MASSACHUSETTS

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Neurology and Neurosurgery
MEDICAL POLICY GROUP

Co-chairs
Ashley Yeats, MD, FACEP, FCFPC, Vice President, Medical Operations
Vivian (Besem) Tambe-Ebot, PharmD, MBA, Clinical Pharmacy Director

January 30th, 2024	12-2 pm	Conference call only. Please email ebr@bcbsma.com for more information.

Invited: Ashley Yeats MD, co-chair (Medical Policy Administration), Vivian (Besem) Tambe-Ebot, co-chair, (Clinical Pharmacy); Theresa Rines CPC, Director, (Medical Policy Administration) Grace Baker MSW, LCSW, (Medical Policy Administration); Hawkins, MD, (Internal Medicine); Peter Lakin, R.Ph, (Pharmacy Operations); Joanna Farrell, RN, CPC, (Medical Policy Administration)

Invited Physician Guest(s): Representatives from the Massachusetts Society of Neurology and Neurosurgery

Policies with Upcoming Coverage Updates	
Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, Biacuplasty and Intraosseous Basivertebral Nerve Ablation (482)	**Effective 2/2024:** **Policy revised**. Investigational policy statement on Intraosseous Basivertebral Nerve Ablation removed from MP 482. See new MP 485 Intraosseous Nerve Ablation describing medically necessary indications.
Intraosseous Basivertebral Nerve Ablation (485)	**Effective 2/2024:** **New medical policy** describing medically necessary indications.
Remote Electrical Neuromodulation for Migraines (145)	**Effective 3/2024:** **Policy revised.** Remote electrical neuromodulation for prevention of migraine is considered investigational.

Policies with Coverage Updates in the Past 12 Months	
InterQual Musculoskeletal Services Management (220)	**Effective 4/2023:** **New policy.** Prior authorization will be required for inpatient and outpatient prescheduled musculoskeletal services, such as spine, joint, and pain management procedures. For the list of codes that will require prior authorization, see InterQual Musculoskeletal Services Management Program CPT and HCPCS Codes, #221.
Minimally Invasive Ablation Procedures for Morton and Other Peripheral Neuromas (719)	**Effective 8/2023:** Policy statements clarified. Minimally invasive ablation procedures, including intralesional alcohol injection, radiofrequency ablation, and cryoablation are considered investigational for the treatment of Morton and other peripheral neuromas. **Effective 1/2023:** Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.

Aducanumab for Alzheimer Disease (946)	**Effective 8/2023:** Policy clarified to remove reference to Medicare from the commercial policy. Medicare policy is followed for Medicare Advantage members. **Effective 4/2023:** Updated to add Leqembi (lecanemab) to the policy as investigational. **Effective 1/12/2023** Policy clarified. Medicare National Coverage Determination (NCD) 200.3: Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease will be followed for Medicare Advantage members.
Diagnostic Laboratory Services (139)	**Effective 10/2023:** Policy revised to include the following note under complete blood count: Children ages 0-4 are covered for anemia screening when billed with 85027. Effective 10/1//2023. **Effective 4/2023:** Policy revised to include the following note under serum iron studies: Children ages 0-3 are covered for serum ferritin for anemia screening. **Effective 2/2023:** Thyroid testing description clarified.
Artificial Intervertebral Disc: Cervical Spine (585)	**Effective 4/2023:** This policy will be retired. InterQual® criteria will be used to determine coverage for this procedure.
Epidural Steroid Injections for Neck and Back Pain (690)	**Effective 4/2023:** This policy will be retired. InterQual® criteria will be used to determine coverage for this procedure. **Effective 1/2023:** Not medically necessary policy language changed to investigational and other minor editorial refinements to policy statements; intent unchanged.
Percutaneous Balloon Kyphoplasty, Radiofrequency Kyphoplasty, and Mechanical Vertebral Augmentation ()	**Effective 4/2023:** This policy will be retired. InterQual® criteria will be used to determine coverage for this procedure.
Spinal Cord and Dorsal Root Ganglion Stimulation (472)	**Effective 4/2023:** This policy will be retired. InterQual® criteria will be used to determine coverage for this procedure.
Biofeedback for the Treatment of Headache (152)	**Effective 1/2023:** Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
Bone Morphogenetic Protein (097)	**Effective 9/2023:** • Policy clarified. Regulatory Status section added. Table 1 clarified.

