MASSACHUSETTS

MEDICAL POLICY ANNOUNCEMENTS

Posted March 2025

This document announces new medical policy changes that take effect June 1, 2025.
Changes affect these specialties:

[Orthopedics](#)
[Plastic Surgery – Panniculectomy](#)

Genetic Testing Guidelines
[Chromosomal Microarray Analysis](#)
[Whole Exome and Whole Genome Sequencing](#)
[Pharmacogenomic Testing](#)
[Predictive and Prognostic Polygenic Testing](#)

Note that revised, clarified, or retired policies may have separate effective dates. See details in the table below.

ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions	111	**Policy retired.** Codes 27415, 27416, 29866 29867 from retired MP 111 added to MP 221 Musculoskeletal Services Management CPT and HCPCS Codes. Code 28446 will no longer require prior authorization effective 3.1.25. This is a covered service.	March 1, 2025	Commercial Medicare	No action required.
Musculoskeletal Services Management CPT and HCPCS Codes	221	**Policy clarified.** Codes 27415, 27416, 29866 29867 from retired MP 111 added to MP 221.	March 1, 2025	Commercial Medicare	PA is required for codes 27415, 27416, 29866 29867 through InterQual.
Musculoskeletal Services Management	220	**Policy clarified.** MP 111 Autografts and Allografts in the Treatment of Focal Articular Cartilage	March 1, 2025	Commercial Medicare	PA is required for codes 27415, 27416, 29866 29867 through InterQual.

		Lesions noted as retired. Codes 27415, 27416, 29866 29867 from retired MP 111 added to MP 221 Musculoskeletal Services Management CPT and HCPCS Codes.			
Meniscal Allografts and Other Meniscal Implants	110	**Policy retired.** Code 29868 from retired MP 110 added to MP 221 Musculoskeletal Services Management CPT and HCPCS Codes. Ongoing investigational code G0428 transferred to MP 400 Non-covered Services List.	March 1, 2025	Commercial Medicare	No action required.
Musculoskeletal Services Management CPT and HCPCS Codes	221	**Policy clarified.** Code 29868 from retired MP 110 added to MP 221.	March 1, 2025	Commercial Medicare	PA is required for code 29868 through InterQual.
Musculoskeletal Services Management	220	**Policy clarified.** MP 110 Meniscal Allografts and Other Meniscal Implants noted as retired. Codes 29868 from retired MP 110 added to MP 221 Musculoskeletal Services Management CPT and HCPCS Codes.	March 1, 2025	Commercial Medicare	PA is required for code 29868 through InterQual.

PLASTIC SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED

Plastic Surgery	068	**Policy revised.** Clinical criteria on panniculectomy updated.	June 1, 2025	Commercial	Prior authorization is required.

Genetic Testing Guidelines

Legend	Text color	Indicates…
Guideline Change Summary	**Blue**	Change to guideline wording
	Black	Preservation of existing guideline wording
		Changes expected to be…
Explanation of Change	**Green**	More expansive on appropriateness
	Red	More restrictive on appropriateness
	Black	Have minimal if any impact on appropriateness review and exists primarily to clarify intent

The following updates will apply to the Carelon Clinical Appropriateness **Guidelines for Genetic Testing.** You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

Clinical Appropriateness Framework
Added this statement that will appear in all Carelon guidelines:
Genetic tests not specifically mentioned in the guidelines are considered not medically necessary.

Carelon Guideline	Policy Change Summary	Effective Date
	Chromosomal Microarray Analysis	
Postnatal/ Pediatric evaluation	**Postnatal/Pediatric evaluation** Chromosomal microarray analysis is considered **medically necessary** as a first-line test in the initial postnatal evaluation of individuals with **ANY** of the following: • Multiple congenital anomalies without an established diagnosis • Congenital or early onset epilepsy (before age 3 years) without suspected environmental causes • Autism spectrum disorder with no identifiable cause (idiopathic) • Developmental delay or intellectual disability with no identifiable cause (idiopathic) • Early neonatal death up to 7 days after birth ○ Note: If chromosomal microarray has been performed prenatally, it is not medically necessary to repeat it postnatally. **Explanation of change** Expansive edit to include neonatal death to the list of indications considered medically necessary for chromosomal microarray analysis.	June 15, 2025
Optical Genome Mapping	**Optical Genome Mapping** Optical Genome Mapping is considered **not medically necessary** in prenatal and postnatal evaluation.	June 15, 2025

	Explanation of change New section for Optical Genome Mapping clarifies current position as not medically necessary. OGM may be an alternative methodology for structural variant analysis, but more studies are required before considering this technique as medically necessary.	

