MASSACHUSETTS

MEDICAL POLICY ANNOUNCEMENTS

Posted November 2022

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

Hematology and Oncology
Obstetrics and Gynecology
Ophthalmology
Oral Maxillofacial Surgery
Plastic and Reconstructive Surgery

AIM Specialty Health Clinical Appropriateness Guidelines
Genetic Testing
Radiation Oncology
Radiology Imaging: Abdomen/Pelvis; Brain; Chest; Head and Neck; Oncologic

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

HEMATOLOGY AND ONCOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Gene Therapies for Thalassemia	215	New pharmacy medical policy describing medically necessary and investigational indications for Zynteglo® (Betibeglogene autotemcel). Prior Authorization Request Form for Gene Therapies for Thalassemia | Zynteglo® (Betibeglogene autotemcel, #216	October 13, 2022	Commercial Medicare	Prior authorization is required.

OBSTETRICS AND ONCOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED

Infertility	086	**Annual policy update.** Medically necessary statement added considering cryopreservation of ovarian tissue a covered service for premenarchal females based on newly published ASRM guidelines. Clarifications made to IVF evaluation requirements, donor sperm section, donor egg and embryo section, and voluntary sterilization section. Medicare prior authorization information removed.	January 1, 2023	Commercial Medicare	Prior authorization is still required.
Pre-implantation Genetic Testing	088	**Policy clarified.** A note was added clarifying that ICSI is covered when performed for approved preimplantation genetic testing. Minor editorial refinements to policy statements; intent unchanged.	November 1, 2022	Commercial Medicare	No action required.

OPHTHALMOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical Technology Assessment Noncovered Services	400	**Policy clarified** to include OMNI Surgical system for canaloplasty and trabeculotomy	October 8, 2022	Commercial Medicare	No action required.

ORAL MAXILLOFACIAL SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Temporo-	035	**Policy clarified.** A note was added stating that	November 1, 2022	Commercial Medicare	No action required.

mandibular Joint Disorder		unless otherwise specified, the reasonable replacement frequency for a durable medical equipment (oral appliance) is once every five years. For additional information, see Durable Medical Policy Payment Policy.			

PLASTIC AND RECONSTRUCTIVE SURGERY

Recons-tructive Breast Surgery/ Management of Breast Implants	428	**Policy clarified.** Indications for explanation of saline-filled implant are the same to those of silicone-filled implant (i.e., infection, extrusion, Baker class IV contracture, or surgical treatment of breast cancer).	November 1, 2023	Commercial Medicare	Prior authorization is still required.

GENETIC TESTING

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Genetic Testing. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Hereditary Cancer Testing	Title changed from Genetic Testing for Hereditary Cancer Susceptibility to Hereditary Cancer Testing • Adds condition-specific criteria based on NCCN recommendations as well as other clinical guidelines • Limits testing in the following scenarios: ○ prostate cancer (in select scenarios) for patients without additional familial risk	February 1, 2023	Commercial	Prior authorization is still required through AIM Specialty Health.

	○ patients with only a second-degree relative with ovarian cancer ○ patients with breast cancer and family history in some select scenarios (e.g., lobular histology only plus personal or family history of gastric cancer)			
Somatic Tumor Testing	Title changed from Molecular Testing of Solid and Hematologic Tumors and Malignancies to Somatic Tumor Testing • Clarifies criteria about tumor stage in cutaneous melanoma and cholangiocarcinoma, and about histology in non-small cell lung cancer, ovarian cancer (epithelial) and prostate cancer (adenocarcinoma) • Chromosomal microarray analysis may require additional review • Specifies the genes that must be included in panels for hematologic malignancy testing • Allows testing for patients with metastatic uveal melanoma • Removes specific language regarding the brand names of tests which are considered medically necessary, and generally does not specifically name the therapeutic agents which must be under consideration, allowing reviewers to appropriately adjudicate when new therapies or tests are approved by the FDA	February 1, 2023	Commercial	Prior authorization is still required through AIM Specialty Health.
Cell free DNA Testing (Liquid Biopsy) for the	Title changed from Molecular Testing of Solid and Hematologic Tumors and Malignancies to Cell	February 1, 2023	Commercial	Prior authorization is still required

