MASSACHUSETTS

MEDICAL POLICY ANNOUNCEMENTS

Posted September 2023

This document announces new medical policy changes that take effect December 1, 2023. Changes affect these specialties:

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

BEHAVIORAL HEALTH

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Digital Health Technologies Therapies for Attention Deficit /Hyperactivity Disorder	947	**Policy statements clarified** from "Prescription digital therapy is considered investigational for the treatment of attention-deficit/hyperactivity disorder" to "The use of EndeavorRx is considered investigational for all indications including attention-deficit/hyperactivity disorder"; intent unchanged.	September 1, 2023	Commercial Medicare	No action required.

DERMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Benign Skin Lesions	707	**Policy criteria revised. Enforcement update** List of covered diagnoses codes added.	January 1, 2024	Commercial	PA is not required.

		New diagnoses-to-CPT codes edit to be implemented on January 1, 2024.			

DURABLE MEDICAL EQUIPMENT

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Manual and Power Operated Wheelchairs	365	**Policy revised** to include coverage for wheelchair accessory, power seat elevation system, any type (HCPCS E2300) for all products.	May 16, 2023	Commercial	Prior authorization **is still required** for Power Operated Wheelchairs.

ENDOCRINOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Artificial Pancreas Device Systems	107	**Prior authorization requirements** • PA is **not required** for type 1 diabetes. PA is **not required** for the following codes A4238; A4239; A9277 for type 1 diabetes. • PA will continue to be **required for type 2 diabetes**. PA is **still required** for the following codes A4238; A4239; A9277 for type 2 diabetes. **Continuous Glucose Monitoring** **Policy revised.** • Medically necessary statement related to type 1 diabetes streamlined to include type 1 diabetes in	December 1, 2023	Commercial	No action required.

		individuals who can use the device. • Medically necessary statements related to type 2 diabetes expanded to include individuals on any insulin therapy. • Adding coverage for the free style libre device for gestational diabetes. **Artificial Pancreas Device Systems** **Policy revised.** New indication and medically necessary policy statement with criteria added for the artificial pancreas device system with a closed-loop insulin delivery system (bionic pancreas).			

MULTISPECIALTY: NOT LIMITED TO GASTROENTEROLOGY | NEUROLOGY | HEMATOLOGY | ENDOCRINOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Vitamin B12 Testing	061	New medical policy describing medically necessary and investigational indications. **Enforcement update** List of covered diagnoses codes added. Diagnoses-to-CPT codes edit to be implemented on December 1, 2023.	December 1, 2023	Commercial Medicare	PA is not required.

NEUROLOGY | REHABILITATION | ORTHOPEDICS

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

Percutaneous Electrical Nerve Stimulation and Percutaneous Neuromodulation Therapy and Restorative Neurostimulation Therapy	172	**Policy revised**. New indication and investigational policy statement added for restorative neurostimulation therapy (Reactiv8). Policy statements for percutaneous electrical nerve stimulation and percutaneous neuromodulation therapy separated out for clarity; intent unchanged. Title changed to reflect new indication.	December 1, 2023	Commercial	No action required.

PLASTIC SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Plastic Surgery	068	**<u>Hair removal</u>** **Policy revised.** Hair removal, including electrolysis and laser, may be considered medically necessary after treatment of a pilonidal cyst to prevent recurrence. **<u>Liposuction or Lipectomy</u>** **Policy clarified.** ▪ Medically necessary statements on Liposuction or Lipectomy updated to state: including, but not limited to lipedema under Disease (last bullet). ▪ Prior authorization table was updated to indicate that PA is required for liposuction/lipectomy for: Commercial PPO and EPO; and Commercial	December 1, 2023 August 9, 2023	Commercial	PA is still required.

		Managed Care (HMO and POS). The PA table was updated to include a separate column for Commercial Indemnity.			
Gender Affirming Services (Transgender and Gender Diverse Services)	189	**Policy revised.** Investigational/non-covered services added to non-covered section. Coding section clarified.	December 1, 2023	Commercial Medicare	Prior authorization **is still required**.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Gene Therapies for Duchenne Muscular Dystrophy	022	**New medical policy** describing medically necessary and investigational indications. 025 Prior Authorization Request Form for Duchenne Muscular Dystrophy.pdf	August 9, 2023	Commercial Medicare	PA is required.
Gene Therapies for Hemophilia B	168	**Policy revised.** Updated criteria for medical necessity to include: • physician attestation and historical records or chart notes to establish severity of hemophilia B; • greater than 150 prior exposure days to treatment for current factor therapy criteria. 169 Prior Authorization Request Form for Gene Therapies for Hemophilia B.pdf	August 9, 2023	Commercial Medicare	PA is still required.

Zolgensma (onasemnogene abeparvovec-xioi) for Spinal Muscular Atrophy (SMA)	008	**Policy revised.** • Updated number of SMN2 copies requirement from no more than 3 to 4. • Updated to match BCBSA updates - removed the weight requirement of ≤13.5kg at time of infusion; added new criteria requirement for baseline liver function. . 085 Prior Authorization Request Form for Zolgensma (onasemnogene abeparvovec-xioi) for Spinal Muscular Atrophy MP 008 prn.pdf	August 9, 2023	Commercial Medicare	PA is still required.
Vascular Endothelial Growth Factor (VEGF) Inhibitors Step Therapy	092	**Policy revised.** Removing Biosimilars as an option to use in Step 1.	December 1, 2023	Commercial	PA is still required.

PULMONOLOGY | INFECTIOUS DISEASE | CLINICAL LABORATORY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Pathogen Panel Testing	045	Respiratory Virus Panel **policy criteria revised.** **Enforcement Update** List of covered diagnoses codes added. New diagnoses-to-CPT codes edit to be implemented on December 1, 2023.	December 1, 2023	Commercial	PA is not required.

New 2023 Category III CPT Codes

All category III CPT Codes, including new 2023 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.

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