MASSACHUSETTS

MEDICAL POLICY ANNOUNCEMENTS

Posted June 2022

This document announces new medical policy changes that take effect September 1, 2022. Changes affect these specialties:

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

CLINICAL LABORATORY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Pathogen Panel Testing	045	**New medical policy** describing: **New investigational indications** for sepsis panel testing, bloodstream infection panel, panel testing for general screening of microorganisms; and wound panel testing. **Ongoing medically necessary indications**	September 1, 2022	Commercial Medicare	No action required.

		for nucleic acid testing using amplified probe technique (with or without quantification of viral load) for the following microorganisms: Babesiosis; Ehrlichiosis, unspecified; Tick-borne rickettsiosis, unspecified; transferred from MP #555 Identification of Microorganisms Using Nucleic Acid Probes. **Ongoing investigational indications** for urinary tract infection panel. Urinary tract infection panel was transferred from MP #555 Identification of Microorganisms Using Nucleic Acid Probes. **CPT codes 87154 and 0140U will not be covered on or after September 1, 2022.** 87154 Culture, typing; identification of blood pathogen and resistance typing, when performed, by nucleic acid (DNA or RNA) probe, multiplexed amplified probe technique including multiplex reverse transcription, when performed, per culture or isolate, 6 or more targets 0140U Infectious disease (fungi), fungal pathogen identification, DNA (15 fungal targets), blood culture, amplified probe technique, each target reported as detected or not detected			

Identification of Micro-organisms Using Nucleic Acid Probes	555	**Policy clarified.** **Ongoing medically necessary** indications for nucleic acid testing using amplified probe technique (with or without quantification of viral load) for the following microorganisms: Babesiosis; Ehrlichiosis, unspecified; Tick-borne rickettsiosis, unspecified; transferred to MP #045 Pathogen Panel Testing. **Ongoing investigational indications** for urinary tract infection panel. Urinary tract infection panel; transferred to MP #045 Pathogen Panel Testing.	September 1, 2022	Commercial Medicare	No action required.

HEMATOLOGY AND ONCOLOGY – GENETIC TESTING

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Expanded Molecular Panel Testing of Cancers to Identify Targeted Therapies	790	**Policy retired**. Effective September 4, 2022, we will be using AIM's Clinical Appropriateness Guidelines for Molecular Testing of Solid and Hematologic Tumors and Malignancies. Providers may access and download a copy of AIM's current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com	September 4, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

INFERTILITY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Uterus Transplan-tation for Absolute Uterine Factor Infertility	060	**New policy** describing **i**nvestigational statement on uterus transplantation for absolute uterine factor infertility.	September 1, 2022	Commercial Medicare	No action required.

ORTHOPEDIC REHABILITATION MEDICINE

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions	111	**Policy clarified.** The word "focal" was added under the Osteochondral Fresh Allografting section.	May 19, 2022	Commercial Medicare	No action required.
Medical Technology Assessment Non-Covered Services List	400	**Policy clarified** to include ZetrOZ™ ZTX Ultrasonic Diathermy Low Intensity Therapeutic Ultrasound Device.	May 3, 2022	Commercial Medicare	No action required.

PULMONOLOGY OTOLARYNGOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome	130	Hypoglossal nerve stimulation for obstructive sleep apnea (OSA) **is being retired** from policy 130. Effective September 11, 2022, we will be using AIM's Clinical Appropriateness Guidelines for Sleep Disorder Management. Providers may access and download a copy of AIM's current guidelines	September 11, 2022	Commercial Medicare	Prior authorization **required** through AIM Specialty Health.

		here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com			

GENETIC TESTING FOR SINGLE GENE AND MULTIFACTORIAL CONDITIONS

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

Thrombophilia Testing	Testing for common variants in factor V (*F5*) and prothrombin (*F2*) is medically necessary for any of the following indications (*for additional genes related to thrombophilia see germline genetic testing criteria above*):
	• Pregnant woman who has a personal history of a venous
	• thromboembolism (VTE)
	• Individual who has a first-degree relative with *F5* or *F2* thrombophilia and one of the following:
	  ○ Surgery is planned
	  ○ Patient is pregnant
	  ○ Females considering estrogen contraception or hormone replacement therapy if results would influence decision to use estrogen
	
	Explanation of Change
	The criterion for an individual with an unprovoked VTE was removed. The revision is considered a restriction in coverage. There are no validated or widely accepted consensus guidelines to support use of thrombophilia molecular testing in this scenario (Freites and Naymagon 2021). Our current criteria are more of an amalgamation of several mostly older papers than direct guideline recommendations (barring ACOG recommendations for pregnancy and family history indications). The 2020 American Society of Hematology recommendations, which are notably silent on the use of molecular testing to guide treatment decision-making, suggest indefinite antithrombotic
		September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	therapy over stopping anticoagulation for patients with unprovoked DVT and/or PE following primary treatment (Ortel et al. 2020). Thrombophilia molecular testing would therefore no longer alter the treatment plan in this scenario.			
Multifactorial (Non-Mendelian) Genetic Testing	Genetic testing such as gene expression classifiers or polygenic risk scores are considered medically necessary if all of the following are met: **Explanation of Change** • Revision is a clarification and does not represent any change in coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