Management of Cancer	free DNA Testing (Liquid Biopsy) for the Management of Cancer • Removes specific language regarding the brand names of tests which are considered medically necessary, and generally does not specifically name the therapeutic agents which must be under consideration, allowing reviewers to appropriately adjudicate when new therapies or tests are approved by the FDA			through AIM Specialty Health.
Chromosomal Microarray Analysis	Title changed from Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis to Chromosomal Microarray Analysis • No substantive changes to criteria	February 1, 2023	Commercial	Prior authorization is still required through AIM Specialty Health.
Carrier Screening in the Prenatal Setting and Preimplantation Genetic Testing	Title changed from Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis to Carrier Screening in the Prenatal Setting and Preimplantation Genetic Testing • Clarifies testing requirements for Fragile X Syndrome in patients with unexplained ovarian failure • Clarifies carrier screening restrictions for autosomal recessive conditions • Expands selected relevant screening for patients at high risk based on ethnicity (e.g., Ashkenazi Jewish, French Canadian, Mennonite) and the conditions for which to test • Expands screening when one or both individuals do not have access to biological family history, and allows preimplantation testing when reproductive donor is of unknown carrier risk	February 1, 2023	Commercial	Prior authorization is still required through AIM Specialty Health.

Prenatal Testing Using Cell Free DNA	Title changed from Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis to Prenatal Testing Using Cell Free DNA • No substantive changes to criteria	February 1, 2023	Commercial	Prior authorization is still required through AIM Specialty Health.
Genetic Testing for Inherited Conditions	Title changed from Genetic Testing for Hereditary Cardiac Disease to Genetic Testing for Inherited Conditions • Clarifies criteria on cardiomyopathies for which testing is medically necessary • Allows for broader panels for arrhythmia and cardiomyopathy syndromes	February 1, 2023	Commercial	Prior authorization is still required through AIM Specialty Health.
Whole Exome Sequencing and Whole Genome Sequencing	Title changed from Chromosomal microassay analysis, whole exome sequencing and whole genome sequencing • Whole exome sequencing – Allows reanalysis using the same criteria as for the initial test • Whole exome sequencing – Limits testing for congenital bilateral hearing loss of unknown etiology, developmental and epileptic encephalopathy, and single anomaly with positive family history	February 1, 2023	Commercial	Prior authorization is still required through AIM Specialty Health.
[Use of] Polygenic Risk Scores in Genetic Testing	Title changed from Genetic Testing for Single-Gene and Multifactorial Conditions to [Use of] Polygenic Risk Scores in Genetic Testing • Limits overall use of polygenic risk score testing	February 1, 2023	Commercial	Prior authorization is still required through AIM Specialty Health.
Pharmacogenomics Testing	Title changed from Genetic Testing for Pharmacogenetic and Thrombophilia to Pharmacogenomics Testing	February 1, 2023	Commercial	Prior authorization is still required

	• Limits testing for patients being treated with warfarin • Specifies biomarkers for which one-time testing is considered medically necessary			through AIM Specialty Health.

RADIATION ONCOLOGY

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Radiation Oncology. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE

Radiation Oncology	**Radiation Therapy (excludes Proton) Image Guidance**
	
	Modalities used in Image Guidance
	• Ultrasound-based guidance
	• Stereoscopic x-ray guidance
	• CT based image guidance
	• Real-time intrafraction guidance
	• Surface-based guidance
	Explanation of change
	Added an additional image-guidance technique. No change in intent or coding.
	
	Image guidance, any modality, is appropriate when ANY of the following conditions are met:
	• Intensity modulated radiation therapy (IMRT) is being utilized
	• Proton beam therapy is being utilized
	• Use of IGRT will allow significant reduction of radiation dose to sensitive normal structures, for example:
	  ○ Left-sided breast cancer treatment with deep inspiration breath hold technique (DIBH) for cardiac sparing is being utilized
	• Implanted fiducial markers have been placed
	• Head and neck cancer
	• Prone breast radiotherapy
	• The treatment field abuts a previously irradiated field
	• There is significant setup variation affecting the treatment target, for example:
	  ○ Individual is morbidly obese (BMI > 35) and receiving treatment of tumors in the mediastinum, abdomen or pelvis
	  ○ There is significant organ movement due to respiration and a 4D planning CT scan was performed with documentation demonstrating that the treatment plan addresses tumor motion that is both accounted for and managed
	Exclusions
	Image guidance not meeting any of the above criteria is considered not medically necessary including, but not limited to:
		April 9, 2023