	• Policy clarified to include prior authorization requests using Authorization Manager. **Effective 4/2023:** • Policy clarified to include guidelines when the use of autograft is not feasible. • Annual policy review. Policy statement updated to note that the use of recombinant human bone morphogenetic protein-2 is considered investigational (instead of "not medically necessary") for all other indications, including but not limited to spinal fusion when the use of autograft is feasible and craniomaxillofacial surgery.
CNS Stimulants (019)	**Effective 10/2023:** Reformatted Policy and updated IC to align with 118E MGL § 51A.
Hyperbaric Oxygen Pressurization (HBO) (653)	**Effective 11/2023:** Annual policy review. Policy revised to include coverage for the treatment of compromised skin grafts and flaps to medically necessary statement. Clarified coding information. Effective 11/1/2023.
Intraoperative Neurophysiologic Monitoring Sensory- Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring (211)	**Effective 9/2023:** Policy clarified to include prior authorization requests using Authorization Manager. **Effective 6/2023:** Policy updated with literature review through March 6, 2023; references added. New indication for spinal instrumentation requiring screws or distraction added. No changes to policy statement as the new indication would be covered within the existing medically necessary policy statement on intraoperative neurophysiologic monitoring during spinal, intracranial, or vascular procedures. Minor editorial refinements to policy statements; intent unchanged**.**
Intravenous Immunogammaglobulin (IVIG) (310)	**Effective 11/2023:** Updated criteria for Myasthenia Gravis and updated IC to align with 118E MGL § 51A. **Effective 7/2023:** Reformatted policy. **Effective 4/2023:** Clarified not covering Organ Rejection.
Multiple Sclerosis Step Therapy (839)	**Effective 9/2023:** Reformatted Policy. Updated IC section to align with 118E MGL § 51A.
Pregabalin (Lyrica® and Lyrica® CR (057)	**Effective 10/2023:** Reformatted Policy and updated IC to align with 118E MGL § 51A.
Special Foods: Special Infant Formula, Enteral Formula, Ketogenic Diet for Seizures, and Formula Infusion Pumps (304)	**Effective 7/2023:** Reformatted Policy. **Effective 6/2023:** Clarified this is both a Medical and Pharmacy policy and which sections are State mandated.

	Effective 4/2023: Removed reference to both Retail benefit and requirement to have Pharmacy Carved-in.
Botulinum Toxin Injections (006)	**Effective 9/2023:** Reformatted policy. Updated IC to align with 118E MGL § 51A. Updated criteria for treatment of severe hyperhidrosis for clarity. Updated to include new FDA-approved toxin - Daxxify **Effective 6/2023:** Updated template. Updated approved indications to include blepharospasms and examples of strabismus. Removed age criteria of 5 years and older for treatment of urinary incontinence
Chelation Therapy (122)	**Effective 1/2023:** Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis (352)	**Effective 1/2023:** Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
Electrical Stimulation for the Treatment of Arthritis (302)	**Effective 1/2023:** Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
Interferons Alpha and Gamma (052)	**Effective 7/2023:** Updated to remove Rebetron due to removal from Market.
Percutaneous Electrical Nerve Stimulation and Percutaneous Neuromodulation Therapy and Restorative Neurostimulation Therapy (172)	**Effective 12/2023:** Annual policy review. References added. 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. Effective 12/1/2023.
Zolgensma (onasemnogene abeparvovec-xioi) for Spinal Muscular Atrophy (008)	**Effective 9/2023:** Policy clarified to include prior authorization requests using Authorization Manager. **Effective 8/2023:** Policy revised. • Updated number of SMN2 copies requirement from no more than 3 to 4. Effective 8/9/2023. • Updated to match BCBSA updates - removed the weight requirement of ≤13.5kg at time of infusion; added new criteria requirement for baseline liver function. Policy updated for with literature review. Policy statement updated. References updated. Effective 8/9/2023.