GENETIC TESTING FOR HEREDITARY CANCER SUSCEPTIBILITY

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Appropriate Use Criteria	Genetic testing for hereditary cancer susceptibility, when the condition is not listed below, is medically necessary when all of the following criteria are met: • Results are expected to lead to a change in medical management • National Comprehensive Cancer Network® (NCCN®) Clinical Practice Guidelines in Oncology (NCCN Guidelines®) include category 1 or 2A, and/or other published management recommendations for an individual who tests positive for the condition/syndrome-specific genes for which testing is being requested • The individual is the most appropriate person to test, or the most appropriate family member is unavailable for testing • An individual's personal and/or family history meets specific testing criteria suggestive of a	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	hereditary cancer syndrome based on best practice guidelines • Testing method is as targeted as possible (e.g., single gene, known familial pathogenic or likely pathogenic (P/LP) variant, etc.) • Testing methodology* has been clinically validated and is the most accurate method unless technical limitations (e.g., poor sample quality) necessitate the need for alternate testing strategies **Explanation of Change** Revisions include clarifications to streamline text and align with additional changes made to the guideline (see below) with no impact on coverage stance.			
Germline Testing Following Identification of a Somatic Variant	After a somatic variant is identified in a solid tumor or hematologic malignancy, follow-up germline testing for that variant is medically necessary when the following criteria are met **Explanation of Change** The revision is a clarification with no impact on coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.
National Compre-hensive Cancer Network ® (NCCN® Criteria)	Delete reference to the Neuroendocrine and Adrenal Tumors *and* Gastric Cancer NCCN® guidelines. This section now only lists the NCCN® Genetic/Familial High-Risk Colorectal Cancer v1.2021 *and* the NCCN® Genetic/Familial High-Risk Breast, Ovarian and Pancreatic guidelines v2.2022. **Explanation of Change** • The NCCN® Neuroendocrine and Adrenal Tumors guidelines and Gastric Cancer guidelines have evolved and become much broader in scope. Claims for genetic testing for Hereditary Paraganglioma-	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	Pheochromocytoma syndromes, von Hippel-Lindau and hereditary diffuse gastric cancer can be adjudicated using our appropriate use criteria. This revision does not impact coverage stance. • The NCCN® Genetic/Familial High-Risk Breast, Ovarian and Pancreatic guidelines were updated on March 9, 2022 to v2.2022. Revisions were only made to the discussion section which do not impact current coverage criteria.			
Hereditary Paragan-Glioma Pheochromo-cytoma Syndromes and von Hippel-Lindau	**Hereditary Paraganglioma-Pheochromocytoma Syndromes** *Entire section is deleted.* **von Hippel-Lindau** *Entire section is deleted.* **Explanation of Change** Claims for genetic testing for Hereditary Paraganglioma-Pheochromocytoma syndromes and von Hippel-Lindau can be adjudicated using the appropriate use criteria. Therefore, these hereditary syndromes do not differ from any others and do not need to be called out in this guideline. This revision does not impact coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

GENETIC TESTING FOR REPRODUCTIVE CARRIER SCREENING AND PRENATAL DIAGNOSIS

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Spinal Muscular Atrophy	**Spinal Muscular Atrophy** Spinal muscular atrophy (SMA) carrier screening by SMN1 dosage/deletion analysis (81329) is medically necessary when testing has not been previously performed. **Explanation of Change** The family history bullet is being deleted; it is a recommendation and not an enforceable coverage criterion.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

MOLECULAR TESTING OF SOLID AND HEMATOLOGIC TUMORS AND MALIGNANCIES

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Scope	This document addresses molecular testing and gene expression profiling of solid and hematologic tumors and malignancies (including cell free tumor DNA/circulating tumor cells/liquid biopsy testing) for the purpose of screening/surveillance, diagnosis, selecting therapeutic agents and predicting risk, prognosis, monitoring, or recurrence of cancer… **Explanation of Change** Revision is a clarification with no impact on current coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.
General Coverage Criteria	Somatic tumor testing is medically necessary when all of the following criteria are met: (Please see below for conditions with separate specific criteria) • The clinical benefit of testing outweighs the potential risk of psychological or medical harm to the individual being tested. • The test is as targeted as possible for the clinical situation (e.g., common variants, genes related to phenotype) **Explanation of Change** The revision creates more consistency in General Coverage Criteria across the GTUM guidelines and does not represent a change in coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.
Conditions for Which Testing May be Medically Necessary	Table 1. Molecular studies are medically necessary for the indications listed below when the above General Coverage Criteria or FDA Companion Diagnostics Coverage Criteria are met (list is not all inclusive) (*see criteria below for chromosomal microarray, cell-*	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	free, and minimal residual disease testing). **Molecular Studies** **Hematologic/Oncologic Testing** **Targeted Genomic Sequencing Panels or Single Gene Tests** • Acute Lymphoblastic Leukemia • Acute Myelogenous Leukemia • B-Cell Lymphoma • Chronic Lymphocytic Leukemia • Chronic Myeloid Leukemia • Myelodysplastic Syndrome • Essential Thrombocythemia or Thrombocytosis* • Polycythemia Vera* • Primary Myelofibrosis, Pre-PMF, suspicion for PMF* • T-Cell Lymphoma, Peripheral **Solid Organ Tumor Testing (for biomarker detection to aid in therapeutic decision-making only)** **Targeted Genomic Sequencing Panels** • Cholangiocarcinoma ○ FDA CDx tests: FoundationOne® CDx or Oncomine Dx Target Test • Colorectal Cancer, Metastatic/Stage IV • Endometrial Cancer • Gastrointestinal Stromal Tumors ○ Prostate Cancer, Metastatic Castration-Resistant o FDA CDx tests: FoundationOne® CDx • Non-Small Cell Lung Cancer, (Stage IIIB and above) ○ FDA CDx tests: FoundationOne® CDx or Oncomine Dx Target Test • Tumor Agnostic/All Applicable Solid Tumors ○ FDA CDx tests: FoundationOne® CDx for			

