MASSACHUSETTS

# MEDICAL POLICY ANNOUNCEMENTS

## Posted January 2024

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



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

## ANESTHESIOLOGY

| POLICY TITLE | POLICY NO. | POLICY CHANGE SUMMARY | EFFECTIVE DATE | PRODUCTS AFFECTED | PROVIDER ACTIONS REQUIRED |
|---|---|---|---|---|---|
| Medical Technology Assessment Noncovered Services | 400 | **Policy clarified** to add the following regional anesthetic blocks to the non-covered list:<br>▪ QLB (Quadratus lumborum) block for abdominal, pelvic and hip surgery<br>▪ ESP (Erector spinae plane) block for thoracic, abdominal, pelvic and hip surgery<br>▪ IPACK (Infiltration between popliteal artery and posterior capsule) block following total knee arthroplasty or arthroscopically assisted ACL reconstruction. | December 8, 2023 | Commercial Medicare | No action required. |

## GASTROENTEROLOGY

| POLICY TITLE | POLICY NO. | POLICY CHANGE SUMMARY | EFFECTIVE DATE | PRODUCTS AFFECTED | PROVIDER ACTIONS REQUIRED |
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| Peroral Endoscopic Myotomy for Treatment of Esophageal Achalasia and Gastroparesis | 451 | **Policy revised.** New investigational policy statement added for use in gastroparesis. Previous policy statement unchanged. | April 1, 2024 | Commercial Medicare | No action required. |
| Fecal Microbiota Transplantation (FMT) | 682 | **Policy revised.** Medically necessary policy statement added for commercially available FDA-approved FMT products, Rebyota and Vowst. | April 1, 2024 | Commercial Medicare | No action required. |

## HEMATOLOGY

| POLICY TITLE | POLICY NO. | POLICY CHANGE SUMMARY | EFFECTIVE DATE | PRODUCTS AFFECTED | PROVIDER ACTIONS REQUIRED |
|---|---|---|---|---|---|
| Omidubicel as Adjunct Treatment for Hematologic Malignancies | 028 | **Policy revised.** Medically necessary statement added. Prior authorization is required on effective date noted. | April 1, 2024 | Commercial Medicare | Prior authorization is required. |

## NEUROSURGERY ORTHOPEDICS

| POLICY TITLE | POLICY NO. | POLICY CHANGE SUMMARY | EFFECTIVE DATE | PRODUCTS AFFECTED | PROVIDER ACTIONS REQUIRED |
|---|---|---|---|---|---|
| Bone Morphogenetic Protein | 097 | **Policy revised.** Prior authorization will no longer be required on effective date noted. | April 1, 2024 | Commercial Medicare | Prior authorization is not required. |

## OBSTETRICS GYNECOLOGY GENETIC TESTING

| POLICY TITLE | POLICY NO. | POLICY CHANGE SUMMARY | EFFECTIVE DATE | PRODUCTS AFFECTED | PROVIDER ACTIONS REQUIRED |
|---|---|---|---|---|---|
| Multitarget Polymerase Chain Reaction Testing for Diagnosis of Bacterial Vaginosis | 711 | **Policy revised** to include coverage for 0352U and 0353U bacterial vaginosis and vaginitis and chlamydia trachomatis and Neisseria gonorrhoeae | April 1, 2024 | Commercial Medicare | No action required. |

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| | | codes when policy criteria are met. | | | |
| Carelon Genetic Testing Management Program CPT and HCPCS Codes | 957 | CPT code 81420 removed. This code is out of scope from the Carelon Program.<br><br>PA is no longer required through Carelon.<br><br>81420 Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21 | February 1, 2024 | Commercial | Prior authorization is not required through Carelon. |

## PHARMACY

| POLICY TITLE | POLICY NO. | POLICY CHANGE SUMMARY | EFFECTIVE DATE | PRODUCTS AFFECTED | PROVIDER ACTIONS REQUIRED |
|---|---|---|---|---|---|
| CNS Stimulants and Psychothera-peutic Agents | 019 | **Policy revised.** Criteria for Armodafinil and Modafinil were updated. | April 1, 2024 | Commercial | Prior authorization is still required. |
| Asthma and Chronic Obstructive Pulmonary Disease Medication Management | 011 | **Policy criteria revised.** FDA approved indications/diagnoses will be required for Breztri and Trelegy. | April 1, 2024 | Commercial | Prior authorization is still required. |
| Medicare Advantage Part B Step Therapy | 020 | **Policy revised** to remove Step Therapy requirement for treprostinil and Remodulin. | December 31, 2023 | Medicare | No action required. |

## RADIOLOGY IMAGING

| POLICY TITLE | POLICY NO. | POLICY CHANGE SUMMARY | EFFECTIVE DATE | PRODUCTS AFFECTED | PROVIDER ACTIONS REQUIRED |
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| Carelon Oncologic Imaging CPT, HCPCS and Diagnoses Codes | 929 | HCPCS code A9608 added. Prior authorization is required through Carelon on effective date.<br><br>A9608 Flotufolastat f18, diagnostic, 1 millicurie | January 1, 2024 | Commercial | Prior authorization is required through Carelon. |

## 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.



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