MASSACHUSETTS

MEDICAL POLICY ANNOUNCEMENTS

Posted March 2024

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

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

BEHAVIORAL HEALTH PSYCHIATRY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Neuropsycho-logical and Psychological Testing	151	Policy clarified to specify that a typical course of neuropsychological testing can be completed in 10 hours.	March 1, 2024	Commercial	Prior authorization is still required for Commercial Managed Care (HMO and POS). Prior authorization is not required for Commercial PPO and Indemnity.

DERMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Fractional Carbon Dioxide (CO2) Laser Ablation Treatment of Hypertrophic Scars or Keloids for Functional Improvement	039	**New medical policy** describing investigational indications	June 1, 2024	Commercial Medicare	No action required. This is not a covered service.

NEUROSURGERY ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Interspinous Fixation (Fusion) Devices	436	**Policy clarified** to include a list of interspinous fixation devices cleared for marketing by the FDA.	February 7, 2024	Commercial Medicare	No action required. This is not a covered service.
Intraoperative Neurophysiologic Monitoring Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring	211	**Policy clarified.** Added cross-reference to related policy #701 regarding electromyography (EMG), and coding clarification regarding the need for both EMG CPT code and intraoperative monitoring code if EMG is being used for intraoperative monitoring.	February 12, 2024	Commercial	Prior authorization is still required.
Electro-myography and Nerve Conduction Studies	701	**Policy clarified.** Added statement regarding medical necessity as part of intraoperative neurophysiologic monitoring and cross-references to related policy #211 and regarding CPT coding.	February 12, 2024	Commercial	Prior authorization is not required.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Glucagon-like Peptide-1 (GLP-1) Agonists Drugs	O56	New medical policy describing medically necessary and investigational indications. GLP-1 agonists will be removed from policy #041 Diabetes Step Therapy and transferred to policy #056.	July 1, 2024	Commercial	Prior authorization is required.

Medicare Advantage Part B Medical Utilization Management	125	Aduhelm removed from Part B Medical Utilization Management.	March 1, 2024	Medicare	Providers will not be required to submit a Prior Authorization request for the use of Aduhelm.
Gene Therapies for Sickle Cell Disease	050	**Casgevy™** **New medical policy** describing medically necessary and investigational indications. Gene Therapies for Sickle Cell Disease Prior Authorization Request Form for Casgevy ™ (Exagamglogene autotemcel), #055 **Lyfgenia™** **New medical policy** describing non-coverage. Lyfgenia does not meet guideline #4 of BCBSMA policy. ▪ 350 Medical Technology Assessment Guidelines; ▪ 400 Medical Technology Assessment Investigational (Non-covered) Service List	January 1, 2024	Commercial Medicare	Prior authorization is required.
Heart Failure and Hypertrophic Cardio-myopathy (HCM) Policy	063	**Policy revised** to add a new step therapy table for kidney disease and other risk factors**.** **Policy title changed** to: Heart Failure, Chronic Kidney Disease and Hypertrophic Cardiomyopathy (HCM) Policy.	April 1, 2024	Commercial	Prior authorization is 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.

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