
ADMINISTRATIVE BULLETIN: 2022–06–001

Date: June 1, 2022

Effective Date: August 1, 2022 *(Unless otherwise indicated)*

Administrative Bulletins supplement and amend the Provider Manual and provider contract. They communicate contractual changes to provider processes.

Topics covered in this Administrative Bulletin are applicable to:

Professional and Facility Providers

- [Notification of New and Revised Medical Policies and Preauthorization Requirements](#)
- [InterQual® Criteria Updated for 2022](#)
- [Medically Unlikely Edit Enhancement](#)
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- [Preventive Services Health Coverage Guidance related to Screening for Alcohol Use](#)

Facility Providers Only

- [Notification of Changes to CMS Regulations and Policy for Dialysis Providers](#)

Professional and Facility Providers

Notification of New and Revised Medical Policies and Preauthorization Requirements

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|---|---|--|
| <input checked="" type="checkbox"/> Traditional and Comprehensive | <input checked="" type="checkbox"/> POS | <input checked="" type="checkbox"/> Medicare Advantage PPO |
| <input checked="" type="checkbox"/> HMO | <input checked="" type="checkbox"/> PPO | <input checked="" type="checkbox"/> Medicare Advantage HMO |

Capital Blue Cross has updated Medical Policies as outlined below. Full details on these policy changes are available for review via the Draft Medical Policies page in the Provider Library. Although highlights are noted, please refer to the draft policies for updated criteria and related coding.

From the “Preauthorization and policies” section of the Provider Library, click the “Draft policies” link under the “Medical policies” heading.

To access medical injectable policies, click on “Medical injectable provider notifications” under the “Medical policies” heading.

Codes requiring preauthorization are maintained in the Capital Blue Cross Single Source Preauthorization list. A link to the Single Source Preauthorization list is located under “Referrals and Authorization” and on the “Resources” tab on the Capital Blue Cross Payer Space page of our provider web portal.

RETAIN A COPY OF THIS ADMINISTRATIVE BULLETIN WITH YOUR PROVIDER MANUAL

Healthcare benefit programs issued or administered by Capital Blue Cross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company®, and Keystone Health Plan® Central. Independent licensees of the Blue Cross Blue Shield Association serving 21 counties in Central Pennsylvania and the Lehigh Valley. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

| Abbreviation Key: E/I – experimental/investigational; INV – investigational; MA – Medicare Advantage; MN – medically necessary; NMN – not medically necessary; PA – preauthorization | | | | |
|--|----------|---------|----------------|---|
| Policy Name | Policy # | Action | Effective Date | Highlights |
| Ablation of Peripheral Nerves to Treat Pain | 2.376 | Revised | 7/1/2022 | <ul style="list-style-type: none"> Radiofrequency ablation of peripheral nerves to treat pain associated with knee osteoarthritis is MN if certain criteria are met. |
| Augmentation Mammoplasty | 1.002 | Revised | 7/1/2022 | <ul style="list-style-type: none"> Expanded unilateral breast hypoplasia criteria to include abnormalities of the chest wall with more examples. Added statement: “The use of adipose-derived stem cells, alone or in conjunction with autologous fat grafting for reconstructive breast surgery, is considered INV as there is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.” |
| Cosmetic and Reconstructive Surgery | 1.004 | Revised | 7/1/2022 | <ul style="list-style-type: none"> Procedure codes 15782, 15877, 30400, 30460, 30462, and 30520 will no longer require PA for MA. |
| Drug Infusion Site of Service | 3.016 | Revised | 7/1/2022 | <ul style="list-style-type: none"> Removed GamaSTAN® (J1460, J1560). |
| Endometrial Ablation | 7.013 | Revised | 7/1/2022 | <ul style="list-style-type: none"> Changed from INV to NMN for postmenopausal members. Language updated to include transgender and non-binary members. |
| General Approach to Genetic Testing | 2.326 | Revised | 8/1/2022 | <ul style="list-style-type: none"> Moved “at-home” testing statement from policy guidelines into a policy statement. Procedure codes 81200, 81205, 81206, 81207, 81162, 81220, 81229, 81243, 81270, 81292, 81329, 81401, 81405, 81406, 81408, 0287U, 0289U will no longer require PA for MA. |

