MEDICAL POLICY ANNOUNCEMENTS

Posted September 2024

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

Behavioral Health
Cardiology
Complementary Medicine
Multispecialty
Neurology Neurosurgery
Obstetrics - Assisted Reproductive Services
Organ Transplantation
Otolaryngology
Pharmacy

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

BEHAVIORAL HEALTH PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Esketamine Nasal Spray (Spravato™) and Intravenous Ketamine for Mental Health Conditions	087	**Policy clarified.** If the medication is received from a Retail Specialty Pharmacy, it must be shipped to the providers office. Prior authorization reviews are managed by the Behavioral Health Unit.	January 1, 2025	Commercial Medicare	Prior authorization is still required.

CARDIOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Transcatheter Mitral Valve Repair or Replacement	692	**Policy revised.** New medically necessary indications added for transcatheter mitral valve-in-valve replacement for patients with a degenerated bioprosthetic valve who	December 1, 2024	Commercial	No action required.

		are at high or prohibitive risk of open surgery.			

COMPLEMENTARY MEDICINE

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Com-plementary Medicine	178	**Policy clarified.** Investigational indications added: ▪ cranial manipulation (chiropractic intervention) ▪ sacro-occiptal technique (chiropractic intervention) ▪ functional medicine. Cupping therapy **clarified** to specify bloodletting cupping.	September 1, 2024	Commercial Medicare	No action required.

MULTISPECIALTY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Biofeedback for Miscellaneous Indications	187	**Policy clarified** to include ongoing investigational indications of Neurofeedback.	September 1, 2024	Commercial	No action required. This is not a covered service.
Neurofeedback	515	**Policy #515 retired.** Ongoing investigational indications on neurofeedback transferred to MP 187 Biofeedback for Miscellaneous Indications.	September 1, 2024	Commercial Medicare	No action required. This is not a covered service.
Medical Technology Assessment Noncovered List	400	**Policy revised** to add: Salivary Hormone Test. **Including but not limited to the One Day Hormone Check™ Gastrointestinal Composition Tests	September 1, 2024	Commercial Medicare	No action required. These services are not covered.

		**Including but not limited to Microbiomix™ Clarified to add exceptions to Salivary Cortisol Test. ** Exceptions are for individuals who have symptoms of Cushing's Syndrome.			

NEUROLOGY NEUROSURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Navigated Transcranial Magnetic Stimulation	596	**Policy #596 retired.** Transfer ongoing investigational indications to MP 400 Medical Technology Assessment Non-Covered List.	September 1, 2024	Commercial Medicare	No action required. This is not a covered service.
High Intensity Laser Therapy for Chronic Musculo-skeletal Pain Conditions and Bell's Palsy	104	**New medical policy** describing investigational indications.	December 1, 2024	Commercial Medicare	No action required. This is not a covered service.
Medical Technology Assessment Noncovered List	400	**Policy clarified. Syn-One test** for Parkinson's disease added to non-covered list.	September 1, 2024	Commercial Medicare	No action required. This is not a covered service.

OBSTETRICS - ASSISTED REPRODUCTIVE SERVICES

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Preimplantation Genetic Testing	088	**Policy clarified.** Any services related to thaw, freeze, or refreeze are only approved for medically necessary preimplantation genetic testing services.	September 1, 2024	Commercial Medicare	Prior authorization is still required.

ORGAN TRANSPLANTATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical Technology Assessment Noncovered List	400	**Policy clarified.** Code 81560 removed from MP 400. Ongoing investigational indications transferred to MP 182 Immune Cell Function Assay in Solid Organ Transplantation. 81560: Transplantation medicine, measurement of donor and third party-induced CD154+T-cytotoxic memory cells	September 1, 2024	Commercial Medicare	No action required. This is not a covered service.
Immune Cell Function Assay in Solid Organ Transplantation	182	**Policy clarified.** Investigational policy statements edited for clarity. Use of immune cell function assay testing for all other indications <u>in the setting of transplantation medicine</u> is considered investigational.	September 1, 2024	Commercial Medicare	No action required. This is not a covered service.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma	066	**Policy revised. Tisagenlecleucel and brexucabtagene autoleucel** were updated to address Philadelphia-chromosome positive individuals. **Tisagenlecleucel, axicabtagene ciloleucel and lisocabtagene**	August 23, 2024	Commercial	Prior authorization is still required.

		maraleucel additional indications were added. **Tisagenlecleucel** is medically necessary for relapsed or refractory individuals with follicular lymphoma. **Axicabtagene ciloleucel** is medically necessary for adults with large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy. **Lisocabtagene maraleucel** is medically necessary for adults with large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy or is refractory to first-line chemoimmunotherapy or relapse after first line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation due to comorbidities or age.			
Immunomodulators for Skin Conditions	010	Drug Rinvoq will get a prescriber criteria added for atopic dermatitis.	December 1, 2024	Commercial	Prior authorization is required.
Medical Utilization Management (MED UM) & Pharmacy Prior Authorization	033	Drug Dupixent will get a prescriber criteria added for atopic dermatitis.	December 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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