MASSACHUSETTS

MEDICAL POLICY ANNOUNCEMENTS

Posted June 2023

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

Anesthesiology Gastroenterology
Behavioral Health
Hematology
Neurosurgery
Otolaryngology
Pharmacy

Carelon
Radiology Extremity Imaging
Radiology Spine Imaging
Radiology Vascular Imaging
Sleep Disorder Management

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

ANESTHESIOLOGY GASTROENTEROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Monitored Anesthesia Care (MAC)	154	**Implementation postponed.** We previously notified you that effective for dates of service on or after July 1, 2023, we would implement diagnosis-driven claim edits to reinforce our existing monitored anesthesia care (MAC) medical policy 154 guidelines. After careful review, we have decided to postpone our enforcement of this medical policy to January 1, 2024.	January 1, 2024	Commercial Medicare	Prior authorization is still not required.
Medical Technology Assessment Investigational (Non-	400	**Policy clarified** to remove Bispectral Index (BIS®) Monitoring for Anesthesia Awareness	June 1, 2023	Commercial Medicare	No action required.

Covered) Services List					

BEHAVIORAL HEALTH

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Digital Health Technologies: Therapeutic Applications	090	**New medical policy** describing investigational indications.	September 1, 2023	Commercial Medicare	No action required.

HEMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Gene Therapies for Hemophilia B	168	**Policy clarified** to align with the National policy. Updated criteria for medical necessity – age, assigned sex at birth, disease severity, FIX therapy requirements, exclusion criteria, baseline test requirements. Prior Authorization Request Form for Hemgenix® (Etranacogene dezaparvovec), #169	May 2, 2023	Commercial Medicare	Prior authorization is still required.

NEUROSURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Intraoperative Neuro-physiologic Monitoring Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring	211	**Policy clarified** on Intraoperative Neurophysiologic Monitoring. New indication for spinal instrumentation requiring screws or distraction added. No changes to policy statement as **the new**	June 1, 2023	Commercial	Prior authorization is still required.

		indication would be covered within the existing medically necessary policy statement on intraoperative neurophysiologic monitoring during spinal, intracranial, or vascular procedures.			

OTOLARYNGOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Steroid-Eluting Sinus Stents	800	**Policy revised** to include coverage for Sinuva when policy criteria are met.	September 1, 2023	Commercial Medicare	Prior authorization is not required.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medicare Advantage Part B Step Therapy	020	Policy updated to include new LCD for Intraarticular Knee Injections of Hyaluronan (L39529).	June 11, 2023	Medicare	Prior authorization is still required.
Drugs for Weight Loss	572	Policy criteria revised.	September 1, 2023	Commercial	Prior authorization is still required.

Carelon Guidelines Announcements

Legend	Text color	Indicates…
Guideline Change Summary	**Blue**	Change to guideline wording
	Black	Preservation of existing guideline wording
		Changes expected to be…
Explanation of Change (row)	**Green**	More expansive on appropriateness
	Red	More restrictive on appropriateness
	Black	Have minimal if any impact on appropriateness review and exists primarily to clarify intent

RADIOLOGY EXTREMITY IMAGING

The following updates will apply to the Carelon 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 Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

CARELON GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE
Extremity Imaging	**Trauma** Acute traumatic injuries –not otherwise specified **Fracture** • Lower extremity: ▪ Femoral neck, proximal femur ▪ Tibia (anterior/lateral/plateau) ▪ Patella ▪ Talus ▪ Navicular ▪ Metatarsal base (second and fifth digits) ▪ Great toe sesamoid ▪ Calcaneus (in individuals when imaging will direct the timing of return to vigorous athletic activity) **Explanation of change** Added small clarification regarding patients in whom advanced imaging of suspected calcaneal fractures is indicated	September 10, 2023
Extremity Imaging	**Perioperative Imaging, unspecified** **Shoulder arthroplasty, presurgical planning** **IMAGING STUDY** • MRI upper extremity (joint) for assessment of rotator cuff status or for planned reverse shoulder arthroplasty • CT upper extremity (joint) for preoperative assessment of bone stock and bone version, or for planned reverse shoulder arthroplasty **Explanation of change** Clarified that MRI should not be used for preoperative assessment of bone stock and bone version	September 10, 2023