Policies with No Coverage Updates
1. Allograft Injection for Degenerative Disc Disease (838) 2. Artificial Intervertebral Disc: Lumbar Spine (592) 3. Automated Percutaneous and Percutaneous Discectomy (231)

4. Autonomic Nervous System Testing (713)
5. Axial Lumbosacral Interbody Fusion (AxiaLIF) (404)
6. Carotid Stent placement (219)
7. Cognitive Rehabilitation (660)
8. Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty) (271)
9. Deep Brain Stimulation (473)
10. Dynamic Posturography to Assess Vestibular Dysfunction (263)
11. Dynamic Spinal Visualization and Vertebral Motion Analysis (195)
12. Electromyography and Nerve Conduction Studies (701)
13. Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures (498)
14. Endovascular Procedures (Angioplasty and/or Stenting) for Intracranial Arterial Disease (Atherosclerosis and Aneurysms) (323)
15. Endovascular Therapies for Extracranial Vertebral Artery Disease (730)
16. Evaluation of Biomarkers for Alzheimer Disease (AD) (581)
17. Functional Neuromuscular Electrical Stimulation (201)
18. Image Guided Minimally Invasive Lumbar Decompression (IG-MLD) for Spinal Stenosis (240)
19. Interferential Stimulation for Treatment of Pain (509)
20. Interspinous Distraction Devices (Spacers) (584)
21. Interspinous Fixation (Fusion) Devices (436)
22. Intravenous anesthetics for the treatment of chronic pain (291)
23. Intravenous Antibiotic Therapy and Associated Diagnostic Testing for Lyme Disease (171)
24. Navigated Transcranial Magnetic Stimulation (nTMS) (596)
25. Neural Therapy (914)
26. Neurofeedback (515)
27. Paraspinal Surface Electromyography (SEMG) to Evaluate and Monitor Back Pain (517)
28. Peripheral Subcutaneous Field Stimulation (513)
29. Quantitative Sensory Testing (258)
30. Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy (716)
31. Sensory Integration Therapy (659)
32. Serum Biomarker Panel Testing for Systemic Lupus Erythematosus (702)
33. Sphenopalatine Ganglion Block for Headache (026)
34. Surgical Deactivation of Migraine Headache Trigger Sites (801)
35. Transcatheter Arterial Chemoembolization to Treat Primary or Metastatic Liver Malignancies (634)
36. Vagus Nerve Stimulation (474)
37. Vertebral Axial Decompression (603)
38. Whole Body Computed Tomography Scan as a Screening Test (447)

Reference Policies	
Policy 072 - Outpatient Prior Authorization Code List	New policy outlining procedure codes that require prior authorization when performed in the outpatient setting.
Policy 132 – Medicare Advantage Management	New policy outlining associated Medicare National Coverage Determinations and Local Coverage Determinations.
Medicare Advantage Part B Step Therapy (020)	New medical policy outlining associated non-oncology indications for drugs with both oncology and non-oncology indications. For the management of oncology or supportive care indications, please see related policies above that are managed by AIM (Medical Policy #099 and #105).
Medicare Advantage Part B Utilization Management (125)	New policy outlining associated Medicare Advantage Part B Medical Utilization Management for treatments requiring Prior Authorization.
Pharmacy Policy 033 – Med UM policy	Medical Utilization Management (MED UM) and Pharmacy Prior Authorization Policy

Pharmacy Policy 034 - MED UM Drug List	Medications requiring prior authorization when covered under the members medical benefits and administered in a clinician's office, outpatient setting, or by the home infusion therapy provider
Carelon Medical Benefits Management Clinical Appropriateness Guidelines (formerly AIM Specialty Health)	Carelon (formerly AIM) Advanced Imaging/Radiology Policy #968 Brain Imaging CPT, HCPCS and Diagnoses Codes list - Medical Policy #931 Head and Neck Imaging CPT, HCPCS and Diagnoses Codes list - Medical Policy #934

For questions: ebr@bcbsma.com