



MEDICAL POLICY ANNOUNCEMENTS

Posted March 2023

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

[Durable Medical Equipment](#)
[Anesthesiology](#) [Gastroenterology](#)
[Plastic Surgery and Dermatology](#)
[Pharmacy](#)

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

DURABLE MEDICAL EQUIPMENT

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Stationary Ultrasonic Diathermy Devices	199	<p>Policy clarified. New medical policy describing investigational indications. Policy is being transferred from MP 400 to MP 199.</p> <p>K1004 Low frequency ultrasonic diathermy treatment device for home use, includes all components and accessories</p>	March 1, 2023	Commercial Medicare	No action required

ANESTHESIOLOGY GASTROENTEROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Monitored Anesthesia Care (MAC)	154	<p>Enforcement update. Diagnoses codes list added. New diagnoses-to-CPT codes edit implemented.</p>	July 1, 2023	Commercial Medicare	Prior authorization is still not required.

PLASTIC SURGERY AND DERMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Bioengineered Skin and Soft Tissue Substitutes	663	Policy revised. ReCell® added to the list of investigational products.	June 1, 2023	Commercial Medicare	No action required

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Gene Therapies for Cerebral Adrenoleukodystrophy	241	New medical policy describing medically necessary indications. The use of elivaldogene autotemcel is considered medically appropriate for individuals with childhood cerebral X-linked adrenoleukodystrophy when certain conditions are met. Prior Authorization Request Form #242, Gene Therapy for Cerebral Adrenoleukodystrophy Skysona® (Elivaldogene autotemcel)	February 1, 2023	Commercial Medicare	Prior authorization is required

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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