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Administrative Bulletin

2025–05-002 Medicare Only

Date: May 1, 2025

Topics covered in this Administrative Bulletin are applicable to:

Professional and Facility Providers

- Annual Review and Updates to Prime Therapeutics™ Guidelines.
- Medically Unlikely Edits (MUE) – Enhancement for Medicare Advantage Claims.
- Single Source Preauthorization List Updates – Medicare Advantage.

Professional Providers Only

- Quarterly Medicare Risk Adjustment Article " Myocardial Infarction (MI) Documentation Tips for Providers" Available Online.

Unless otherwise noted, if you have any questions regarding the information in this bulletin, please contact your Provider Engagement Consultant or visit capbluecross.com/wps/portal/cap/provider/pec-look-up and enter your NPI or Tax ID to identify your designated point of contact at Capital Blue Cross.

Professional and Facility Providers

Annual Review and Updates to Prime Therapeutics™ Guidelines

☐ CHIP	☐ EPO	☐ FEP PPO	☐ HMO	☒ Medicare Advantage HMO
☐ POS	☐ PPO	☐ Traditional and Comprehensive		☒ Medicare Advantage PPO

☒ New Information ☐ Updated Information ☐ Reminder

KEY POINT: Please review updates to Capital Blue Cross' clinical guidelines made by our vendor, Prime Therapeutics, during their annual review.

Providers are advised to share with office staff the changes made to the vendor's clinical guidelines and how this may affect requests for authorization for services **effective July 1, 2025**.

PRIME THERAPEUTICS (MEDICARE) Approved Clinical Guidelines, effective 7/1/2025		
Policy #	**Policy Name**	**Highlights**
PartB ST CBC AR0223	Step Therapy Requirements for Outpatient (Part B) Medications	New category added: • Respiratory Tract Agents, J2786 Cinqair now managed through step therapy. New codes added to existing categories:

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		• Q5146 (Antineoplastics), Q5148 (Colony Stimulating Factors), Q5151 (Compiment Inhibitors), Q5152 (Compliment Inhibitors)

Medically Unlikely Edits (MUE) – Enhancement for Medicare Advantage Claims

☐ CHIP ☐ EPO ☐ FEP PPO ☐ HMO ☒ Medicare Advantage HMO
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KEY POINT: Effective June 1, 2025, Capital Blue Cross is enhancing our claims system to better handle claim lines that exceed the MUE limits. This change will align Medicare Advantage with the current commercial claim procedures, which allows claim lines with excessive MUE units to be reported on two lines.

Capital will enhance the Medically Unlikely Edit (MUE) to address when the units of service reported on the same service date exceed the MUE value by allowing the service to be reported on two separate lines.

With this change, units of service ***up to*** the MUE value are reported on one line. **It is critical the units up to the MUE are reported on a line before the excess units.** Units of service ***over*** the MUE value are reported on the subsequent line. This is to allow the units of service *up to* the MUE value to be considered eligible for payment.

NOTE: If all units are submitted on **one line**, the entire line will continue to deny. Please see the examples below:

Correct
- Line 1 – Procedure 86317, 6 units (MUE is 6)
- Line 2 – Procedure 86317, 2 units (excess units will deny)

Incorrect
- Line 1 – Procedure 86317, 8 units (will deny all units)

Incorrect
- Line 1 – Procedure 86317, 2 units
- Line 2 – Procedure 86317, 6 units (will deny)

Other Important Considerations: **Bilateral procedures** that are performed at the same session should be billed on one line with **modifier 50** and one unit with the full charge for both procedures. Bilateral procedures broken out and reported on two lines may exceed the per-day MUE limit, and the edit will prevent payment. Please see examples below.

Correct

- Procedure 19303 50 modifier, 1 unit

Incorrect

- Procedure 19303 LT modifier, 1 unit
- Procedure 19303 RT modifier, 1 unit

Single Source Preauthorization List Updates – Medicare Advantage

☐ CHIP ☐ EPO ☐ FEP PPO ☐ HMO ☒ Medicare Advantage HMO
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KEY POINT: Updates to the Single Source preauthorization list will occur as described below.

Effective July 1, 2025, the following procedure codes *will* require preauthorization for Medicare Advantage.

Code	Description
J0870	Rytelo, will require preauthorization.
J9024	Tecentriq Hybreza, will require preauthorization.
J9026	Imdelltra, will require preauthorization.
J9028	Anktiva, will require preauthorization.
J9161	Lymphir, will require preauthorization.
Q9997	Pyzchiva, will require preauthorization.
Q9998	Selarsdi, will require preauthorization.
Q9999	Otulfi, will require preauthorization.
J1552	Alyglo, will require preauthorization.
J1307	Piasky, will require preauthorization.

Code	Description
J2351	Ocrevus Zunovo, will require preauthorization.
Q5146	Hercessi, will require preauthorization.
Q5148	Nypozi, will require preauthorization.
Q5151	Epysqli, will require preauthorization.
Q5152	Bkemv, will require preauthorization.