	tumor mutational burden (TMB) only **Targeted Single Gene Testing** • Breast Cancer (PIK3CA) • Cutaneous Melanoma (BRAF, KIT) • Non-Small Cell Lung Cancer, Resected Stage IB-IIIA (EGFR) • Ovarian, Fallopian Tube, or Primary Peritoneal Cancer (BRCA1, BRCA2) • Thyroid Cancer (BRAF, RET fusions) • Tumor Agnostic (MSI, NTRK) *2016 WHO Criteria must be met The entire table is new - for readability **Explanation of Change** Revisions to this table are primarily formatting for clarity/transparency and do not impact current coverage stance. FoundationOne Ⓡ is considered medically necessary for Non-Small Cell Lung Cancer (Stage IIIB and above) and targeted multigene panels are now considered medically necessary for endometrial cancer.			
The following tests are not medically necessary	• Whole exome tumor sequencing for any indication (including other genome-wide interrogation strategies, e.g. transcriptome) • Whole genome tumor sequencing for any indication (including other genome-wide interrogation strategies, e.g. transcriptome) **Explanation of Change** This revision is a clarification for transparency in order to address an evolving clinical space and does not represent a change in coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.
Breast Cancer Gene	AND all of the following criteria are met:	September 4, 2022	Commercial	Prior authorization **still required** through

Expression Classifiers	• Patient has undergone surgery and full pathological staging prior to Testing MammaPrint® (81521) is medically necessary to assess the risk for recurrence in an individual when all of the following criteria are met: **Explanation of Change** "Prior to testing" was added to this criterion for all breast cancer GECs listed in the guideline as a point of clarification and does not represent a change in current coverage stance. The CPT code for the microarray platform of MammaPrint® was added in order to convey that we intend to only cover this version and not the next generation sequencing platform now available (*See the CPT Code section of this guideline below for additional detail.*)			AIM Specialty Health.
Cell-Free Testing	• Locally Advanced or Metastatic Non-Small Cell Lung Cancer (NSCLC) ○ Initial Biomarker Determination ▪ FDA approved companion diagnostic tests (i.e., cobas EGFR Mutation Test v2, FoundationOne® Liquid CDx, or Guardant360® CDx) or a targeted multi-gene panel (i.e., ctDx Lung™ or Target Selector™ NGS Lung Panel) are medically necessary when tissue-based testing cannot be performed, e.g., insufficient tissue **Explanation of Change** ctDx Lung™ and Target Selector™ NGS Lung Panel are listed as the only approvable *targeted* multi-gene panels for initial biomarker determination in locally advanced or metastatic NSCLC. The Target	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	Selector™ NGS Lung Panel has a similar composition/utility to ctDx Lung™, and the "i.e." is now being used to provide clarification and increased transparency regarding the tests we currently consider medically necessary.			
Chromo-somal Microarray Analysis	Chromosomal microarray analysis is medically necessary in any of the following clinical scenarios when general coverage criteria above are met: • To aid diagnosis when part of the initial work-up involves cytogenetic (karyotype) and/or FISH analyses and testing was uninformative or could not be performed • For methylation analysis (e.g., Brain/Central Nervous System cancers) **Explanation of Change** This section is necessary following revisions to Table 1 and does not represent a change in current coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.
Minimal Residual Disease (MRD) Monitoring	**For hematological cancers:** NGS immunosequencing for MRD clone identification is covered when the following criteria is met: • There is a confirmed diagnosis of B-cell acute lymphoblastic leukemia which is Philadelphia chromosome (BCR-ABL) negative • Testing is performed on bone marrow NGS minimal residual disease (MRD) testing for Philadelphia chromosome (BCR-ABL) negative B-cell ALL is covered when all of the following criteria are met: • Immunosequencing at the time of diagnosis identified at least one clone for MRD tracking • Complete cytologic remission is achieved • Testing is performed on bone marrow Targeted testing with prospective evidence of clinical utility for the	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	tumor type and disease characteristics is medically necessary. **For solid tumors:** Molecular testing for MRD and/or disease monitoring is not medically necessary. **Explanation of Change** Revisions are clarifications and do not impact current coverage stance			
Cancer Screening	**Prostate Cancer (symptomatic cancer screening)** PCA3 (81313) or ConfirmMDx (81551) is medically necessary for men ≥50 years with prior negative biopsy when repeat biopsy is being considered after PSA testing (within 6 months of this test request) reveals a persistently elevated PSA of 3.1-10.0 ng/mL. **Indeterminate Thyroid Nodules** Targeted multi-gene panels, Afirma® Genomic Sequence Classifier, ThyGeNEXT®/ThyraMIR™, or ThyroSeq® v3.0 are medically necessary for Bethesda Category III (AUS/FLUS) indeterminate thyroid nodules.* Targeted multi-gene panels,ThyGeNEXT®/ThyraMIR™, or ThyroSeq® v3.0 are medically necessary for Bethesda Category IV (FN/SFN) indeterminate thyroid nodules.* *FNA samples with Hurthle cell predominance are excluded from coverage. **Explanation of Change** • Timing of PSA testing in relation to the PCA3 or ConfirmMDx test was added for clarification. • Criteria for gene expression classifier testing for ITNs was moved from Table 1 to this section for clarity/improved organization.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

