MASSACHUSETTS

MEDICAL POLICY ANNOUNCEMENTS

Posted October 2024

This document announces new medical policy changes that take effect January 1, 2025. Changes affect these specialties:

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

DERMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Amniotic Membrane and Amniotic Fluid	643	**Policy revised.** AmnioExcel added to the list of medically necessary products for the treatment of nonhealing diabetic lower-extremity ulcers.	January 1, 2025	Commercial Medicare	No action required.
Bioengineered Skin and Soft Tissue Substitutes	663	**Policy revised.** mVASC and TheraSkin added to medically necessary statement for diabetic lower-extremity ulcers. Several products added to investigational list.	January 1, 2025	Commercial Medicare	No action required.

GENERAL SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Treatment of Hyperhidrosis	406	**Policy clarified.** Endoscopic transthoracic sympathectomy and surgical excision of	October 1, 2024	Commercial	No action required.

		axillary sweat glands (CPT 32664) retired and removed from the policy. **This is a covered service.** 32664 Thoracoscopy, surgical; with thoracic sympathectomy .			

OBSTETRICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Assisted Reproductive Services	086	**Policy clarified.** Cryochoice kits are not covered.	October 1, 2024	Commercial	Prior authorization is still required.

ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Ablation Procedures for Peripheral Neuromas	719	**Policy 719 retired.** This is a covered service.	October 1, 2024	Commercial	No action required.

PLASTIC SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Plastic Surgery	068	**Policy clarified.** Hair transplants statement removed. Coverage is determined by the subscriber certificate.	October 1, 2024	Commercial	Prior authorization is still required.
Gender Affirming Services	189	Investigational indications **revised.**	January 1, 2025	Commercial Medicare	Prior authorization is still required.

PULMONOLOGY SLEEP DISORDER MANAGEMENT

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Actigraphy	533	**Policy 533 retired.** Code 95803 transferred to MP 400 Medical Technology Assessment Non-Covered List. 95803 Actigraphy testing, recording, analysis, interpretation and report (minimum of 72 hours to 14 consecutive days of recording)	October 1, 2024	Commercial	No action required.

TRANSPLANTATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Allogeneic Pancreas Transplant	328	**Policy revised.** Policy Guidelines updated to remove obesity-related criteria.	October 1, 2024	Commercial	Procedure is performed inpatient.

UROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Whole Gland Cryoablation of the Prostate	149	**Policy 149 retired.** This is a covered service.	October 1, 2024	Commercial	No action 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.