RADIOLOGY SPINE IMAGING

The following updates will apply to the Carelon 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 Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

CARELON GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE
Spine Imaging	**Infectious and Inflammatory Conditions** **Spinal infection** *Includes epidural abscess, arachnoiditis, discitis, and vertebral osteomyelitis.* Advanced imaging of the spine is considered medically necessary in **EITHER** of the following scenarios: • Diagnosis in patients with new or worsening spinal pain or neurological abnormalities, and **ANY** of the following: ○ Documented fever ○ Elevated ESR or CRP	September 10, 2023

	○ Known bloodstream infection ○ **ANY** of the following risk factors: ▪ Diabetes mellitus ▪ Intravenous drug use ▪ Malignancy ▪ HIV ▪ Dialysis ▪ Recent spinal intervention (examples include: surgery with or without hardware placement, stimulator implantation, or pain injection) ▪ Decubitus ulcer or wound overlying the spine **Explanation of change** Added criterion for imaging in patients at risk for infection, based on ACR appropriate use criteria (Ortiz, 2021)	
Spine Imaging	**Trauma** **Cervical injury** ***ADULT*** **IMAGING STUDY** • CT cervical spine for initial diagnosis or management • MRI cervical spine for management of trauma, except follow up of known fracture ***PEDIATRIC*** **IMAGING STUDY** • CT cervical spine for initial diagnosis, or for diagnosis or management of trauma • MRI cervical spine for diagnosis or management of trauma **Explanation of change** Added language to clarify modality appropriateness	September 10, 2023
Spine Imaging	**Thoracic or lumbar injury** **IMAGING STUDY** • CT thoracic or lumbar spine for initial diagnosis or for management • MRI thoracic or lumbar spine for management of trauma, except follow up of symptomatic fracture **Explanation of change** Added language to clarify modality appropriateness	September 10, 2023
Spine Imaging	**Signs and Symptoms** **Radiculopathy** **IMAGING STUDY** • CT cervical, thoracic, or lumbar spine when MRI cannot be performed or is nondiagnostic; or when being done as CT myelography • MRI cervical, thoracic, or lumbar spine **Explanation of change** Added indication for CT being done as a CT myelogram, based on ACR rating of "may be appropriate" (Hutchins, 2021) plus feedback from subject matter experts	September 10, 2023

RADIOLOGY VASCULAR IMAGING

The following updates will apply to the Carelon 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 Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

CARELON GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE
Vascular Imaging	**Procedure-related Imaging** **Vascular anatomic delineation prior to surgical and interventional procedures, not otherwise specified*** **IMAGING STUDY** • CTA head, neck, chest, abdomen and pelvis, or extremities (based on specific procedure) MRA head, neck, chest, abdomen and pelvis, or extremities (based on specific procedure) ***Exclusions:** stenting or angioplasty of the dural venous sinus **Explanation of change** Removed to align with added allowances below for Duplex carotid and CTA/MRA neck	September 10, 2023
Vascular Imaging	**Vascular evaluation prior to transcatheter aortic valve implantation/replacement (TAVI/TAVR)** **IMAGING STUDY** • Duplex arterial ultrasound for carotid artery evaluation • CT or CTA chest, abdomen and pelvis; CTA neck requires initial duplex arterial ultrasound • MRA chest, abdomen and pelvis; MRA neck requires initial duplex arterial ultrasound **Explanation of change** Allow CT in addition to CTA for preop TAVR evaluation (contrast-enhanced CT sufficient for evaluation).	September 10, 2023
Vascular Imaging	**Brain, Head and Neck** **Stenosis or occlusion, extracranial carotid arteries** *See separate indication for acute stroke or transient ischemic attack.* Vascular imaging is considered medically necessary in patients who are candidates for carotid revascularization in **ANY** of the following scenarios: • Screening ○ Starting 5 years post-neck irradiation and every 3 years thereafter ○ Evaluation prior to cardiac surgery when needed to determine surgical strategy • Diagnosis of suspected carotid stenosis ○ Hollenhorst plaques (cholesterol emboli) or retinal neovascularity on retinal examination • Management of known carotid stenosis ○ Worsening neurologic symptoms or signs attributable to the anterior circulation ○ Initial baseline evaluation, and one additional evaluation during the first year following carotid revascularization **Explanation of change**	September 10, 2023