	• IGRT when used in conjunction with superficial x-rays or electron beam therapy in the treatment of non-melanoma skin cancer. **Explanation of change** Deleted general language which was being inappropriately used. Separated out the specific criteria previously used as examples. Added statement that IGRT is not medically necessary to guide superficial radiotherapy for non-melanoma skin cancer. This is supported by an ASTRO Clinical Practice Guideline which states: "Daily imaging is neither necessary nor useful when treating with electron beam, ELS, or skin surface brachytherapy."	
Radiation Oncology	**CNS Cancers** Intracranial Lesions Stereotactic Radiosurgery (SRS/SBRT) is appropriate for metastatic brain lesions when **ANY** of the following conditions are met: • Primary treatment of 4 or fewer unresected brain metastases • Postoperative treatment of 1-2 brain metastases • To treat a previously irradiated field **Explanation of change** This aligns with the ASCO-SNO-ASTRO Guideline on Treatment for Brain Metastases (Vogelbaum et al. J Clin Oncol. 2022 Feb)	April 9, 2023
Radiation Oncology	**Gastrointestinal Cancers: Cholangiocarcinoma, Esophageal, Gastric, Hepatocellular, Pancreatic** Intensity Modulated Radiation Therapy (IMRT) is appropriate for the curative treatment of **cholangiocarcinoma** when **EITHER of the following conditions is met**: • Primary or postoperative treatment when there is no evidence of distant metastasis • To treat a previously irradiated field Intensity Modulated Radiation Therapy (IMRT) is appropriate for the curative treatment of **esophageal** cancer **when EITHER of the following conditions is met**: • Primary or postoperative treatment when there is no evidence of distant metastasis • To treat a previously irradiated field Intensity Modulated Radiation Therapy (IMRT) is appropriate for the curative treatment of **gastric** cancer **when EITHER of the following conditions is met:** • Primary or postoperative treatment when there is no evidence of distant metastasis • To treat a previously irradiated field Intensity Modulated Radiation Therapy (IMRT) is appropriate for the curative treatment of **hepatocellular** carcinoma **when EITHER of the following conditions is met**: • Primary or postoperative treatment when there is no evidence of distant metastasis • To treat a previously irradiated field	November 6, 2022 Highlighted in green: Expansive changes become effective on this date

	Intensity Modulated Radiation Therapy (IMRT) is appropriate for the curative treatment of **pancreatic** cancer **when EITHER of the following conditions is met**: • Primary or postoperative treatment when there is no evidence of distant metastasis • To treat a previously irradiated field **Explanation of change** Removed plan comparison requirement because IMRT has become standard of care for curative treatment of these GI malignancies.	
Radiation Oncology	**Lung Cancer** Stereotactic Body Radiation Therapy (SBRT) is appropriate for metastatic lesions in the lung **when EITHER of the following conditions is met:** • To treat oligometastatic disease (see separate section) • To treat a previously irradiated field **Explanation of change** Intent is neutral. Removed confusing language given separate indication for Oligometastatic Extracranial Disease.	April 9, 2023
Radiation Oncology	**Oligometastatic Extracranial Disease** **Stereotactic Body Radiation Therapy (SBRT) is medically necessary for extracranial oligometastatic disease when ALL of the following conditions are met:** • One (1) to three (3) metastatic lesions involving the lungs, liver, adrenal glands, or bone • Primary tumor is breast, colorectal, melanoma, non-small cell lung, prostate, renal cell, or sarcoma • Primary tumor is controlled • No prior history of metastatic disease **Explanation of change** Added indication for adrenal metastases as SABR-COMET trial listed this as one of the most common sites treated in that trial.	November 6, 2022 Highlighted in green: Expansive changes become effective on this date
Radiation Oncology	**Low risk of recurrence** Brachytherapy is appropriate as monotherapy for low-risk prostate cancer. **EITHER of** the following is appropriate: • Low dose rate (LDR) brachytherapy • High dose rate (HDR) brachytherapy *Note: Active surveillance is a reasonable alternative to radiation treatment in individuals with low-risk prostate cancer.* **Intermediate risk of recurrence** Brachytherapy is appropriate as either monotherapy or as a boost in combination with external beam radiotherapy. **EITHER of the following is appropriate:** • Low dose rate (LDR) brachytherapy • High dose rate (HDR) brachytherapy [removed "as boost only"] **Explanation of change** Added indication for HDR brachytherapy monotherapy in low- and intermediate-risk disease based on revised recommendations from	November 6, 2022 Highlighted in green: Expansive changes become effective on this date

