June 2021 Medical Policy Announcements
Posted: June 2021
New and revised policies: Effective September 2021 (for variable effective dates see table below)
Clarified policies: Posted June 2021 (for variable posted dates see table below)
Retired policies: Effective June 2021

To make it easier for providers to find the new policies and revisions, the Medical Policy Administration department is posting the following searchable lists of new, revised, clarified and retired policies.

The following tables of contents are organized by policy type and alphabetically by policy title. The entries in each table are also color coded to help identify new, revised, clarified and retired policies. Clicking on a title in any of the tables of contents will take you to a summary of the new or revised policy.

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.

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NEW MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Chimeric Antigen Receptor Therapy for Multiple Myeloma	942	New medical policy describing medically necessary indications of idecabtagene vicleucel	June 4, 2021	Commercial	Hematology Oncology

		(ABECMA) for individuals with relapsed and/or refractory multiple myeloma and have received four or more prior lines of therapy and when certain conditions are met. See new policy **#943** Prior Authorization Request Form for CAR T-Cell Therapy Services for Multiple Myeloma (Idecabtagene vicleucel)			

REVISED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Assisted Reproductive Services	086	Policy updated to add language that intrauterine insemination (IUI) must be done in the office setting and that donor sperm is only covered when used for IUI in the office setting.	September 1, 2021	Commercial Medicare	Obstetrics Gynecology Endocrinology
Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Artificial Pancreas Device Systems	107	Artificial Pancreas: Medically necessary policy statement added for use of an FDA-approved hybrid closed loop system in children ages 2 to 6 years.	September 1, 2021	Commercial	Endocrinology
Plastic Surgery	068	New medically necessary indications described. Lipoma removal may be considered medically necessary when the lipoma is painful and causes functional limitations with activities of daily living based on its location.	September 1, 2021	Commercial	Plastic Surgery

Advanced Imaging Radiology
Effective for dates of service on and after September 12, 2021, the following updates will apply to the AIM Advanced Imaging Clinical Appropriateness Guidelines. 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	Contains updates to the following:	Effective Date	Products Affected	Policy Type
Imaging of the Extremities	Osteomyelitis or septic arthritis; myositis • Removed CT as a follow-up to nondiagnostic MRI due to lower diagnostic accuracy of CT	September 12, 2021	Commercial Medicare	Radiology

	Epicondylitis and Tenosynovitis – long head of biceps • Removed due to lack of evidence supporting imaging for this diagnosis Plantar fasciitis and fibromatosis • Removed CT as a follow-up to nondiagnostic MRI due to lower diagnostic accuracy of CT • Added specific conservative management requirements Brachial plexus mass • Added specific requirement for suspicious findings on clinical exam or prior imaging Morton's neuroma • Added requirements for focused steroid injection, orthoses, plan for surgery Adhesive capsulitis • Added requirement for planned intervention (manipulation under anesthesia or lysis of adhesions) Rotator cuff tear; Labral tear – shoulder; Labral tear - hip • Defined specific exam findings and duration of conservative management • Recurrent labral tear now requires same criteria as an initial tear (shoulder only) Triangular fibrocartilage complex tear • Added requirement for radiographs and conservative management for chronic tear Ligament tear – knee; meniscal tear • Added requirement for radiographs for specific scenarios • Increased duration of conservative management for chronic meniscal tears Ligament and tendon injuries – foot and ankle • Defined required duration of conservative management Chronic anterior knee pain including chondromalacia patella and patellofemoral pain syndrome • Lengthened duration of conservative management and specified requirement for chronic anterior knee pain Intra-articular loose body • Requirement for mechanical symptoms Osteochondral lesion (including osteochondritis dissecans, transient dislocation of patella)			