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| Policy Name | Policy # | Action | Effective Date | Highlights |
| Genetic Testing for FLT3, NPM1, and CEBPA Variants in Cytogenetically Normal Acute Myeloid Leukemia | 2.357 | Revised | 8/1/2022 | <ul style="list-style-type: none"> Added FLT3-TKD testing as MN. Procedure codes 81218, 81245, and 81310 will no longer require PA for MA. |
| Hyperbaric Oxygen Pressurization (HBO) | 2.070 | Revised | 8/1/2022 | <ul style="list-style-type: none"> Added actinomycosis, burns, and intracranial abscess to the list of MN indications (as well as related ICD-10 codes). Added "where there is recent trauma coupled with persistent ischemia to the traumatized tissue" to traumatic ischemia indication and frostbite as example. |
| Iron Replacement Products Including Ferumoxytol (Feraheme®) and Ferric Carboxymaltose Injection (Injectafer®) | 2.146 | Revised | 7/1/2022 | <ul style="list-style-type: none"> Indications for Injectafer® now include pediatric patients one year of age and older. |
| Total Parenteral Nutrition to Parenteral Nutrition throughout the policy | 3.008 | Revised | 8/1/2022 | <ul style="list-style-type: none"> Change in title – formerly "Parenteral Home Infusion Therapy (Including Total Parenteral Nutrition)." Added criteria that Parenteral Nutrition is not to be used based solely on the medical diagnosis and enteral nutrition should be considered first. Removed mention of surgery, burns, and multiple injuries from prolonged paralytic ileus criteria. Added pancreatitis and hyperemesis gravidarum to the list of clinical situations where enteral nutrition may not be an option. |

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| Policy Name | Policy # | Action | Effective Date | Highlights |
| Total Parenteral Nutrition to Parenteral Nutrition throughout the policy (continued) | 3.008 | Revised | 8/1/2022 | <ul style="list-style-type: none"> Added information regarding ongoing evaluation of GI function, nutritional status, and growth for pediatric patients to determine the continuation of Parenteral Nutrition. Changed criteria requiring < 30% PO intake to 50% or more of requirements for energy, protein, and micronutrients or when impaired gastrointestinal function precludes 100% absorption of nutrient needs. Added end of life criteria. Removed home infusion services section. |
| Percutaneous Left-Atrial Appendage Closure Device for Stroke Prevention in Atrial Fibrillation | 1.127 | Revised | 7/1/2022 | <ul style="list-style-type: none"> Added surgical closure of the left atrial appendage as MN with criteria. |
| Procedures of Questionable Current Usefulness | 4.009 | Revised | 7/1/2022 | <ul style="list-style-type: none"> Added Pulsed Irrigation and Evacuation Systems from E/I to NMN. |
| Recombinant and Autologous Platelet-Derived Growth Factors as Treatment of Wound Healing and Other Non-Orthopedic Conditions | 2.033 | Revised | 7/1/2022 | <ul style="list-style-type: none"> Policy remains unchanged; however, the specific criteria moved from the policy guidelines to the policy statement. |
| Retinal Telescreening for Diabetic Retinopathy and Intraocular Photography | 2.086 | Revised | 7/1/2022 | <ul style="list-style-type: none"> Change in title – formerly “Retinal Telescreening for Diabetic Retinopathy.” Added Intraocular Photography as MN. Added retinopathy screening in individuals treated with chloroquine and hydroxychloroquine as NMN. |

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| Policy Name | Policy # | Action | Effective Date | Highlights |
|---|----------|---------|----------------|--|
| Surgical Treatment of Snoring and Obstructive Sleep Apnea | 1.128 | Revised | 7/1/2022 | <ul style="list-style-type: none"> 42975 changed from INV to MN |

Medical Specialty Injectable Policies Updates

Beginning May 1, 2022, Capital Blue Cross is updating medical specialty policies (Commercial Only) to be more medication-specific. There will be changes in the appearance and formatting of the policies as well as updated clinical criteria.