	GEC-ESTRO ACROP Prostate Brachytherapy Guidelines, NCCN, and Anderson et al. J Contemp Brachytherapy 2021. This has become standard of care.	
Radiation Oncology	**Skin Cancer** **Exclusions** **Indications other than those addressed in this guideline are considered not medically necessary including, but not limited to:** • Electronic brachytherapy • IGRT when used in combination with superficial x-rays or electron therapy (see IGRT section) **Explanation of change** Added statement that IGRT is not medically necessary to guide superficial radiotherapy for non-melanoma skin cancer. This is supported by an ASTRO Clinical Practice Guideline which states: "Daily imaging is neither necessary nor useful when treating with electron beam, ELS, or skin surface brachytherapy."	April 9, 2023
Radiation Oncology	**Therapeutic Radiopharmaceuticals** **Lutetium Lu 177 vipivotide tetraxetan** Lutetium Lu 177 vipivotide tetraxetan A single course of Lutetium Lu 177 vipivotide tetraxetan (Pluvicto™), up to six doses given every 6 weeks, is considered medically necessary for treatment of prostate cancer when **ALL** of the following conditions are met: • Individual is age 18 or older • Individual has castrate-resistant, metastatic prostate cancer • Prostate-specific membrane antigen (PSMA)-positive disease demonstrated by a positive PSMA-11 based PET scan • Previous treatment with taxane-based chemotherapy • Previous treatment with **ONE** of the following androgen receptor (AR) pathway inhibitors: o Abiaterone o Apalutamide o Enzalutamide o Darolutamide Lutetium Lu 177 vipivotide tetraxetan (Pluvicto) is considered not medically necessary when: • The above criteria are not met and for all other indications **Explanation of change** Added Lutetium Lu 177 vipivotide tetraxetan (Pluvicto™), FDA approved for the treatment of adult patients with prostate-specific membrane antigen (PSMA)-positive metastatic castration-resistant prostate cancer who have been treated with AR pathway inhibition and taxane-based chemotherapy	November 6, 2022 Highlighted in green: Expansive changes become effective on this date
Radiation Oncology	**Proton Beam Therapy – guidelines reaffirmed** Discussion and References updated	N/A
Radiation Oncology	**Hydrogel Spacer for Prostate Radiotherapy – guidelines reaffirmed**	N/A

	Discussion and References updated	

RADIOLOGY ABDOMEN AND PELVIS IMAGING

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Radiology. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE
Abdomen and Pelvis Imaging	**Female Reproductive System and Obstetric Indications** **Uterine leiomyomata (fibroids)** Advanced imaging is considered medically necessary following nondiagnostic ultrasound in **EITHER** of the following scenarios: • When ultrasound features suggest leiomyosarcoma • For management prior to a fertility-sparing procedure, with the exception of MR-guided focused ultrasound **Explanation of change** Added indication for characterization of an indeterminate leiomyoma separate from planned fertility sparing procedure (this would previously have been approvable under tumor NOS, but no longer falls under that category since this indication was renamed – previously called "uterine artery embolization.")	April 9, 2023

Abdomen and Pelvis Imaging	**Pancreatic Indications**
	
	Pancreatic duct dilatation
	Advanced imaging is considered medically necessary for evaluation of pancreatic duct dilatation seen on ultrasound or CT.
	IMAGING STUDY
	MRI/MRCP abdomen
	Explanation of change
	Added indication to assess isolated dilatation of the pancreatic duct (there is an existing indication for biliary tract dilatation)
	
