



**Psychiatry and Ophthalmology
MEDICAL POLICY GROUP**
Co-chairs
Katherine Dallow, MD, MPH • Vice President • Clinical Programs and Strategy
Desiree Otenti, ANP, MPH, Senior Director • Medical Policy Administration

July 27 th 2021	12-2pm	Conference call only. Please email ebr@bcbsma.com for more information.
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Invited: Katherine Dallow, MD, MPH, co-chair (Medical Policy Administration), Desiree Otenti, ANP, co-chair, (Medical Policy Administration); Grace Baker, MSW, LCSW, (Medical Policy Administration); Laura Barry, RN, BSN, (Medical Policy Administration); Craig Haug, MD, (Surgery); Thomas Hawkins, MD, (Internal Medicine); Kenneth Duckworth, MD, (Psychiatry); Peter Lakin, R.Ph, (Pharmacy Operations);

Invited Physician Guest(s): Representatives from the Massachusetts Society of Orthopedics, Rehabilitation Medicine and Rheumatology

Policies with Upcoming Coverage Updates	
POLICY	N/A

Policies with Coverage Updates in the Past 12 Months	
1. Intravitreal and Punctum Corticosteroid Implants (272)	<p>Effective 4/2021: BCBSA National medical policy review. References updated. Policy statements unchanged.</p> <p>Effective 8/1/2020: BCBSA National medical policy review. Added new policy statements for all 3 new indications – medically necessary for Dextenza for individuals with ocular inflammation and pain following ophthalmic surgery; investigational for Yutiq for treatment of chronic noninfectious posterior uveitis affecting the posterior segment of the eye, and investigational for prophylactic Ozurdex for individuals with noninfectious intermediate uveitis or posterior uveitis and cataract undergoing cataract surgery. Policy title changed. Clarified coding information. Effective 8/1/2020.</p>
2. Intraoperative Neurophysiologic Monitoring (Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring) (211)	<p>Effective 6/1/2021: Monitoring of the laryngeal nerve clarified. Total thyroidectomy clarified to include hemithyroidectomy. 6/1/21.</p>
3. Topical Ocular Hydrating Agents (426)	<p>Effective 4/2021: Clarified age for Xidra.</p> <p>Effective 1/2021: Updated to add Eysuvis™ to the policy.</p>

<p>4. Esketamine Nasal Spray (Spravato™) and Intravenous Ketamine for Treatment-Resistant Depression (087)</p>	<p>Effective 3/1/2021: New medically necessary indications added. Description, Summary and references updated. 3/1/2021.</p>
<p>5. Botulinum Toxin Injections (006)</p>	<p>Effective 7/2021: Updated to include Botox & Dysport preferred.</p> <p>Effective 4/2021: Updated detrusor overactivity criteria with age and clarified coding in strabismus and blepharospasm.</p>
<p>6. Urine Drug Testing in Pain Management and Substance Abuse Treatment Settings (674)</p>	<p>Effective 1/1/21: Terminology in policy statement corrected from "not medically necessary" to "investigational" when criteria are not met. Policy statements otherwise unchanged. Clarified coding information. Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.</p> <p>Effective 8/1/2021: BCBSA National medical policy review. Policy converted to review informed by guidelines format. Clarifications made to policy statements regarding documentation required in medical record; Policy Guidelines expanded to provide guidance regarding factors that determine appropriate testing modalities and intervals. Effective 8/1/2020.</p>
<p>Retired Policies:</p>	<p>Implantation of Intrastromal Corneal Ring Segments (235) Effective 5/1/21: Policy is retired.</p> <p>Keratoprosthesis (221) Effective 5/1/21: Policy is retired.</p> <p>Implantable Miniature Telescope - IMT (464) Effective 4/1/2021: Policy retired. This is now a covered service. 4/1/21.</p> <p>Corneal Endothelial Microscopy-Specular Microscopy (050) Effective 2/1/21: Policy retired. Procedure is done in conjunction with evaluation and management procedure and should not be billed separately. 2/1/21.</p> <p>Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions (343) Effective 11/1/2020: Policy is retired. For coverage information, see Vascular Endothelial Growth Factor (VEGF) Inhibitors Step Therapy #092.</p> <p>Intravitreal Angiogenesis Inhibitors for Retinal Vascular Conditions (401) Effective 11/1/2020: Policy is retired. For coverage information, see Vascular Endothelial Growth Factor (VEGF) Inhibitors Step Therapy #092.</p> <p>Phototherapeutic keratectomy (597) Effective 1/1/2021: Policy retired. This is now a covered service.</p>

