MASSACHUSETTS

MEDICAL POLICY ANNOUNCEMENTS

Posted February 2025

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

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

GASTROENTEROLOGY ONCOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Analysis of Human DNA or RNA in Stool Samples as a Technique for Colorectal Cancer Screening	557	**Policy revised.** Cologuard Plus and Colosense added to evidence review and policy statements as medically necessary. Title expanded to include RNA tests.	May 1, 2025	Commercial	No action required.

NEUROLOGY REHABILITATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Transcutaneous Electrical Nerve Stimulation and Transcutaneous Afferent Patterned Stimulation and Transcutaneous Afferent Patterned Stimulation	003	**Policy revised.** Added new policy statements to differentiate TAPS as investigational for both essential tremor and action tremor associated with Parkinson disease. Updated title to incorporate TAPS. Other policy statements unchanged.	May 1, 2025	Commercial	No action required.

NEUROSURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Intraosseous Basivertebral Nerve Ablation	485	**Policy revised** to include that treatment of 3 or more vertebral bodies during a single session is investigational.	May 1, 2025	Commercial Medicare	Prior authorization is required.

OBSTETRICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Assisted Reproductive Services	086	**Policy clarified.** Selective fetal reduction removed. Coverage is determined by the subscriber certificate.	February 1, 2025	Commercial	Prior authorization is required.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma	066	**Policy clarified.** Policy criteria 1a under Axicabtagene ciloleucel (Yescarta): Non-Hodgkin Lymphoma statements clarified: Histologically confirmed diagnosis of large B-cell lymphoma that is considered refractory to first line chemoimmunotherapy, or relapsed within 12 months, following first-line chemoimmunotherapy that included an anti-CD20 monoclonal antibody and anthracycline-containing regimen.	January 14, 2025	Commercial	Prior authorization is required.

		Axicabtagene ciloleucel (Yescarta): Non-Hodgkin Lymphoma footnote c removed.			

UROLOGY LABORATORY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical Technology Assessment Noncovered List	400	**Policy revised.** CPT 82610 Cystatin C removed from the noncovered list.	May 1, 2025	Commercial Medicare	No action 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.