If preauthorization is required, submit your request via the online portal, per your usual process.

For further details on Medical Injectable policies (Commercial Only), please follow these instructions:

- Log in to our provider web portal via Availity Essentials ([availity.com/provider-portal](https://www.availity.com/provider-portal)).
- Click on Payer Spaces and select Capital Blue Cross.
- Click on the “Resources” tab.
- Select “Provider Library.”
- Click on “Preauthorization and policies.”
- Select “Medical Injectable Provider Notifications” under the “Medical policies” heading.

| Policy Name | Action | Effective Date | Highlights |
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| Colony Stimulating Factors policy | Retirement | 7/1/2022 | |
| Adopting three medication-specific Colony Stimulating Factors policies: 1) Pegfilgrastim 2) Filgrastim 3) Leukine® | Replacing Colony Stimulating Factors policy | 7/1/2022 | <ul style="list-style-type: none"> Releuko® (Filgrastim) (C9096) will require preauthorization. |

InterQual® Criteria Updated for 2022

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| <input checked="" type="checkbox"/> Traditional and Comprehensive | <input checked="" type="checkbox"/> POS | <input checked="" type="checkbox"/> Medicare Advantage PPO |
| <input checked="" type="checkbox"/> HMO | <input checked="" type="checkbox"/> PPO | <input checked="" type="checkbox"/> Medicare Advantage HMO |

Capital Blue Cross uses InterQual® criteria for many of its medical reviews. **Effective August 1, 2022**, in all areas for which we currently use InterQual 2021, Capital Blue Cross will transition to the utilization of InterQual 2022.

Medically Unlikely Edit Enhancement

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Effective August 1, 2022, Capital Blue Cross will enhance the Medically Unlikely Edits (MUE) applied to professional and facility claims. These changes will align with the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy.

An MUE for a Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) is the maximum units of service allowable by the same provider for the same patient on the same date of service. MUEs are applied at both the line level and the claim level as follows:

There are three MUE adjudication indicators (MAI) applied to CPT/HCPCS codes.

MUEs for HCPCS codes with an MAI of “1” will continue to be adjudicated as a claim line edit. Since each line of a claim is adjudicated separately (MAI 1) against the MUE of the code on that line, the appropriate use of CPT modifiers to report the same code on separate lines of a claim will enable a provider to report medically necessary units of service in excess of an MUE. Thus, if a CPT/HCPCS code is reported on more than one line of the claim by using Anatomical modifiers such as E1–E4 (Eyes), FA–F9 (Fingers), and TA–T9 (Toes), each line with that code is separately adjudicated against the MUE.

MUEs for HCPCS codes with an MAI of “2” will be an absolute date of service edit. These are “per day edits based on policy.” HCPCS codes with an MAI of “2” have been rigorously reviewed and vetted within CMS and obtain this MAI designation because unit of service (UOS) on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation, or subregulatory guidance.

MUEs for HCPCS codes with an MAI of “3” are “per day edits based on clinical benchmarks.” MUEs assigned an MAI of “3” are based on criteria (e.g., nature of service, prescribing information) combined with data such that it would be possible but medically highly unlikely that higher values would represent correctly reported medically necessary services. If the MUE is adjudicated as a DOS MUE (MAI 2 and/or 3), all UOS on each claim line for the same date of service for the same HCPCS/CPT code are summed, and the sum is compared to the MUE value. If the summed UOS exceed the MUE value, all lines for the HCPCS/CPT code and DOS for that current claim are denied. Exceptions are rare. Supporting documentation is required on appeal.

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.

*Unless provider contract states otherwise.

References: CMS Practitioner Services MUE Table, CMS Facility Outpatient Services MUE Table, CMS National Correct Coding Initiative Edits.

New Hepatitis B Vaccine

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The following information is applicable to Commercial products and the Children's Health Insurance Program (CHIP).