GENETIC TESTING FOR HEREDITARY CARDIAC DISEASE

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED

Appropriate Use Criteria	Genetic testing is medically necessary when all of the following criteria are met:
	• The test is clinically reasonable:
	  ○ Symptoms and presentation are consistent with the suspected condition
	  ○ Results are expected to lead to a change in medical management
	  ○ If testing guidelines* exist, the clinical scenario falls within those recommendations
	  ○ The test is customarily recognized as clinically and technically appropriate in the diagnosis and/or treatment of the suspected condition
	• The clinical benefit of testing outweighs the potential risk of psychological or medical harm to the individual being tested
	• The test is as targeted as possible for the clinical situation (e.g., familial pathogenic or likely pathogenic (P/LP) variant testing, common variants, genes related to phenotype)
	• The clinical presentation warrants testing of multiple genes when a multi-gene panel is requested
	• The testing methodology has been clinically validated and is the most accurate method unless technical limitations (e.g., poor sample quality) necessitate the need for alternate testing strategies
	
	**See the Professional Society Guidelines section.*
		September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	Genetic Testing of Affected Individuals In addition to the above appropriate use criteria, confirmatory or diagnostic genetic testing for hereditary arrhythmias (i.e., Brugada syndrome (BrS), catecholaminergic polymorphic ventricular tachycardia (CPVT), Long QT syndrome (LQTS)) and cardiomyopathies (i.e., arrhythmogenic right ventricular cardiomyopathy (ARVC), dilated cardiomyopathy (DCM), hypertrophic cardiomyopathy (HCM), left ventricular non-compaction cardiomyopathy (LVNC), restrictive cardiomyopathy (RCM)) is medically necessary when all of the following criteria are met: • The individual has a clinical diagnosis of a hereditary cardiomyopathy or arrhythmia **OR** the individual has a suspected syndromic, metabolic or neuromuscular form of a hereditary cardiomyopathy or arrhythmia • The requested testing is as targeted as possible to a specific subset of genes with a demonstrated gene/disease association with the individual's diagnosed or suspected condition Single-site genetic testing of asymptomatic individuals for a known familial deleterious or suspected deleterious pathogenic or likely pathogenic (P/LP) variant is medically necessary. **Genetic Testing in the Evaluation of Unexplained Sudden Cardiac Arrest** Cardiac genetic testing of an individual with an unexplained sudden cardiac arrest is medically necessary in the following circumstances: • Comprehensive clinical cardiac evaluation (heart rhythm monitoring, cardiac imaging, provocative testing, etc.) has			

	not confirmed a diagnosis of a specific underlying heritable cardiac condition (e.g., ARVC, HCM, LQTS, etc.) • Non-genetic causes of sudden cardiac arrest have been ruled out (toxicology, ischemic coronary artery disease, etc.) **Post-Mortem Genetic Testing** Post-mortem cardiac genetic testing of an individual with sudden unexplained death, whose first degree family member is a covered member, is medically necessary in the following circumstances: • When the autopsy reveals evidence for a *specific* underlying heritable cardiac condition (e.g., ARVC, HCM, DCM, RCM) AND all of the following criteria are met: a. The corresponding targeted testing is ordered (e.g., HCM panel testing in cases where autopsy revealed evidence for HCM) • In 'autopsy negative' cases when cause of death remains unknown after completion of autopsy and toxicology testing and one of the following criteria are met: a. documented arrhythmic death is suggestive of an arrhythmia syndrome b. deceased individual is less than 40 years old at time of death c. sudden cardiac death event is preceded by specific triggers associated with familial arrhythmia syndromes **Tests Not Clinically Appropriate** • Broad "multi-condition" panel testing (e.g., pan-cardio panel, arrhythmia panel) is not medically necessary for routine cardiac genetic testing			

	• Genetic testing for short QT syndrome and atrial fibrillation is not medically necessary • Genetic testing for isolated left ventricular noncompaction cardiomyopathy (LVNC) is not medically necessary **Explanation of Change** This GTUM is undergoing significant global revisions and will now include general criteria for genetic testing of affected individuals, genetic testing in the evaluation of sudden cardiac arrest and genetic testing in the post-mortem setting. The National Institute of Health Clinical Genomic Resources (ClinGen) recently completed an evidence-based appraisal of genes associated with hereditary cardiac disease, and the resulting curated lists of genes associated with these conditions are much more restrictive than gene content found on most current commercially available genetic testing panels. The GTUM will not include granular detail on panel size in the criteria, but case adjudication using this new GTUM will take into account ClinGen curation (*which will be described in the GTUM Background*) as well as considering commercial availability.			

PHARMACOGENOMIC TESTING

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Scope	Pharmacogenomic testing broadly describes how one's genome, or multiple genes, can influence drug response while more targeted pharmacogenetic testing describes genotyping a specific gene to predict response to certain medications. This document addresses pharmacogenomic testing for the purpose of informing medication selection, dosage, and risk of adverse side effects. This	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	guideline does not address tumor testing (see GTUM Guideline: Molecular Testing of Solid and Hematologic Tumors and Malignancies), germline testing (see GTUM Guideline: Genetic Testing for Hereditary Cancer Susceptibility) or gene expression classifiers as well as genetic testing to generate polygenic risk scores (see GTUM Guideline: Single-Gene and Pharmacogenetic testing of common variants associated with drug metabolism is medically necessary when all of the following criteria are met:
	• All of the following:
	  ○ The individual is a candidate for a targeted drug therapy associated with a specific genotype
	  ○ The results of the pharmacogenetic test will directly impact clinical decision-making and clinical outcome for the individual
	  ○ Published, peer-reviewed studies have proven that identifying the specific genetic variant improves clinical outcomes
	• Identification of the genetic variant is required or recommended in a specific population prior to initiating therapy with the target drug as noted by the U.S. Food and Drug Administration (FDA)-approved prescribing label
	• The clinical benefit of testing outweighs the potential risk of psychological or medical harm to the individual being tested
	• The test is as targeted as possible for the clinical situation (e.g., genes related to phenotype)
	
	Multi-gene pharmacogenomic genotyping assays in which each included target does not meet the above criteria are not medically necessary.
	