	Screening: Limitation to preoperative evaluation prior to cardiac surgery Management: Clarification to allow follow-up per current ACC guidelines (addresses content gap for allowable 9–12-month eval)	
Vascular Imaging	**Chest** **Pulmonary hypertension** Advanced imaging is considered medically necessary for diagnosis and management in **EITHER** of the following scenarios: • To evaluate suspected pulmonary hypertension, including chronic thromboembolic pulmonary hypertension (CTEPH) • To evaluate disease extent after diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) in patients being considered for surgery **Explanation of change** Clarification of heading indication and allowance for evaluation of suspected PH (any etiology)	September 10, 2023
Vascular Imaging	**Abdomen and Pelvis** **Unexplained hypotension** Vascular imaging is considered medically necessary for evaluation of volume status in patients with unexplained hypotension. **IMAGING STUDY** • Duplex ultrasound of the IVC **Explanation of change** Removal of indication more appropriate for inpatient assessment	September 10, 2023
Vascular Imaging	**Venous thrombosis or occlusion** **IMAGING STUDY** • Duplex ultrasound • CTA abdomen or CTA abdomen/pelvis • MRA abdomen with or without MRA pelvis **Explanation of change** Addition of Duplex ultrasound as a modality option (no content change – allowance currently operationalized in system)	September 10, 2023

Vascular Imaging	**Lower Extremity**
	
	Peripheral arterial disease (PAD)
	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
	• Persistent claudication following a trial of 3 months of conservative therapy including a supervised exercise therapy program in patients being evaluated for initial revascularization
	• Post revascularization with any new or worsening lower extremity non-joint pain not addressed above, following nondiagnostic
		September 10, 2023

	physiologic testing (physiologic testing not required if venous graft was used) • Post revascularization when surveillance physiological testing is inconclusive (ABI > 1.40), borderline (ABI 0.91–0.99), or abnormal (ABI ≤ 0.90) • Baseline evaluation after surgical revascularization using a venous graft or after endovascular revascularization (angioplasty, stent, or atherectomy) **Surveillance** • After surgical revascularization using a venous graft: At 3-month intervals within the first 2 years, and annually thereafter • After endovascular revascularization (angioplasty, stent, or atherectomy): At 4-month intervals within the first year, and annually thereafter **Explanation of change** Removal of cilostazol as prerequisite therapy (specialty panel feedback). Addition of baseline evaluation & surveillance indications post endovascular revascularization. (Post-venous graft surveillance moved to "Surveillance" section; no content change).	

Vascular Imaging	**Popliteal artery aneurysm**
	Advanced imaging is considered medically necessary in **ANY** of the following scenarios:
	• Diagnosis of suspected aneurysm
	• Management for known aneurysm with signs or symptoms suggestive of change in size or patency
	• Surveillance for:
	  ○ Unrepaired aneurysms less than 2 cm, in patients who are candidates for revascularization: annually
	  ○ Following open or endovascular repair at 3, 6, and 12 months following repair, then annually
	Explanation of change
	Addition of diagnosis/management and unrepaired surveillance scenarios, the latter aligned with SVS guidelines
		September 10, 2023

SLEEP DISORDER MANAGEMENT

The following updates will apply to the Carelon 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 Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

CARELON GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE
Sleep Disorder Management	**Home Sleep Testing** Home sleep apnea test/study **Explanation of change** Change terminology throughout guidelines to home sleep “apnea” study to be more expansive and specific	September 10, 2023