	Pancreatic mass, indeterminate cystic (IPMN/IPMT)
	ADULT
	Advanced imaging is considered medically necessary for diagnosis, management, and surveillance in surgical candidates when EUS/FNA has not been performed or is nondiagnostic in **ANY** of the following scenarios:
	• Initial evaluation of an indeterminate mass identified on ultrasound
	• Age 80 or greater at the time of diagnosis: every other year for up to 4 years or every other year if enlarging
	• Cysts less than 1.5 cm
	  ○ Age less than 65 at diagnosis: every 12 months for up to 9 years from the time of initial diagnosis
	  ○ Age 65 to 79 at diagnosis: every 24 months for up to 10 years from the time of initial diagnosis, or annually if the lesion has worrisome features (enhancing nodules or peripheral calcification) or if the patient has high risk of pancreatic malignancy
	Explanation of change
		April 9, 2023

	Added allowance for more frequent follow up of lesions with suspicious features or in high-risk patients, for those age 65-79 at diagnosis **Pancreatitis** **IMAGING STUDY** • CT abdomen or CT abdomen and pelvis • MRI abdomen in pediatric patients; MRI abdomen in adults when CT cannot be performed • MRCP for recurrent acute pancreatitis to evaluate suspected pancreatic duct anomalies **Explanation of change** Removed indication for MRI following nondiagnostic CT as the evidence does not support superior diagnostic accuracy for MRI	
Abdomen and Pelvis Imaging	**Renal, Adrenal, and Urinary Tract Indications** **Polycystic kidney disease** Advanced imaging is considered medically necessary for diagnosis and management following nondiagnostic ultrasound, to evaluate total kidney volume **AND** to assist in decisions on medical therapy. **IMAGING STUDY** • CT abdomen or CT abdomen/pelvis • MRI abdomen **Explanation of change** Added CT abdomen/pelvis	April 9, 2023
Abdomen and Pelvis Imaging	**Miscellaneous Conditions** **Pelvic floor disorders** Advanced imaging is considered medically necessary for diagnosis and management in **EITHER** of the following scenarios: • Functional disorder of the pelvic floor associated with urinary or bowel incontinence • Chronic constipation, when anorectal manometry or balloon expulsion tests are nondiagnostic **IMAGING STUDY** • MRI pelvis • Dynamic MRI (MR defecography) may be of benefit in some clinical scenarios [119, 120] **Explanation of change** Added indication for MR pelvis (MR defecography) in chronic constipation	April 9, 2023
Abdomen and Pelvis Imaging	**Nonspecific Signs and Symptoms** Abdominal and/or pelvic pain, undifferentiated **IMAGING STUDY** • CT abdomen for upper quadrant (right or left) and epigastric pain • CT abdomen and/or pelvis for lower quadrant (right or left) and generalized abdominal pain • CT pelvis for pelvic pain • MRI pelvis for pelvic pain • MRI abdomen in pediatric patients; MRI abdomen in adults when CT cannot be performed	April 9, 2023

	Explanation of change Removed indication for MRI following nondiagnostic CT, as there is no evidence supporting superior diagnostic accuracy for MRI compared to CT in assessing undifferentiated abdominopelvic pain	

RADIOLOGY BRAIN IMAGING

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Radiology. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE
Brain Imaging	**Tumor or Neoplasm** **Meningioma** Advanced imaging is considered medically necessary in **EITHER** of the following scenarios: Management • For a patient with known meningioma and new or worsening symptoms • Surveillance in **EITHER** of the following scenarios: • Every 6 months if **ANY** of the following are present: ○ Vasogenic edema on prior MRI ○ Interval growth on prior imaging ○ Lesion is located in the sphenoid wing, venous sinus, or skull base regions ○ Atypical or malignant/anaplastic meningioma (WHO grade II or grade III) on pathology • Every 12 months if none of the above features are present **Explanation of change** Additional indication for more frequent follow up, based on prior evidence review and clinician feedback	April 9, 2023
Brain Imaging	**Miscellaneous Conditions** **Bell's palsy (peripheral facial nerve palsy)** **IMAGING STUDY** • CT brain when MRI cannot be performed • MRI brain **Explanation of change** Limited the use of CT to scenarios where MRI cannot be performed **Seizure disorder and epilepsy** **PEDIATRIC** Advanced imaging is considered medically necessary in **ANY** of the following scenarios: • Neonatal/infantile seizure (age 2 years or younger) when **EITHER** of the following is present: ○ Initial evaluation of seizure not associated with fever ○ Periodic follow up at 6 month intervals up to 30 months, if initial imaging study is nondiagnostic • Childhood/adolescent seizure (over age 2) for diagnosis and management when **ANY** of the following is present: ○ Focal neurologic findings at the time of the seizure ○ Persistent neurologic deficit in the postictal period	April 9, 2023