Effective May 1, 2022, Capital Blue Cross is covering a new Hepatitis B vaccine, PreHevbrio[®], as recommended by the Advisory Committee on Immunization Practices (ACIP) and adopted by the Centers for Disease Control and Prevention (CDC). Upon new Food and Drug Administration (FDA) approval, immunization services are adopted as preventive within one (1) year of posting in the CDC Morbidity and Mortality Weekly Report (MMWR). Coverage of this new vaccine is in addition to the current available vaccines previously approved for prevention of Hepatitis B.

The following procedure code is applicable to the new vaccine and will be covered as preventive with no member cost sharing*:

90759 – Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, three-dose schedule, for intramuscular use.

Please refer to [CDC guidance for healthcare providers](#) for updated information related to preventive immunizations.

**Member eligibility and benefits should be verified prior to vaccine administration to confirm member has preventive coverage for vaccinations.*

Preventive Services Health Coverage Guidance related to Screening for Alcohol Use

- Traditional and Comprehensive POS Medicare Advantage PPO
- HMO PPO Medicare Advantage HMO

Capital Blue Cross has developed preventive health coverage guidelines, which include recommended applicable codes for provider reference. The Preventive Services Health Coverage Guidelines apply to Commercial products and the Children’s Health Insurance Program (CHIP).

Preventive screening and assessment for unhealthy alcohol use in adults 18 years and older is recommended by the U.S. Preventive Services Task Force (USPSTF). In order to ensure this service is covered with no member cost sharing*, providers are reminded to submit the appropriate procedure code(s) related to the screening and/or assessment and apply a screening diagnosis as the primary diagnosis on the claim. Please refer to the following recommendations within the guidelines.

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| ALCOHOL (unhealthy use): (USPSTF/Bright Futures) | | | Age 18* years or older engaged in risky or hazardous drinking behavior <i>*Bright Futures recommends risk assessment for adolescents beginning at age 11 for alcohol use as part of the annual well child visit</i> | |
| | Screening | G0442 | | Z13.39 |
| | Assessment | 99408, 99409 | | Z13.39 |
| Counseling in primary care | G0443 | F10.10—F10.99 | | |

**Member eligibility and benefits should be verified to confirm member has coverage for preventive care services.*

As a reminder, the information provided in these guidelines highlights the preventive care services available as required under the Patient Protection and Affordable Care Act of 2010 (PPACA). These guidelines are reviewed and updated periodically based on the recommendations of the USPSTF, Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services (HHS), and other applicable laws and regulations. Accordingly, the content of this document is subject to change.

The Capital Blue Cross Preventive Services Health Coverage Guidelines are available in the Provider Library accessed via the provider web portal in the Education and Manuals section under Guidelines.

Facility Providers Only

Notification of Changes to CMS Regulations and Policy for Dialysis Providers

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The following information is applicable to Dialysis providers.

Due to changes in the Centers for Medicare & Medicaid Services (CMS) regulations and policy, calcimimetics (J0604) is now included as part of the per diem reimbursement rate. Please be aware of this change. We are reviewing your existing agreement. If contractual changes are necessary, we will be in contact with the impacted providers in the near future.

A link to the CMS update and reference to this change is included below:

[r10568bp.pdf \(cms.gov\)](#)

Effective January 1, 2021, calcimimetics are no longer paid for under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) using the Transitional Drug Add-on Payment Adjustment (TDAPA) (§ 413.234[c]) and instead are paid for through the ESRD PPS base rate. Also effective January 1, 2021, calcimimetics are eligible for outlier payments as ESRD outlier services under § 413.237.

As discussed in CR 10281, since the oral calcimimetic (HCPCS code J0604) is included under the ESRD PPS base rate effective January 1, 2021, this drug has transitioned to the bundled payment amount. Therefore, no separate payment would be made for J0604 when it is furnished by an ESRD facility to an individual with Acute Kidney Injury (AKI). With regard to the injectable calcimimetic (HCPCS code J0606), this drug is not indicated for AKI and therefore no bills should be submitted for Parsabiv in the AKI population.
