; **without evidence of retinopathy**
Eye Exam WITH Evidence of Retinopathy (All options MUST be interpreted by an ophthalmologist or optometrist)	
2022F	Dilated retinal eye exam **with evidence of retinopathy**
2024F	Seven standard field stereoscopic retinal photos **with evidence of retinopathy**
2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; **with evidence of retinopathy**

Questions? Contact Select Health Quality Consultant RN: Amber.Wray@selecthealth.org

Coding Updates, Continued

Controlling Blood Pressure (CBP)

Each year Select Health participates in the HEDIS audit with some HEDIS measures also impacting our STARS rating. **Controlling blood pressure (CBP**) is one of these measures.

In our efforts to improve the rating of this measure 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.

The CBP measure requires 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.

In the past, we requested patient charts by directly accessing clinic EMRs, asking clinics to pull and send charts, or having our reviewers come to the clinic to gather needed charts. That process required a great deal of time for clinic staff as well as Select Health nurse reviewers.

Now when a claim is submitted with CPT II codes for blood pressure, the codes are captured administratively, and no further action is needed. There is no need for either the clinic to send a chart or for the Select Health nurse auditor to review the chart.

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. It will also allow us to target education and resources to those members most in need.

Table 5 below indicates the CPT II codes that should be used when submitting claims.

Questions? Contact Kirstin Johnson at **801-442-8224** (**kirstin.johnson@selecthealth.org**) or Amber Naluai at **385-563-2992** (**amber.naluai@selecthealth.org**).

Table 5. Claims Coding for Blood Pressure

CPT 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