	○ Idiopathic generalized epilepsy with atypical clinical course ○ Partial seizures ○ Electroencephalogram (EEG) findings inconsistent with idiopathic epilepsy or nondiagnostic EEG ○ Management of patients without an established diagnosis of idiopathic generalized epilepsy in **ANY** of the following scenarios: ▪ Evaluation of seizures increasing in frequency or severity despite optimal medical management ▪ Prior to discontinuation of anticonvulsant therapy in patients who have not been previously imaged ▪ Epilepsy refractory to optimal medical management in surgical candidates • Complex febrile seizure (age 6 months to 5 years) when **EITHER** of the following is present: ○ More than one seizure during a febrile period ○ Seizure lasting longer than 15 minutes **Explanation of change** Moved "management" indications for pediatric seizure into the "childhood/adolescent seizure" section for clarity; no change in content Added criterion for imaging of pediatric patients with nondiagnostic EEG	

RADIOLOGY CHEST IMAGING

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Radiology. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE
Chest Imaging	**Perioperative evaluation, not otherwise specified** **Lung volume reduction procedures** Advanced imaging is considered medically necessary for evaluation prior to planned lung volume reduction procedures [24, 25] **IMAGING STUDY** • CT chest **Explanation of change** Added indication for pre-procedure CT	November 6, 2022 Highlighted in green: Expansive changes become effective on this date
Chest Imaging	**Abnormal Test Findings** **Imaging abnormalities** Advanced imaging is considered medically necessary for follow up of **ANY** of the following abnormalities identified on chest X-ray or other thoracic imaging study: • Pulmonary mass, structural or parenchymal abnormality • Hilar enlargement or mediastinal widening • Hyperlucent lung in pediatric patients	April 9, 2023

	• Unexplained diaphragmatic elevation or immobility • Findings on other imaging suggesting tracheal or bronchial pathology **Explanation of change** Added indication for tracheobronchial abnormalities on other imaging	

RADIOLOGY HEAD AND NECK IMAGING

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Radiology. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE

Head and Neck Imaging	**Tumor/Soft Tissue Mass**
	
	Neck mass (including lymphadenopathy)
	ADULT
	• Management:
	  ○ To direct management of a known benign or benign-appearing mass incompletely characterized on ultrasound or laryngoscopy
	  ○ For evaluation of established lymphadenopathy which is persistent and unexplained
	PEDIATRIC
	• Management:
	  ○ To direct management of a known benign or benign-appearing mass incompletely characterized on ultrasound or laryngoscopy
	  ○ For management of established lymphadenopathy in **ANY** of the following scenarios:
	  ▪ Ultrasound findings suggestive of nodal malignancy
	  ▪ Nondiagnostic ultrasound and failure to resolve following a 6-week course of empiric therapy
	  ▪ Nondiagnostic ultrasound and **ANY** of the following features:
	  • Absence of pain or tenderness
	  • Constitutional symptoms
	  • Firm/immobile and size greater than 3 cm in diameter
	  • Persistent enlargement on exam for longer than 2 weeks
	  • Presence of ulceration
	  • Supraclavicular or posterior triangle location
	Note: Biopsy may be more appropriate than imaging when any of these features are present.
	Explanation of change
	Moved criteria for management of established lymphadenopathy from signs/symptoms to this indication
		April 9, 2023

Head and Neck Imaging	**Perioperative imaging** **Perioperative imaging, not otherwise specified** *Includes only indications not listed elsewhere in this guideline document* Advanced imaging is considered medically necessary in the following scenarios: • For preoperative planning related to orthognathic surgery • For preoperative planning related to facial feminization surgery **Explanation of change** Added indication for preoperative assessment for facial feminization surgery	April 9, 2023

RADIOLOGY ONCOLOGIC IMAGING

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Radiology. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE

Oncologic Imaging	**Cancer Screening**
	
	Breast cancer screening
	• Individuals known to have **ANY** of the following established genetic mutations:
	  ○ ATM
	  ○ BARD1
	  ○ CDH1
	  ○ CHEK2
	  ○ NF-1
	  ○ PALB2
	  ○ PTEN
	Explanation of change
	NCCN alignment for genetic mutations: Addition of BARD1 (strong evidence for triple neg disease); removal of NBN (no established association w/ breast cancer)
		April 9, 2023

