MASSACHUSETTS

MEDICAL POLICY ANNOUNCEMENTS

Posted December 2022

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

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

BEHAVIORAL HEALTH

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Applied Behavior Analysis (ABA)	091	**Policy reformatted.** Adaptive behavior assessment services, adaptive behavior treatment services, and clinician directed treatment sections reformatted. References added.	December 1, 2022	Commercial	No action required

DURABLE MEDICAL EQUIPMENT; ENDOCRINOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Artificial Pancreas Device Systems	107	**HCPCS Code A4238** Supply allowance for adjunctive continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service **Prior authorization is required effective March 1, 2023**	March 1, 2023	Commercial	Prior authorization will be required

		HCPCS Code A4239 Supply allowance for non-adjunctive, non-implanted continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service **Prior authorization is required effective January 1, 2023**	January 1, 2023		

GASTROENTEROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Serological Diagnosis of Celiac Disease	138	**Policy revised** to include that monitoring adherence to a gluten-free diet with serum IgA anti-gliadin or IgA transglutaminase (TTG) levels is considered medically necessary. added.	March 1, 2023	Commercial Medicare	No action required

NEUROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Evaluation of Biomarkers for Alzheimer Disease	581	Existing investigational policy statement on urinary and blood biomarkers **clarified.**	December 1, 2022	Commercial Medicare	No action required
Intravenous Antibiotic Therapy and Associated Diagnostic Testing for Lyme Disease	171	Policy statement on diagnostic testing **clarified** to include Outer surface protein A (OspA) antigen testing.	December 1, 2022	Commercial	No action required

OBSTETRICS AND GYNECOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Multitarget Polymerase Chain Reaction Testing for Diagnosis of Bacterial Vaginosis	711	**Policy revised.** New medically necessary indications described for PCR testing for bacterial vaginosis.	March 1, 2023	Commercial Medicare	No action required

PLASTIC AND RECONSTRUCTIVE SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Plastic Surgery	068	**Cleft Lip/Cleft Palate Repair** Policy statement **clarified** for members <18 years of age (from birth through age 17).	March 1, 2023	Commercial	No action required
Plastic Surgery	068	**Lipoma removal** **Policy revised** to include medically necessary statement on lipoma removal when the lipoma is painful and causes functional limitations with activities of daily living based on its location.	March 1, 2023	Commercial	No action required
Plastic Surgery Mandibular or maxillary	068	**Mandibular or maxillary** **Policy clarified.** These surgical procedures were transferred to new medical policy #179, Orthognathic Surgery. • Mandibular or maxillary osteotomy/plasty for prognathism or micrognathism with documented severe handicapping malocclusion.	March 1, 2023	Commercial	No action required

		• Other osteotomy/plasty for congenital conditions that cause severe facial or cranio-facial deformities including but not limited to Crouzon's syndrome, Treacher Collin's dysostosis, or Romberg's disease. • Mentoplasty.			
Orthognathic Surgery	179	**New medical policy** describing ongoing and expanded medically necessary and not medically necessary indications. The following surgical procedures were transferred from policy #068 Plastic Surgery to new medical policy #179, Orthognathic Surgery. • Mandibular or maxillary osteotomy/plasty for prognathism or micrognathism with documented severe handicapping malocclusion. • Other osteotomy/plasty for congenital conditions that cause severe facial or cranio-facial deformities including but not limited to Crouzon's syndrome, Treacher Collin's dysostosis, or Romberg's disease. • Mentoplasty.	March 1, 2023	Commercial Medicare	Prior authorization is still required

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.

MPC_033121-3Q-1-PO (rev 10/21)