MASSACHUSETTS

MEDICAL POLICY ANNOUNCEMENTS

Posted September 2025

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

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

CARDIOLOGY UROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Renal Denervation for Uncontrolled Hypertension	919	**Policy revised. Radiofrequency ablation** of renal sympathetic nerves is medically necessary. **Ultrasound ablation** of renal sympathetic nerves is medically necessary.	December 1, 2025	Commercial Medicare	No action required. Prior authorization is not required.
Catheter Ablation for Cardiac Arrhythmias	126	**Policy reactivated** describing medically necessary and investigational indications.	December 1, 2025	Commercial Medicare	No action required. Prior authorization is not required.

DURABLE MEDICAL EQUIPMENT ONCOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Tumor Treating Fields Therapy	111	**New medical policy** describing medically necessary indications for **newly diagnosed glioblastoma** and investigational	December 1, 2025	Commercial	No action required. Prior authorization is not required.

		indications including but not limited to malignant pleural mesothelioma and non-small cell lung cancer.			

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Adjunct Medications to Support Hematopoietic Stem Cell Transplantation and its Complications	028	**Policy revised.** Ryzneuta added to the policy. Policy title updated (formerly known as *Omidubicel as Adjunct Treatment for Hematologic Malignancies*).	September 15, 2025	Commercial	Prior authorization is required.
Oncology Drugs	409	**Policy revised.** Revuforj added to the policy.	September 15, 2025	Commercial	Prior authorization is required.
Carelon Oncology Program	099	**Policy revised.** Bizengri added to the policy.	September 15, 2025	Commercial	Prior authorization is required.
Injectable Asthma Medications	017	**Policy revised.** New indication for Nucala added.	September 15, 2025	Commercial	Prior authorization is required.
Anti-Migraine Policy	021	**Policy revised.** Symbravo added as a Step 3 drug.	September 15, 2025	Commercial	Prior authorization is required.
Medical Utilization Management (MED UM) & Pharmacy Prior Authorization Policy	33	**Policy revised.** Berinet, Cinryze, Haegarda, Ruconest, Kalbitor, Takhzyro, icabitant, Sajazir, and Firazyr moved to Medical Policy #058. New indication for Gamifant added.	September 15, 2025	Commercial	Prior authorization is required.

Drug Management & Retail Pharmacy Prior Authorization	049	**Policy revised.** Orladeyo moved to Medical Policy #058.	September 15, 2025	Commercial	Prior authorization is required.
GLP-1 Receptor Agonists and Related Drugs for the Treatment of Type 2 Diabetes	056	**Policy revised.** Added generic Byetta, exenatide to the policy.	September 15, 2025	Commercial	Prior authorization is required.
Drugs for the Treatment of Hereditary Angioedema (HAE)	058	**New Medical Policy** that will house all Hereditary Angioedema Drugs from Medical Policies #033 and #049.	September 15, 2025	Commercial	Prior authorization is required.
Hepatitis C Medication Management	344	**Policy revised.** Updated Mavyret age requirement due to FDA label expansion.	September 15, 2025	Commercial	Prior authorization is required.
Supportive Care Treatments for Patients with Cancer	105	**A Policy revised.** Ryzneuta added to the policy.	September 30, 2025	Commercial	Prior authorization is required.
Medical Utilization Management (MED UM) & Pharmacy Prior Authorization Policy	033 034	**Policy revised.** Adding new prior authorization criteria for Krystexxa under Medical Utilization Management.	January 1, 2026	Commercial	Medical Utilization Management (MEDUM) is required.

PLASTIC SURGERY ONCOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers	354	**Policy revised.** Policy statements for use of pneumatic compression pumps for lymphedema were revised to **medically necessary chest and trunk** use with criteria. Medically necessary policy statement added for **non-pneumatic compression pumps** with criteria.	December 1, 2025	Commercial	No action required. Prior authorization is not required.

		Use of compression pumps for **head and neck lymphedema** was maintained as **investigational.**			
Bioimpedance Devices for the Detection of Lymphedema	261	**Policy revised** to include medically necessary criteria and investigational indications based on clinical input.	December 1, 2025	Commercial Medicare	No action required. Prior authorization is not required.
Liposuction for Lipedema and Lymphedema	043	**Policy revised.** **Lipedema:** Policy criteria updated to align with association medically necessary and investigational indications following review of clinical input. **Lymphedema**: New policy criteria describing medically necessary and investigational indications following review of clinical input. The title changed to include liposuction for Lymphedema.	December 1, 2025	Commercial Medicare	No action required. Prior authorization is required.
Surgical Treatments for Lymphedema	037	**Policy revised.** Debulking Treatments for Lymphedema removed from MP 037. Debulking Treatments for Lymphedema/Liposuction for Lymphedema is addressed in MP 043. Title changed to Surgical Treatments for Lymphedema.	December 1, 2025	Commercial Medicare	**Commercial** Prior authorization is required. **Medicare Advantage** Prior authorization is not required.

RADIOLOGY NEUROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Carelon Advanced Imaging Radiology CPT and HCPCS Codes	900	Magneto-encephalography recording and analysis codes 95965; 95966 added. These codes require prior authorization through Carelon.	November 15, 2025	Commercial Medicare	No action required. Prior authorization is required through Carelon.

UROLOGY ORGAN TRANSPLANTATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Urinary Test for Renal Allograft Rejection	065	**New medical policy** describing investigational indications.	December 1, 2025	Commercial Medicare	No action required. Prior authorization is not required.

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.