Policies with No Coverage Updates

Ophthalmology Policies:

1. Anterior Eye Segment Optical Imaging ([084](#))
2. Antihyperlipidemics ([013](#))
3. Aqueous Shunts and Devices for Glaucoma ([223](#))
4. Confocal Laser Endomicroscopy ([618](#))
5. Corneal Collagen Cross-linking ([905](#))
6. Diabetes Step Therapy ([041](#))
7. Endothelial Keratoplasty ([180](#))
8. Eyelid Thermal Pulsation for the Treatment of Dry Eye Syndrome ([613](#))
9. Gene Therapy for Inherited Retinal Dystrophy ([911](#))
10. Growth Hormone and Insulin Like Growth Factor ([257](#))
11. Intraocular Radiation Therapy for Age-Related Macular Degeneration ([610](#))
12. Occipital Nerve Stimulation ([237](#))
13. Ophthalmic Prostaglandins ([346](#))
14. Ophthalmologic Techniques for Evaluating Glaucoma ([053](#))
15. Optical Coherence Tomography for Imaging of Coronary Arteries ([915](#))
16. Orthoptic Training for the Treatment of Vision or Learning disabilities ([611](#))
17. Photocoagulation of Macular Drusen ([607](#))
18. Photodynamic Therapy for Choroidal Neovascularization ([599](#))
19. Retinal Prosthesis ([606](#))
20. Retinal Telescreening for Diabetic Retinopathy ([065](#))
21. Suprachoroidal Delivery of Pharmacologic Agents ([609](#))
22. Transpupillary Thermotherapy for Treatment of Choroidal Neovascularization ([600](#))
23. Viscocanalostomy and Canaloplasty ([372](#))
24. Vision Services ([675](#))
25. Medical Technology Assessment Non-Covered Services List ([400](#))

Psychiatry policies:

26. Anesthetics for the Treatment of Chronic Pain ([291](#))
27. Biofeedback for the Treatment of Miscellaneous Conditions ([187](#))
28. Deep Brain Stimulation ([473](#))
29. Electrical Stimulation Devices for Psychiatric and Neurological Conditions ([157](#))
30. Methadone Treatment and Intensive Detoxification or Ultra-Rapid Detoxification for Opiate Addiction ([274](#))
31. Neurofeedback ([515](#))
32. Neuropsychological and Psychological Testing ([151](#))
33. Outpatient Psychotherapy ([423](#))
34. Quantitative Electroencephalography as a Diagnostic Aid for Attention-Deficit/Hyperactivity Disorder ([554](#))
35. Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders ([297](#))
36. Vagus Nerve Stimulation ([474](#))
37. Zulusso (brexanalone) for the Treatment of Post-partum Depression ([147](#))

Reference Policies	
Outpatient Prior Authorization Code List (072)	New policy outlining procedure codes that require prior authorization when performed in the outpatient setting.
Compound Drug List (704)	Pharmacy Compound Inclusion List for MP 579 Compounded Medications
Compound Exclusion List (705)	Compounded Exclusion List of Bulk Chemicals for MP 579 Compounded Medications
MED UM Drug List (034)	Medications requiring Prior Authorization when covered under the member's medical benefits and administered in the outpatient setting.
Medicare Advantage Management (132)	BCBSMA is required to make coverage determinations for services that each Medicare Administrative Contractor (MAC)* publishes as the Local Coverage Determination. The LCDs utilized for coverage determinations are based on the jurisdiction of the member's residency (unless otherwise specified by

	CMS). When there is no LCD or benefit statement that addresses the service/procedure, BCBSMA Commercial medical policies are followed for Medicare Advantage members.
AIM Specialty Health Guidelines	AIM Genetic Testing Guidelines https://aimspecialtyhealth.com/resources/clinical-guidelines/genetic-testing/

For questions: ebr@bcbsma.com