Sleep Disorder Management	**Contraindications to Home Sleep Apnea Studies** Chronic opiates when discontinuation is not an option. Diagnostic sleep testing for patients using opiates for acute self-limited conditions should ideally be deferred until the medications have been stopped **Explanation of change** Change opiate terminology to current definition and usage	September 10, 2023
Sleep Disorder Management	**In-Lab (Attended) Sleep Studies in Adult Patients (Age 19 Years or Older)** Suspected sleep disorder other than OSA An in-lab supervised sleep study is considered medically necessary when there is suspicion of **ANY** of the following: • Central sleep apnea • Narcolepsy • Nocturnal seizures • Parasomnia • Idiopathic hypersomnia • Periodic limb movement disorder (PLMD)—to support a suspicion of PLMD in this context, ONE of the following must be documented: pregnancy, renal failure, iron deficiency anemia, peripheral neuropathy, use of antidepressant or antipsychotic medications, or continued hypersomnia and clinical symptoms of PLMD after sleep disordered breathing is ruled out by home sleep apnea testing • Nocturnal desaturation (due to severe COPD or certain restrictive thoracic disorders) • Any of the following conditions (right heart failure, polycythemia, cardiac arrythmias occurring solely during sleep, or pulmonary hypertension) when the etiology is unclear **Explanation of change** Modified language to be more restrictive of conditions	September 10, 2023
Sleep Disorder Management	**Established sleep disorder (OSA or other) – follow-up laboratory studies** A follow-up in-lab sleep study is considered medically necessary for a patient with an established diagnosis of OSA if **ANY** of the following apply: • To assess efficacy of surgery (adenotonsillectomy or upper airway surgery) or oral appliances/devices in a patient with a contraindication to a home sleep apnea study • … • To optimize device settings on one occasion following insertion of a hypoglossal or phrenic nerve stimulator **Explanation of change** Modified language to be more expansive and specific	September 10, 2023
Sleep Disorder Management	**Contraindications to APAP** Moderate or severe chronic obstructive pulmonary disease: FEV1/FVC less than or equal to 0.7 and FEV1 less than 80% of predicted **Explanation of change** Add more specific parameters to COPD	September 10, 2023

Sleep Disorder Management	**Bi-Level Positive Airway Pressure (BPAP) Devices** **BPAP (with or without back-up rate feature) for patients with obesity hypoventilation syndrome)** Obesity Hypoventilation Syndrome (OHS) defined as a body mass index (BMI) greater than 30 kg/m2 and hypoventilation which cannot be solely attributed to other conditions such as pulmonary disease, skeletal restriction, neuromuscular weakness, hypothyroidism, pleural pathology, or medications. **Explanation of change** New indication is expansive and includes OHS definition	September 10, 2023
Sleep Disorder Management	**Ongoing treatment with BPAP** Ongoing treatment with BPAP for obstructive or central sleep apnea* is considered medically necessary for adult patients who demonstrate compliance with therapy. Demonstration of compliance is required for adult patients every 90 days for the first year of treatment and annually thereafter. Compliance is defined as EITHER of the following: • Use of the BPAP device for at least 4 hours per night on 70% of nights during a consecutive 30-day period within the preceding 90 days • Clinical evidence that demonstrates continued clinical benefit from use of the PAP device is submitted by the treating provider * Demonstration of compliance is not required for non-adult patients or when BPAP is used for disorders other than OSA and CSA **Explanation of change** Add more expansive and specific language for BPAP usage	September 10, 2023

Sleep Disorder Management	**Multiple Sleep Latency Testing and Maintenance of Wakefulness Testing**
	
	Initial MSLT and/or MWT are considered medically necessary for suspected narcolepsy when BOTH of the following criteria are met:
	• Daytime hypersomnolence has been present for at least 8 weeks
	• The patient has at least **ONE** of the following:
	  ○ Disrupted nocturnal sleep
	  ○ Cataplexy
	  ○ Hallucinations (hypnagogic or hypnopompic)
	  ○ Sleep paralysis
	  ○ The patient has undergone PSG or HSAT and symptoms persist despite adequate treatment of obstructive sleep apnea (if present)
	Explanation of change
	Add clarifications to be more expansive and specific
		September 10, 2023

Sleep Disorder Management	**MSLT and/or MWT are considered medically necessary for idiopathic hypersomnia when BOTH of the following criteria are met:**
	• Daytime hypersomnolence has been present for at least 8 weeks
	• The patient has at least ONE of the following:
	  ○ Difficult morning awakening
	  ○ Prolonged sleep during primary sleep period
	  ○ Sleep drunkenness
	  ○ Frequent non-refreshing daytime naps
		September 10, 2023

	○ The patient has undergone PSG or HSAT and symptoms persist despite adequate treatment of obstructive sleep apnea (if present) **Explanation of change** Add clarifications to be more expansive and specific	

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.

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