



MEDICAL POLICY ANNOUNCEMENTS

Posted May 2023

This document announces new medical policy changes that take effect August 1, 2023. Changes affect these specialties:

[Cardiology](#)

[Durable Medical Equipment: Orthopedics/ Oncology/ Rehabilitation](#)

[Neurosurgery/Orthopedics](#)

[Obstetrics/Infertility](#)

[Pharmacy/Hematology](#)

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
Cardiac Rehabilitation in the Outpatient Setting	916	Policy revised. Added investigational policy statement for virtual cardiac rehabilitation.	August 1, 2023	Commercial	No action required

DURABLE MEDICAL EQUIPMENT: ORTHOPEDICS/ ONCOLOGY/ REHABILITATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Postsurgical Home Use of Limb Compression Devices for Venous Thromboembolism (VTE) Prophylaxis	541	Policy clarified. Policy statement regarding postsurgical home use of limb compression devices for VTE prophylaxis for periods longer than 30 days postsurgery was changed from "not medically necessary" to "investigational." Editorial refinements to remaining policy statements; intent unchanged.	May 1, 2023	Commercial	No action required
Pneumatic Compression Pumps for	354	Policy clarified. Investigational policy statement regarding the	May 1, 2023	Commercial	No action required

Treatment of Lymphedema and Venous Ulcers		use of lymphedema pumps to treat the trunk or chest in patients with lymphedema was clarified to apply regardless of the involvement of the upper and/or lower limbs; intent unchanged.			
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NEUROSURGERY / ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Bone Morpho-genetic Protein	097	Policy clarified to include guidelines when the use of autograft is not feasible.	March 31, 2023	Commercial Medicare	No action required
Diagnosis and Treatment of Sacroiliac Joint (SIJ) Pain	320	Policy clarified. Policy reactivated to reinstate policy statements on minimally invasive fixation/fusion of the sacroiliac joint. Policy statements on anesthetic injection for diagnosing SIJ pain and corticosteroid injection for treatment of SIJ pain remain retired. Diagnosis and Treatment of Sacroiliac Joint Pain Prior Authorization Request Form, #927	May 1, 2023	Commercial	Prior authorization is still required for minimally invasive fixation/fusion of the SIJ.
InterQual Musculo-skeletal Services Management	220	Policy clarified. Policy #320 Diagnosis and Treatment of Sacroiliac Joint (SIJ) Pain removed from retired policies list. Policy 320 reactivated to reinstate policy statements on minimally invasive fixation/fusion of the sacroiliac joint. Policy statements on anesthetic injection for diagnosing SIJ pain and corticosteroid injection	May 1, 2023	Commercial Medicare	Use Authorization Manager to submit initial authorization requests for these musculoskeletal services.

		for treatment of SIJ pain remain retired.			
InterQual Musculo-skeletal Services Management CPT and HCPCS Codes	221	Policy clarified. Removed code 27279 and added back to policy #320 Diagnosis and Treatment of Sacroiliac Joint (SIJ) Pain.	May 1, 2023	Commercial Medicare	Use Authorization Manager to submit initial authorization requests for these musculoskeletal services.

OBSTETRICS /INFERTILITY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Assisted Reproductive Services	086	Policy criteria on ICSI clarified. Minor editorial refinements to policy statements, intent unchanged.	May 1, 2023	Commercial	No action required

PHARMACY/HEMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Gene Therapies for Hemophilia B	168	New policy describing medically necessary and investigational indications. Policy created with literature review. Prior Authorization Request Form for Gene Therapies for Hemophilia B Hemgenix® (Etranacogene dezaparvovec), #169. Policy clarified. Removed - Baseline anti-AAV5 antibodies > 1:678 from criteria #5 list of exclusions. It is not an FDA requirement	April 3, 2023 April 13, 2023	Commercial Medicare	Prior authorization is required.

		and is not present in the Hemgenix product label.			
Medicare Advantage Part B Medical Utilization Management	125	Policy clarified. Legembi added to Part B Medical Utilization Management.	May 1, 2023	Medicare	Prior authorization is required for Legembi.

New 2023 Category III CPT Codes

All category III CPT Codes, including new 2023 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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