	Explanation of Change			

	The revision is a clarification for consistency across GTUMs and does not change current coverage stance.			

CHROMOSOMAL MICROARRAY ANALYSIS, WHOLE EXOME AND WHOLE GENOME SEQUENCING

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Whole Exome Sequencing	**Phenotype Suspicious for a Genetic Diagnosis** • Individual with confirmed congenital bilateral sensorineural hearing loss of unknown etiology **Explanation of Change** Revision is a clarification that reflects how claims are currently being adjudicated and does not represent a change in coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

RADIOLOGY - EXTREMITY 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	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
General Information/ Overview	**General prerequisites for extremity imaging: Conservative management** ○ Exception to specified duration of conservative management may be made in unusual circumstances (for example, worsening of symptoms during a course of conservative management) when clearly documented in the medical record, or when the duration period is substantiated by documentation of serial evaluation **Explanation of change**	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	Allow exception to specified durations of conservative management in rare cases			
Inflammatory Conditions	**Plantar fasciitis and fibromatosis** Advanced imaging is considered medically necessary in EITHER of the following scenarios: • Evaluation for plantar fasciitis following a failure of at least 6 months of treatment, including at least two of the following: mechanical de-weighting, foot orthosis, night splints, taping, or manual therapy **Explanation of change** Removed phrase "conservative management" because the full definition of "conservative management" in this document does not apply here	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Trauma	**Fracture** Advanced imaging is considered medically necessary in ANY of the following scenarios: • Evaluation of supracondylar, intra-articular, or Salter-Harris (growth plate) fractures when radiographs are insufficient for management • To assess fracture healing for delayed union or nonunion when radiographs are nondiagnostic **IMAGING STUDY** • MRI upper extremity (joint or non-joint); MRI lower extremity • CT upper or lower extremity for preoperative planning • CT upper or lower extremity for detection of occult fracture when MRI cannot be performed • CT upper extremity (joint or non-joint) for delayed union or nonunion of the scaphoid as an alternative to MRI • CT lower extremity as an alternative to MRI for evaluation of tibial plateau fracture	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	Explanation of change Added indication for evaluation of supracondylar fracture Added CT as an alternative to MRI for tibial plateau fracture			

Ligament and Tendon Derangement of the Upper Extremity	**Rotator cuff tear**
	Advanced imaging is considered medically necessary for diagnosis and management when **ALL** of the following apply:
	• Radiographs or ultrasound are nondiagnostic
	• At least one positive sign to support the diagnosis of rotator cuff tear has been demonstrated
	• **EITHER** of the following:
	  ○ At least one positive sign of a complete rotator cuff tear
	  ○ Failure of at least 6 weeks of conservative management
	
	Explanation of change
	Combined acute and chronic rotator cuff tear due to overlap in prerequisites
	Standardized conservative management to 6 weeks (previously 4 weeks for acute rotator cuff tear)
		September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

Miscella-neous Conditions	**Chronic anterior knee pain (including chondromalacia patella and patellofemoral pain syndrome)** Advanced imaging is considered medically necessary following nondiagnostic radiographs when **BOTH** of the following criteria are met: • Chronic anterior knee pain not attributable to a specific injury • Failure of at least 6 weeks of conservative management **Explanation of change** Modified language around prior injury for clarity	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Perioperative Imaging, unspecified	**Shoulder arthroplasty, presurgical planning**	September 11, 2022	Commercial Medicare	Prior authorization **still required** through

	Advanced imaging is not indicated for robotic-assisted shoulder arthroplasty.
	Advanced imaging is considered medically necessary for evaluation in **ANY** of the following scenarios:
	• For preoperative assessment of bone stock and bone version prior to shoulder arthroplasty
	• For assessment of rotator cuff status to determine the surgical approach
	• For planned reverse shoulder arthroplasty in **ANY** of the following scenarios:
	  ○ Reconstruction after a tumor resection
	  ○ Glenohumeral osteoarthritis with irreparable rotator cuff tear
	  ○ Failed hemiarthroplasty
	  ○ Failed total shoulder arthroplasty with non-repairable rotator cuff
	  ○ Shoulder fracture that is not repairable or cannot be reconstructed with other techniques
	  ○ Advanced joint disease of the shoulder with severe osteoarthritis, pain and loss of function for at least 6 months duration and not responsive to at least 6 weeks of conservative management
	IMAGING STUDY
	• MRI upper extremity (joint)
	• CT upper extremity (joint) for preoperative assessment of bone stock and bone version, or for planned reverse shoulder arthroplasty
	
	Explanation of change
	Modified language to clarify intent – total shoulder arthroplasty should not require advanced imaging
				AIM Specialty Health.