Oncologic Imaging	**Cervical Cancer** **FDG-PET/CT** Management- Indicated in **ANY** of the following scenarios: • Standard imaging cannot be performed or is nondiagnostic for recurrent or progressive disease • Assessment of response to definitive chemoradiation when performed at least 12 weeks following therapy • Signs or symptoms concerning for recurrent or metastatic disease **Explanation of change** PET Management: stage II and higher no longer specified by NCCN for Suspected Recurrence or Metastasis (2A rec)	April 9, 2023
Oncologic Imaging	**Head and Neck Cancer**	April 9, 2023

	FDG-PET/CT Diagnostic Workup- Indicated in **EITHER** of the following scenarios: • Evaluation of locoregionally advanced cancers (T3-T4 primary or ≥ N1 nodal staging) of the oral cavity, oropharynx, hypopharynx, nasopharynx, larynx, and sinus • Following biopsy suggestive of a head and neck primary tumor (squamous cell cancer, adenocarcinoma, or anaplastic undifferentiated epithelial tumor) when CT or MRI evaluation of the neck has not detected a primary site of tumor **Explanation of change** PET diagnostic workup: NCCN alignment (expansive for HPV-mediated oropharhyngeal cancer, otherwise no change for other subtypes)	
Oncologic Imaging	**Histiocytic Neoplasms** **FDG-PET/CT** Surveillance- Indicated for **EITHER** of the following scenarios: • LCH: every 3-6 months for first 2 years following treatment completion, then annually • ECD/RDD: every 3-6 months after starting therapy until stabilization of disease **Explanation of change** PET/CT Surveillance: frequency/duration aligned with NCCN 2A recommended intervals	April 9, 2023
Oncologic Imaging	**Lymphoma – Non-Hodgkin and Leukemia** **Lymphoma – Non-Hodgkin: Indolent non-Hodgkin lymphoma** CT neck, CT chest, CT abdomen and pelvis Surveillance- Indicated in **EITHER** of the following scenarios: • Follicular, marginal zone/MALT, or mantle cell lymphoma: Up to 2 years following completion of treatment and every 12 months thereafter • All other subtypes: Not to exceed 2 years following completion of treatment **Explanation of change** NHL CT surveillance: NCCN 2A frequency alignment by subtype beyond 2 years following treatment completion **Lymphoma – Non-Hodgkin: Intermediate and high-grade non-Hodgkin lymphoma** CT chest, CT abdomen and pelvis Surveillance- Indicated in **EITHER** of the following scenarios: • Follicular, marginal zone/MALT, or mantle cell lymphoma: Up to 2 years following completion of treatment and every 12 months thereafter • All other subtypes: Not to exceed 2 years following completion of treatment **Explanation of change** NHL CT surveillance: NCCN 2A frequency alignment by subtype beyond 2 years following treatment completion	April 9, 2023

Oncologic Imaging	**Multiple Myeloma** MRI (bone marrow blood supply) Management- Indicated for **ANY** of the following scenarios: • Multiple myeloma • Smoldering myeloma or solitary plasmacytoma: restaging/treatment response, or follow-up every 12 months **Explanation of change** NCCN 2A alignments for "Follow-up/Surveillance" imaging: "as needed" for MM, and "annually or as clinically indicated" for SP/SM (more specific for bone marrow MRI with SP/SM). **FDG-PET/CT** Management- Indicated for **ANY** of the following scenarios: • Multiple myeloma • Smoldering myeloma or solitary plasmacytoma: restaging/treatment response, or follow-up every 12 months **Explanation of change** NCCN 2A alignments for "Follow-up/Surveillance" imaging: "as needed" for MM, and "annually or as clinically indicated" for SP/SM (permissive for PET/CT with MM).	April 9, 2023