Carelon Guideline	Policy Change Summary	Effective Date
Whole Exome and Whole Genome Sequencing		
Whole Exome Sequencing	**Whole Exome Sequencing** Whole exome sequencing (WES) is considered **medically necessary** in the following scenarios. **GENERAL CRITERIA** **ALL** of the following general criteria must be met: • The results of testing would confirm or establish a clinical diagnosis • Counseling, which encompasses **ALL** of the following components, has been performed: ○ Interpretation of family and medical histories to provide a risk assessment for disease occurrence or recurrence ○ Education about inheritance patterns, genetic testing, disease management, prevention, and resources ○ Counseling to promote informed choices and adaptation to the risk or presence of a genetic condition ○ Counseling for the psychological aspects of genetic testing ○ Counseling should include the following details: ▪ Limitations of the testing used ▪ A negative result does not indicate heritable risk is zero or low ▪ Identification of incidental secondary findings and inconclusive results called variants of uncertain significance is possible ▪ Modifications to genetic variants' pathogenicity interpretations can occur, and patients may be recontacted with reclassified results in the future • Post-test counseling should be performed for genetic test results SPECIFIC CRITERIA REQUIRED BASED ON CLINICAL PRESENTATION: **A. Prenatal** (required): • Abnormal fetal anatomic findings which are characteristic of a genetic abnormality and no diagnostic findings found on karyotype and/or chromosomal microarray testing **OR**	June 15, 2025

	B. Postnatal: Whole exome sequencing (WES) is indicated if **ONE** of the following criteria is met: • Multiple anomalies (i.e., structural and/or functional) apparent before one year of age not suggestive of a specific genetic condition for which a targeted gene panel is available or chromosomal microarray is the appropriate diagnostic methodology • Developmental delay, autism spectrum disorders, or intellectual disability with onset prior to 18 years of age with no identifiable cause (idiopathic) • Congenital or early onset epilepsy (before age 3 years) without suspected environmental etiology Whole exome sequencing (WES) is considered **not medically necessary** in the following scenario: • Genomic autopsy for early neonatal death (up to 7 days after birth) ***Note:*** *WES may include comparator WES testing of the biologic parent(s) or sibling (duo or trio testing) of the affected individual.* **Explanation of change** Clarify and restructure the criteria for improved readability. Restrictive edit specifies that WES for early neonatal death is an exclusion.	

Carelon Guideline	Policy Change Summary	Effective Date
Pharmacogenomic Testing		
Pharmaco-genomic Testing	For each of the therapies and associated biomarkers in **Table 1**, genotyping for the appropriate biomarker is considered **medically necessary** when **ALL** the following conditions are met: • The medication for which genotyping is being done is the most appropriate treatment for the individual's underlying condition • The pharmacogenomic test has demonstrated analytical and clinical validity and clinical utility for the individual, including consideration of the frequency of relevant alleles in the individual's subgroup (when applicable) • The biomarker testing is focused on the specific genetic polymorphisms relevant to guiding treatment for the individual's condition and expected treatment **Explanation of change** Clarifications	June 15, 2025

Table 1. Therapies and associated biomarkers **considered medically necessary** for genotyping

Biomarker	Drug	Therapeutic Area
ApoE4	Lecanemab, donanemab-azbt	Neurology
CFTR	ivacaftor	Pediatrics
CYP2C19	clopidogrel	Cardiology
CYP2C9	siponimod	Neurology
CYP2C9	deuruxolitnib	Dermatology
CYP2D6	eliglustat	Hematology
CYP2D6	tetrabenazine	Neurology
G6PD	rasburicase	Hematology
G6PD	tafenoquine, primaquine	Infectious Diseases
HLA-B*1502	carbamazepine, oxcarbazepine	Neurology
HLA-B*5701	abacavir	Infectious Diseases
HLA-B*58:01	allopurinol	Rheumatology
NAGS	carglumic acid	Gastroenterology
POLG	divalproex sodium, valproic acid	Neurology
TPMT NUDT15	mercaptopurine, thioguanine	Hematology

Explanation of change
Clarified title of Table
Expansive changes:

- **donanemab-azbt** added for association with genotyping for ApoE ε4 in the realm of Neurology for treatment of Alzheimer's disease
- **deuruxolitinib** added for association with genotyping for CYP2C9 in the realm of Dermatology for treatment of alopecia areata
- **NUDT15** risk allele added to explain the majority of thiopurine-related myelosuppression risk in Asians and Hispanics. It is reasonable to expand the table and include it in this testing

Clarification: eliglustat's therapeutic area clarified as being related to hematology rather than pediatrics

Predictive and Prognostic Polygenic Testing
Guideline reaffirmed. Edited Description/Scope and Rationale.

New 2025 Category III CPT Codes

All category III CPT Codes, including new 2025 codes are **non-covered** unless they are explicitly described as "medically necessary" in a BCBSMA medical policy. To search for a particular code, click the following link:

https://www.bluecrossma.org/medical-policies/
and type the code in the search box on the page. Consult the coverage statement of any associated medical policy. ***If there is no associated policy, the code is non-covered*.**

A full draft version of each policy is available only by request, to ordering participating clinician providers, one month prior to the effective date of the policy. To request draft policies, contact Medical Policy Administration at ebr@bcbsma.com.

Definitions

Medically Necessary: Procedure, services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine.

Edits: Blue Cross Blue Shield of Massachusetts uses edits to enforce medical policies. These system edits use CPT/HCPCS and ICD-10 diagnosis codes to ensure claims are processing according to the medical policy.

Post Payment Review: After a claim has been paid, Blue Cross Blue Shield of Massachusetts will review the paid claim and determine if the claim has been paid appropriately.

Prior Authorization: Certain inpatient and outpatient services are reviewed to determine if they are medically necessary and appropriate for the member. If the determination is made that the services are medically necessary, an approval—or authorization— is sent in writing to the member, primary care provider (PCP), the treating physician, and the facility (if applicable) to let them know that the services have been approved.