Perioperative Imaging (including delayed hardware failure), not	**Perioperative Imaging (including delayed hardware failure), not otherwise specified** Includes conditions not otherwise referenced in the Extremity Imaging guidelines. *Advanced*	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

otherwise specified	*imaging is not indicated for robotic-assisted hip arthroplasty.* **Explanation of change** Excluded robotic-assisted hip arthroplasty as robotic-assisted surgery in general does not provide net benefit over conventional arthroplasty			

RADIOLOGY - SPINE 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	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
General Information/ Overview	**General prerequisites for spine imaging:** **Conservative management** ○ Exception to specified duration of conservative management may be made in unusual circumstances (for example, worsening of symptoms during a course of conservative management) when clearly documented in the medical record, or when the duration period is substantiated by documentation of serial evaluation **Explanation of change** Allow exception to specified durations of conservative management in rare cases	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Trauma	**Cervical injury** Advanced imaging is considered medically necessary in the following scenarios: *ADULT* • Initial diagnosis of trauma with **ANY** of the following: • Management of trauma in **ANY** of the following scenarios: ○ Post-traumatic neurologic deficit on exam ○ Soft tissue injury suggested by CT or radiography	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	○ Progressively worsening pain unexplained by CT ○ Follow up of known fracture ○ Presurgical planning **IMAGING STUDY** • CT cervical spine • MRI cervical spine for management of trauma, except follow up of known fracture ***PEDIATRIC*** • Diagnosis or management of trauma in **ANY** of the following scenarios: ○ Post-traumatic neurologic deficit on exam **Explanation of change** • Modified "diagnosis" and "management" language to mirror thoracic/lumbar section • Clarified that post-traumatic neurologic deficit refers specifically to a finding on exam • Added "imaging study" section for adults for greater clarity			
Thoracic or lumbar injury	**Thoracic or lumbar injury** Advanced imaging is considered medically necessary in the following scenarios: • Initial diagnosis of trauma in **EITHER** of the following scenarios: • Management of trauma in **ANY** of the following scenarios: ○ Post-traumatic neurologic deficit on exam **Explanation of change** Clarified that "neurologic deficit" refers to an exam finding rather than a subjectively reported symptom	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Miscella-neous Conditions of the Spine	**Osteoporosis and osteopenia Management indications** • Testing at 2- to 3-year intervals in persons being treated for osteoporosis or osteopenia	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	• Testing at 3- to 5-year intervals in untreated individuals who met the criteria for initial evaluation, without interval development of risk factors for accelerated bone loss *Note: For patients with interval development of a risk factor for accelerated bone loss, please refer to Screening and Diagnostic Indications.* **IMAGING STUDY** CT bone density **Explanation of change** Removed statement in management section about testing at 3-5 year intervals in patients "without significant osteopenia on prior study" for clarity (this follow up interval is for patients who are not being treated so coverage position is intended to be unchanged).			
Perioperative and Periproce-dural Imaging	**Perioperative and periprocedural Imaging, including delayed hardware failure or healing related to prior surgery, not otherwise specified** *Includes conditions not otherwise referenced in the Spine guidelines. For pain after spine surgery beyond the perioperative time frame, please refer to the Pain indications.* Advanced imaging is considered medically necessary for diagnosis and management following nondiagnostic radiographs. **Explanation of change** Added requirement for initial evaluation with radiographs	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

RADIOLOGY - VASCULAR 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	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Brain, Head and Neck	**Pulsatile tinnitus** **IMAGING STUDY** • CTA or MRA head • CTA or MRA neck **Explanation of change** Allow optional CTA/MRA Neck evaluation	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

Stroke or transient ischemic attack (TIA), intracranial evaluation	**Stroke or transient ischemic attack (TIA), intracranial evaluation**
	Also see Brain Imaging guidelines.
	Vascular imaging is considered medically necessary in **ANY** of the following scenarios:
	• Acute (7 days or less) stroke/TIA in **ANY** of the following scenarios:
	  ○ Acute stroke in an interventional candidate
	  ○ Evidence of acute ischemia or infarct on brain imaging
	  ○ Evaluation following acute TIA
	• Subacute (within 30 days) stroke/TIA in **EITHER** of the following scenarios:
	  ○ Signs or symptoms attributable to the anterior circulation, when the presence of intracranial stenosis will lead to use of dual antiplatelet therapy
	  ○ Signs or symptoms other than syncope attributable to the posterior circulation
	
	Explanation of change
	Recategorization into dedicated Stroke/TIA section (no content change)
		September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

