MASSACHUSETTS

MEDICAL POLICY ANNOUNCEMENTS

Posted August 2024

This document announces new medical policy changes that take effect November 1, 2024. Changes affect these specialties:

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

CARDIOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Ambulatory Event Monitors and Mobile Cardiac Outpatient Telemetry	347	**Policy #347 retired.** Coverage information transferred to new MP #119 Ambulatory Electrocardiograph (AECG) Monitoring.	October 1, 2024	Commercial	No action required.
Progenitor Cell Therapy for the Treatment of Damaged Myocardium Due to Ischemia	652	**Policy 652 retired.** Ongoing investigational indications transferred to MP 400, Medical Technology Assessment Non-Covered List.	August 1, 2024	Commercial Medicare	No action required.

DERMATOLOGY PLASTIC SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Negative Pressure Wound	543	**Policy clarified** and reformatted. Policy statements unchanged.	November 1, 2024	Commercial	No action required.

Therapy in the Outpatient Setting		Prior authorization is no longer required. Procedure-to-diagnoses edits will be implemented.			

ENDOCRINOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medicare Advantage Management	132	**Policy revised.** Prior authorization for type 2 diabetes is no longer required for codes A4238, A4239 and A9277 under MP #107 Continuous Glucose Monitoring. Procedure-to-diagnoses edits will be implemented.	October 1, 2024	Medicare	No action required. Prior authorization **is not required** for T2D.

HEMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Gene Therapies for Thalassemia	215	**Policy revised** to include medically necessary and investigational indications for Exagamglogene autotemcel (Casgevy) for individuals with transfusion dependent beta thalassemia when certain conditions are met. Prior Authorization Request Form: Casgevy™ (Exagamglogene autotemcel) for Beta thalassemia, #217	August 1, 2024	Commercial Medicare	No action required. Prior authorization **is required.**

NEUROLOGY NEUROSURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Implantable Peripheral Nerve Stimulation for Chronic Pain Conditions	103	**New medical policy** describing investigational indications. PNS to treat chronic pain of peripheral nerve origin is considered investigational.	November 1, 2024	Commercial Medicare	No action required.
Endovascular Therapies for Extracranial Vertebral Artery Disease	730	**Policy 730 retired.** Codes 0075T and 0076T are still considered investigational/not covered.	August 1, 2024	Commercial	No action required.
Medical Technology Assessment Non-Covered List	400	**Policy revised** to include InTandem Medical Device /Rhythmic Auditory Stimulation (RAS).	August 1, 2024	Commercial Medicare	No action required.

NEUROSURGERY ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Intraoperative Neuro-physiologic Monitoring Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring	211	**Policy revised.** Motor evoked potentials expanded to include additional medically necessary indications.	November 1, 2014	Commercial	No action required.

OBSTETRICS – ASSISTED REPRODUCTIVE SERVICES

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

Assisted Reproductive Services	086	**Policy clarified.** All frozen eggs/embryos must be used before any fresh cycle may be approved.	August 1, 2024	Commercial	No action required. Prior authorization **is required**.

ONCOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Adoptive Cell Therapies for Melanoma	089	**New medical policy** describing medically necessary and investigational indications. Prior Authorization Request Form for Lifileucel (Amtagvi), #096	August 1, 2024	Commercial Medicare	No action required. Prior authorization **is required**.
Adoptive Immunotherapy	455	**Policy clarified.** Reference and link to MP #089 Adoptive Cell Therapies for Melanoma, #089 added.	August 1, 2024	Commercial Medicare	No action required. This is not a covered service.

OPHTHALMOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Intravitreal and Punctum Corticosteroid Implants	272	**Policy revised.** Policy statement added for new investigational indication for Dextenza for ocular itching associated with allergic conjunctivitis.	November 1, 2024	Commercial Medicare	No action required.

PHARMACY NEUROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Monoclonal Antibodies for Treatment of	946	**Policy clarified**	August 1, 2024	Commercial	No action required.

Alzheimer Disease		**Donanemab-AZBT (Kisunla):** medically necessary and investigational indications added. **Aducanumab (Aduhelm):** removed from the policy. This drug was discontinued by the manufacturer. **J0172** Injection, aducanumab-avwa, 2 mg transferred to MP 400 Medical Technology Assessment Non-Covered List.			Prior authorization is still required.
Medicare Advantage Part B Medical Utilization Management	125	**Donanemab-AZBT (Kisunla)** is added to Part B Medical Utilization Management.	August 1, 2024	Medicare	Providers will need to submit prior authorization requests for Kisunla.

UROLOGY GYNECOLOGY LABORATORY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Identification of Micro-organisms Using Nucleic Acid Probes	555	**Policy revised.** Mycoplasma genitalium added to list of medically necessary nucleic acid testing. Code 87563 will be covered on effective date. 87563 Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma genitalium, amplified probe technique.	November 1, 2024	Commercial Medicare	No action required.

New 2024 Category III CPT Codes

All category III CPT Codes, including new 2024 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.