Oncologic Imaging	**Prostate Cancer**
	
	18F Fluciclovine PET/CT or 11C Choline PET/CT
	Management- Indicated when **ALL** of the following criteria are met:
	• Original clinical stage T1-T3 and NX or N0 treated with prostatectomy and/or radiation therapy
	• Negative or nondiagnostic imaging within past 60 days, based on most recent PSA value (if applicable):
	  ○ PSA ≤ 1 ng/ml and rising: Prostate MRI
	  ○ PSA > 1 ng/ml and < 10 ng/ml: none
	  ○ PSA ≥ 10 ng/ml: Any conventional imaging[2]
	• Patient is a candidate for curative intent salvage therapy[3]
	• PET/CT with 18F Fluciclovine or 11C Choline has not been performed within the past 3 months
	Explanation of change
	18F Fluciclovine or 11C Choline PET/CT Management: Conventional imaging not required when PSA > 1 but < 10 ng/ml (prostate MRI still required when PSA ≤ 1 and rising; conventional imaging still required when PSA ≥ 10 ng/ml)
	
	68GaProstate-specific membrane antigen (PSMA) PET/CT or 18F-DCFPyL (piflufolastat or Pylarify) PET/CT
	Management- Indicated in **EITHER** of the following scenarios:
	• When ALL of the following criteria are met:
	  ○ Original clinical stage T1-T3 and NX or N0 treated with prostatectomy and/or radiation therapy with biochemically recurrent/persistent disease[1]
	  ○ Negative or nondiagnostic imaging within past 60 days, based on most recent PSA value (if applicable):
	  ▪ PSA ≤ 1 ng/ml and rising: none
	  ▪ PSA > 1 ng/ml and < 10 ng/ml: none
	  ▪ PSA ≥ 10 ng/ml: Any conventional imaging[2]
		November 6, 2022
		
		Highlighted in green: Expansive changes become effective on this date
		
		Other updates are effective April 9, 2023

	○ Patient is a candidate for curative intent salvage therapy[3] ○ PET/CT has not been performed within the past 3 months • Metastatic castrate-resistant disease previously treated with androgen receptor pathway inhibition and taxane-based chemotherapy, prior to planned treatment with radioligand therapy. **Effective November 6, 2022** **Explanation of change** 68Ga PSMA or 18F-DCFPyL PET/CT Management: Conventional imaging only required when PSA ≥ 10 Addition of theranostic indication aligned with FDA-approved use of Pluvicto (radioligand) treatment	
Section footnotes	**Section footnotes:** 2 Conventional imaging: CT Abdomen and/or Pelvis or MRI pelvis, or mpMRI, or bone scan. **Explanation of change** PET/CT footnote (all tracers): Removal of low-risk disease waiver from conventional imaging footnote (*current PSA may be more appropriate to determine utility of conventional imaging for suspected recurrence rather than original disease risk)*	April 9, 2023
Oncologic Imaging	**Cancers of the Pleura, Thymus, Heart, and Mediastinum** **FDG-PET/CT** Diagnostic Workup- Indicated in **EITHER** of the following scenarios: • When surgical resection is being considered and metastatic disease has not been detected by CT or MRI • For surgical evaluation of malignant pleural mesothelioma (clinical stage I-IIIA and epithelioid histology), after CT chest and abdomen **Explanation of change** NCCN 2A FDG PET/CT alignment for workup/surgical evaluation of MPM (new scenario allowing presurgical PET without negative CT)	April 9, 2023
Oncologic Imaging	**Thyroid Cancer** **FDG-PET/CT** Diagnostic Workup- Indicated for **ANY** of the following subtypes: • Poorly differentiated papillary • Anaplastic • Hürthle Cell Management- Indicated in **ANY** of the following scenarios: • Follow up of poorly differentiated papillary or anaplastic carcinoma • Suspected recurrence of well-differentiated papillary, follicular, or Hürthle cell cancer when I-131 scan is negative (or has been negative in the past) and stimulated thyroglobulin level is > 2 ng/dL • Suspected recurrent medullary carcinoma when detectable basal calcitonin or elevated CEA, and standard imaging is negative **Explanation of change**	April 9, 2023

	NCCN alignment: FDG PET/CT: Hurthle cell carcinoma (management); medullary carcinoma (diagnostic workup/management) **Somatostatin receptor PET/CT** Diagnostic Workup- Indicated for medullary carcinoma Management- Indicated for suspected recurrent medullary carcinoma when detectable basal calcitonin or elevated CEA, and standard imaging is negative **Explanation of change** NCCN alignment: SR PET/CT: Addition of modality for diagnostic workup/management of medullary carcinoma	

New 2022 Category III CPT Codes

All category III CPT Codes, including new 2022 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.