Chest	**Acute aortic syndrome** **IMAGING STUDY** • CTA chest • MRA chest **Explanation of change**	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	Allow either CTA or MRA chest for thoracic dissection (surveillance sometimes done w/ MR)			
Abdomen and Pelvis	**Acute aortic syndrome** **IMAGING STUDY** • CTA abdomen or CTA Abdomen/Pelvis • MRA abdomen with or without MRA pelvis • CT or MRI; alternatives to CTA or MRA above **Explanation of change** Addition of optional pelvic imaging for possible iliac vessel involvement – prior content gap	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Aneurysm of the abdominal aorta or iliac arteries	**Aneurysm of the abdominal aorta or iliac arteries** Vascular imaging is considered medically necessary in **ANY** of the following scenarios: **Screening** One time evaluation in: • Previously diagnosed aneurysm of the thoracic aorta, iliac, femoral or popliteal arteries **Management** • Baseline and initial 12-month evaluation following endograft repair **Surveillance** • Stable aneurysms treated with endografts: Duplex arterial ultrasound annually; CT every 5 years • Stable aneurysms treated with open surgical repair: every 5 years **IMAGING STUDY** • Duplex arterial ultrasound; all indications • CT abdomen and/or pelvis for management, surveillance with endografts or surgical repair, or when duplex arterial ultrasound cannot be performed or is nondiagnostic • CTA abdomen and/or pelvis for management, surveillance with surgical repair, or when duplex arterial ultrasound	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	cannot be performed or is nondiagnostic • MRI abdomen and/or pelvis for management, surveillance with surgical repair, or when duplex arterial ultrasound cannot be performed or is nondiagnostic • MRA abdomen and/or pelvis for management, surveillance with surgical repair, or when duplex arterial ultrasound cannot be performed or is nondiagnostic **Explanation of change** • Screening: addition of femoral aneurysm to listed lower extremity sites predisposing to AAA (content gap) • Management: alignment with SVS guidelines for post-endovascular repair only, repeat imaging in 12 months after baseline • Surveillance: alignment with SVS guidelines for annual surveillance post endovascular repair			
Venous thrombosis or occlusion	**Venous thrombosis or occlusion** Advanced imaging is considered medically necessary for diagnosis and management of thrombosis or occlusion of major abdominal vessels in **EITHER** of the following scenarios: • Evaluation of the hepatic or portal veins when duplex venous ultrasound cannot be performed or is nondiagnostic • Evaluation of all other abdominal venous structures **IMAGING STUDY** • CTA abdomen or CTA abdomen/pelvis • MRA abdomen with or without MRA pelvis **Explanation of change** • Restructure for clarification of intent, no content change for indications. • Duplex venous US removed from “Imaging Study” options	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	(not managed by AIM) – no content change. • Imaging study corrected to include optional added pelvic imaging (not only pelvic vein imaging)			
Upper Extremity	**Peripheral arterial disease (PAD)** Vascular imaging is considered medically necessary for diagnosis, management, and surveillance in **ANY** of the following scenarios: **Diagnosis** of suspected PAD: • Any sign or symptom with inconclusive physiologic testing (including exercise testing) **Management** of known PAD in **ANY** of the following scenarios: • Resting ischemic pain or signs of atheroembolic disease of the upper extremities (such as ischemic or discolored fingers, livedo reticularis etc.) • Atypical symptoms with inconclusive physiological testing • Persistent claudication despite a trial of conservative therapy in initial revascularization candidates • Baseline study following percutaneous or surgical revascularization • Post-revascularization, with any new or worsening upper extremity signs or symptoms • Post revascularization when surveillance physiological testing is inconclusive **Explanation of change** • Diagnosis: suspected PAD without physiologic testing (including exercise testing) not indicated • Management: adding items from 2016 guideline currently still operationalized (no operational content change)	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Lower Extremity	**Peripheral arterial disease (PAD)**	September 11, 2022	Commercial Medicare	Prior authorization **still required** through

	Vascular imaging is considered medically necessary in **ANY** of the following scenarios: **Screening** • Not indicated **Diagnosis** of suspected PAD: • Any sign or symptom with inconclusive physiologic testing (including exercise testing) **Management** of known PAD in **ANY** of the following scenarios: • Prior diagnosis of PAD with **ANY** of the following new or worsening signs or symptoms: ○ Resting ischemic pain, non-healing wounds, and gangrene ○ Ischemic or discolored toes, and livedo reticularis ○ Sudden onset of pain associated with pulselessness, pallor, loss of motor or sensory function • Post revascularization with any new or worsening lower extremity non-joint pain not addressed above, following nondiagnostic physiologic testing (physiologic testing not required if venous graft was used) **Surveillance** • Annual follow up after surgical revascularization when a venous graft has been used **Explanation of change** • Diagnosis: suspected PAD without physiologic testing (including exercise testing) not indicated (added scenarios aligned with PAD upper extremity) • Management post-revascularization: clarification of symptoms not addressed in section above (redundant) and physiologic testing requirement			AIM Specialty Health.
Popliteal artery aneurysm	**Popliteal artery aneurysm** Advanced imaging is considered medically necessary surveillance of popliteal artery aneurysm following open or endovascular	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	repair at 3, 6, and 12 months following repair, then annually. **IMAGING STUDY** Duplex arterial ultrasound **Explanation of change** New indication for Arterial US surveillance for repaired popliteal artery aneurysm (in alignment with 2021 SVS guidelines)			

SLEEP DISORDER MANAGEMENT

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Sleep Disorder Management. 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