	• New requirement for radiographs Entrapment neuropathy • Exclude carpal and cubital tunnel Persistent lower extremity pain • Defined duration of conservative management (6 weeks) • Exclude hip joint (addressed in other indications) Upper extremity pain • Exclude shoulder joint (addressed in other indications) • Diagnostic testing strategy limiting use of CT to when MRI cannot be performed or is nondiagnostic Knee arthroplasty, presurgical planning • Limited to MAKO and robotic assist arthroplasty cases Perioperative imaging, not otherwise specified • Require radiographs or ultrasound prior to advanced imaging			
Imaging of the Spine	Congenital vertebral defects • New requirement for additional evaluation with radiographs Scoliosis • Defined criteria for which presurgical planning is indicated • Requirement for radiographs and new or progressive symptoms for postsurgical imaging Spinal dysraphism and tethered cord • Diagnostic imaging strategy limiting the use of CT to cases where MRI cannot be performed • New requirement for US prior to advanced imaging for tethered cord in infants age 5 months or less Multiple sclerosis • New criteria for imaging in initial diagnosis of MS Spinal infection • New criteria for diagnosis and management aligned with IDSA and University of Michigan guidelines Axial spondyloarthropathy • Defined inflammatory back pain • Diagnostic testing strategy outlining radiography requirements Cervical injury • Aligned with ACR position on pediatric cervical trauma Thoracic or lumbar injury • Diagnostic testing strategy emphasizing radiography and limiting the use of MRI for known fracture	September 12, 2021	Commercial Medicare	Radiology

	• Remove indication for follow-up imaging of progressively worsening pain in the absence of fracture or neurologic deficits Syringomyelia • Removed indication for surveillance imaging Non-specific low back pain • Aligned pediatric guidelines with ACR pediatric low back pain guidelines			
Vascular Imaging	• Alternative non-vascular modality imaging approaches, where applicable Hemorrhage, Intracranial • Clinical scenario specification of subarachnoid hemorrhage indication. • Addition of Pediatric intracerebral hemorrhage indication. Horner's syndrome; Pulsatile Tinnitus; Trigeminal neuralgia • Removal of management scenario to limit continued vascular evaluation Stroke/TIA; Stenosis or Occlusion (Intracranial/Extracranial) • Acute and subacute time frame specifications; removal of carotid/cardiac workup requirement for intracranial vascular evaluation; addition of management specifications • Sections separated anatomically into anterior/posterior circulation (Carotid artery and Vertebral or Basilar arteries, respectively) Pulmonary Embolism • Addition of non-diagnostic chest radiograph requirement for all indications • Addition of pregnancy-adjusted YEARS algorithm Peripheral Arterial Disease • Addition of new post-revascularization scenario to both upper and lower extremity PAD evaluation	September 12, 2021	Commercial Medicare	Radiology

CLARIFICATIONS TO MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Posted Date	Products Affected	Policy Type
Gender Affirming Services (Transgender Services)	189	Policy statement clarified to include neck lift as a covered procedure only if the excess skin impairs the outcome of	June 1, 2021	Commercial Medicare	Plastic Surgery

		the covered facial feminization or masculinization procedures. Prior authorization table updated to clarify that prior authorization is not required for surgically implanted puberty blockers.			
Medical Technology Assessment Noncovered Services	400	Guidance UTI Test - Pooled Antibiotic Susceptibility Testing (P-AST) added.	June 1, 2021	Commercial Medicare	Urology
Percutaneous Vertebroplasty and Sacroplasty	484	Investigational policy statement edited for clarity. Policy statements otherwise unchanged.	June 1, 2021	Commercial	Orthopedics Neurosurgery
Prescription Digital Therapeutics for Substance Abuse	127	New policy on hold for further review.	TBD	Commercial Medicare	Behavioral Health

RETIRED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
None	N/A	N/A	N/A	N/A	N/A

NEW PHARMACY MEDICAL POLICIES			
Medical Policy Title	Policy Number	Policy Change Summary	Effective date
None	N/A	N/A	N/A

REVISED PHARMACY MEDICAL POLICIES			
Medical Policy Title	Policy Number	Policy Change Summary	Effective date
None	N/A	N/A	N/A

New 2021 Category III CPT Codes
All category III CPT Codes, including new 2021 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.com/common/en_US/medical_policies/medcat.htm 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*.**