Note: *Commercial preauthorization remains unchanged. Preauthorization is required.*

Effective July 1, 2025, the following procedure codes will *not* require preauthorization for Medicare Advantage.

Code	Description
J9037	Blenrep, removed from market, removed from Single Source list.

Note: *Commercial remains unchanged, preauthorization is not required.*

Reminder: Codes that require preauthorization are maintained on the Capital Blue Cross Single Source Preauthorization list. A link to the Single Source Preauthorization list is located in the Preauthorization and policies section of the Provider Library and on the “Resources” tab on the Capital Blue Cross Payer Space page of our provider web portal.

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Professional Providers Only

Quarterly Medicare Risk Adjustment Article " Myocardial Infarction (MI) Documentation Tips for Providers" Available Online

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KEY POINT: Accurate medical coding ensures proper payment and reduces denials, improves patient care, minimizes fraud and abuse, and ensures compliance with regulations. Capital Blue Cross has created Myocardial Infarction (MI) Documentation Tips for Providers to help you properly code this chronic condition.

Accurate coding and documentation play a crucial role in reflecting a patient's true health status and capturing complex health conditions. Clear, complete, and specific clinical documentation is the catalyst for coding, billing, and auditing. It also provides evidence of the quality and continuity of care you provide to your patients.

Each quarter we will provide tips to assist with support for the documentation accuracy of diagnosis codes reported for billing, payment, and quality measure purposes.

AVAILABLE NOW: The latest risk adjustment provider tips titled **"Myocardial Infarction (MI) Provider Tips**" are attached to this bulletin and are available online in the Provider Library accessed via the provider web portal in the "Education and Manuals" section under "Quick Reference Guides".

Myocardial Infarction (MI)

Documentation Tips for Providers

Subjective

- Document any patient-reported symptoms such as chest pain, shortness of breath, fatigue, etc.
- Include symptom descriptors: onset, duration, quality, severity, and location.
- Note any recent cardiac-related events or history of MI.

Objective

- Document relevant vital signs, physical exam findings, and cardiac assessments.
- Include diagnostics such as EKG results, troponins, echocardiogram, and imaging.

Final assessment/impression

- Clearly document the type (Type 1, Type 2, Type 3, 4, 5, or unspecified; STEMI; NSTEMI), status (acute, subsequent, old) location (e.g., anterior wall, inferior wall), and date of onset. Include any MI-related conditions such as post-MI angina, heart failure, or arrhythmia.

Plan

- Detail treatment plan: medications, referrals, diagnostics, monitoring, or hospital admission or transfer.
- If no current treatment, state whether the MI is healed or resolved.

Common Documentation Pitfalls

- Using vague terms like “chest pain” and “cardiac event” without specifying MI or diagnosis.
- Failing to document the type or date of onset of the MI.
- Not stating whether the MI is resolved, ongoing, or under active treatment.
- Omitting documentation updates when the MI transitions from acute to aftercare.

Coding tips

- Acute MI (≤ 4 weeks from onset)
    - Applies to initial and follow-up care within 28 days or less from MI onset.
- STEMI Type 1 → I21.0-I21.3
    - Assign code based on affected portion(s) of heart (e.g., main coronary artery, right coronary artery).
- NSTEMI (Non-ST-Elevation MI)
    - NSTEMI Type 1 (atherothrombotic origin) → I21.4
        - If a NSTEMI evolves into a STEMI during the same encounter, assign the appropriate STEMI code (I21.0-I21.3)
    - NSTEMI Type 2 (MI due to demand ischemia or secondary to ischemic imbalance) → I21.A1
        - Document clearly when MI is due to supply/demand mismatch (e.g., tachycardia, sepsis, hypoxia).
- Subsequent MI (within 4 weeks of initial MI)
    - I22.- category – only if both the initial and subsequent MIs are Type 1 or unspecified
    - If subsequent MI is a different type:
        - Type 2 → I21.A1
        - Type 3, 4, or 5 → I21.A9
- After 4 Weeks:
    - If history of acute MI and outside of the 4-week period I25.2 Old myocardial infarction would be coded.

Resources

1. ICD-10-CM Official Coding Guidelines FY 2025
2. ICD-10 | CMS

ICD-10 Code	Description
I2101	ST elevation (STEMI) myocardial infarction involving left main coronary artery
I2102	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
I2109	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
I2111	ST elevation (STEMI) myocardial infarction involving right coronary artery
I2119	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
I2121	ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery
I2129	ST elevation (STEMI) myocardial infarction involving other sites
I213	ST elevation (STEMI) myocardial infarction of unspecified site
I214	Non-ST elevation (NSTEMI) myocardial infarction
I219	Acute myocardial infarction, unspecified
I21A1	Myocardial infarction type 2
I21A9	Other myocardial infarction type
I21B	Myocardial infarction with coronary microvascular dysfunction
I220	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
I221	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
I222	Subsequent non-ST elevation (NSTEMI) myocardial infarction
I228	Subsequent ST elevation (STEMI) myocardial infarction of other sites
I229	Subsequent ST elevation (STEMI) myocardial infarction of unspecified site

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