POLICY TITLE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Polysomnography and Home Sleep Testing				
In-Lab (Attended) Sleep Studies in Adult Patients (Age ≥ 19 yrs)	**Established sleep disorder (OSA or other) – follow-up laboratory studies** A patient with established diagnosis of OSA should have a follow-up in-lab sleep study if **ANY** of the following (1-3) apply: 1. To assess efficacy of surgery (including adenotonsillectomy or upper airway) or oral appliances/devices in a patient who has a contraindication to a home sleep study (as outlined in Table 1* above) 2. To re-evaluate the diagnosis of OSA and need for continued CPAP if there is significant weight loss (defined as 10% of body weight) since the most recent sleep study in a patient who has a contraindication to a home sleep study (as outlined in Table 1* above) 3. To optimize device settings on one occasion following insertion of a hypoglossal nerve stimulator A patient with established diagnosis of OSA or other sleeping disorders should have a follow-up in-lab study if ANY of the following (1-3) apply: 1. To titrate CPAP/BPAP in a patient who has a contraindication* to the use of APAP or for whom an attempt at APAP titration has been unsuccessful 2. To titrate CPAP/BPAP in a patient with a contraindication** to the use of APAP (or has failed APAP	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	retitration) whose attempted split-night study did not adequately establish appropriate CPAP/BPAP treatment parameters 3. To retitrate CPAP/BPAP in a patient who has a contraindication** to APAP (or has failed APAP retitration) and has recurrence of symptoms or worsening of symptoms despite PAP adherence as defined by CMS criteria (use of PAP greater than or equal to 4 hours per night on 70% of nights during a consecutive 30-day period) *Table outlines contraindications to home sleep study but is not shown here. **Contraindications to APAP are not shown here. **Explanation of change** • Clarification specifies patient having contraindication for home sleep study. • One follow-up in-lab sleep study as appropriate following insertion of a hypoglossal nerve stimulator. • Revised definition of PAP therapy adherence per CMS criteria.			
In-Lab (Attended) Sleep Studies in non-Adult Patients (Age ≤ 18)	**Established sleep disorder (OSA or other) – follow-up studies** A follow-up in-lab sleep study is appropriate in ANY of the following (1–5) situations: 1. A patient with established OSA continues to exhibit persistent snoring or other symptoms of sleep disordered breathing despite PAP adherence as defined by CMS criteria (use of PAP greater than or equal to 4 hours per night on 70% of nights during a consecutive 30-day period) 2. The patient has undergone adenotonsillectomy more than 8 weeks previously for management of established OSA	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	3. To re-evaluate the diagnosis of OSA and need for continued PAP if there is significant weight loss (defined as 10% of body weight) since the most recent sleep study 4. To titrate CPAP or BPAP in a patient whose diagnostic study confirms that the patient is a candidate for positive airway pressure therapy and split-night study has not been performed or was inadequate 5. The initial sleep study has led to a diagnosis other than OSA and the repeat study is requested because of a change in clinical status or to assess efficacy after a change in therapy **Explanation of change** Revised definition of PAP therapy adherence per CMS criteria			
Multiple Sleep Latency Testing (MSLT) and/or Maintenance of Wakefulness Testing (MWT)				
In-Lab (Attended) Sleep Studies in Adult Patients (Age ≥ 19 yrs)	**Repeat MWT is appropriate for occupational safety evaluation when BOTH of the following conditions are met** 1. The patient has an established diagnosis of a sleep breathing disorder or narcolepsy 2. The test is performed while on the current treatment to determine adequacy of therapy **Explanation of change** New indication for MWT in occupational safety evaluation	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Management of OSA using Oral Appliances (OA)				
Custom Fabricated Oral Appliances (CPT E0486)	**Treatment with OA is appropriate for patients 16 years of age or older with severe OSA (apnea/hypopnea index [AHI] greater than 30) meeting BOTH of the following criteria (A-B)** A. The appliance is a TRD or a MRA which complies with CMS criteria B. **ONE** of the following (a-c) applies: a. The patient is not a candidate for positive airway pressure therapy	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	b. Positive airway pressure therapy has not been effective despite a 45-day trial and participation in a positive airway pressure compliance program c. The patient has tried continuous positive airway pressure (CPAP) but has not been compliant despite a 45-day trial and participation in a positive airway pressure compliance program. **Explanation of change** Limit oral appliance use to patients 16 years and older			
Custom Fabricated Oral Appliances (CPT E0486)	**Treatment with OA is appropriate for patients 16 years of age or older with mild or moderate OSA meeting ALL of the following criteria (A-C)** A. At least **ONE** of the following (a-b): a. AHI greater than or equal to 15 and less than or equal to 30 b. AHI 5–14 with any of the following: excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, treatment-resistant hypertension (persistent hypertension in a patient taking three or more antihypertensive medications), ischemic heart disease, history of stroke B. At least **ONE** of the following (a-d): a. The patient is not a candidate for positive airway pressure therapy b. Positive airway pressure therapy has not been effective despite a 45-day trial and participation in a positive airway pressure compliance program c. The patient has tried CPAP but has not been compliant despite a 45-day	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	trial and participation in a positive airway pressure compliance program d. The patient prefers to use an OA rather than PAP as the initial therapy C. The appliance is a TRD or a MRA which complies with CMS criteria **Explanation of change** Limit oral appliance use to patients 16 years and older			
Management of OSA using Implanted Hypoglossal Nerve Stimulators				
Implanted Hypoglossal Nerve Stimulators	**Treatment with HNS is appropriate for adult patients with OSA meeting ALL of the following criteria (A-E)** A. Age 18 years or older B. AHI or RDI > 15 and < 65 with less than 25% central events C. BMI < 32 D. Have failed or are intolerant of PAP therapy E. Non-concentric retropalatal obstruction on drug-induced sleep endoscopy **Treatment with HNS is appropriate for adolescent and young adult patients with Down syndrome and OSA meeting ALL of the following criteria (A-E)** A. Age 10-21 years B. AHI or RDI >10 and <50 with less than 25% central apneas after prior adenotonsillectomy C. BMI < 95th percentile for age D. Have either had tracheotomy or been ineffectively treated with CPAP due to noncompliance, discomfort, undesirable side effects, persistent symptoms despite compliance use, or refusal to use the device E. Non-concentric retropalatal obstruction on drug-induced sleep endoscopy **Explanation of change** New criteria for use of hypoglossal nerve stimulators (HNS) in the management of OSA in adults in	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	addition to young adults and adolescents with Down syndrome.			

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.

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