



Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

Gastroenterology, Nutrition and Organ Transplantation MEDICAL POLICY GROUP

Co-chairs
Desiree Otenti, ANP, MPH, Senior Director • Medical Policy Administration
Peter Lakin,

October 26 th 2021	12-2 pm	Conference call only. Please email ebr@bcbsma.com for more information.
-------------------------------	---------	--

Invited: Desiree Otenti, ANP, Chair, (Medical Policy Administration); Peter Lakin, R.Ph, (Pharmacy Operations) Co-Chair; Vivian Tembe-Ebot, PharmD, MBA, Director, Clinical Pharmacy, Thomas Hawkins, MD, (Internal Medicine); Grace Baker, MSW, LCSW, (Medical Policy Administration); Laura Barry, RN, MHA, BSN, (Medical Policy Administration);

Invited Physician Guest(s): Representatives from the Massachusetts Society of Gastroenterology; Massachusetts Society of Organ Transplantation

Policies with Upcoming Coverage Updates	
Adjunctive Techniques for Screening and Surveillance of Barrett Esophagus and Esophageal Dysplasia (841)	<p>Effective January 2022:</p> <ul style="list-style-type: none"> New medical policy describing investigational indications. <p>*A draft will be available December 1, 2021. Please email ebr@bcbsma.com for more information.</p>
AIM guideline: Advanced Imaging (930)	<p>Effective March 13th 2022:</p> <p>Gastrointestinal Indications (Explanation of change)</p> <ul style="list-style-type: none"> Removed as a standalone indication because advanced imaging is not routinely recommended for imaging suspected intussusception <p>Colorectal cancer screening</p> <p>CT colonography (CTC) is indicated in ANY of the following scenarios:</p> <ul style="list-style-type: none"> Screening CT colonography is indicated for average risk individuals* as an alternative to conventional colonoscopy at 5-year intervals, beginning at age 45 <p>*Average risk:</p> <ul style="list-style-type: none"> No personal history of colonic adenoma, serrated sessile polyp (SSP), or colorectal cancer (CRC) No personal history of inflammatory bowel disease Negative first-degree family history for CRC, confirmed advanced adenoma (i.e., high-grade dysplasia, ≥ 1 cm, villous or tubulovillous histology or an advanced SSP) <p>Explanation of change</p> <p>Alignment with updated USPSTF recommendation</p> <p>Pancreatic cancer screening</p> <p>Annual CT or MRI (preferred) Abdomen is indicated as an alternative to endoscopic ultrasound in ANY of the following scenarios:</p> <ul style="list-style-type: none"> Peutz-Jeghers syndrome (LKB1/STK11 mutations), starting at age 40 Familial Atypical Multiple Melanoma and Mole syndrome (FAMMM; CDKN2A, p16 mutation), starting at age 40 BRCA1, PALB2, ATM, or MLH1/MSH2/MSH6 (Lynch syndrome) gene mutation and at least one first degree relative (FDR) with pancreatic

	<p>cancer, starting at age 45 or 10 years earlier than the youngest affected relative</p> <ul style="list-style-type: none"> BRCA2 gene mutation with EITHER of the following, starting at age 45 or 10 years earlier than the youngest affected relative: <ul style="list-style-type: none"> At least one FDR with pancreatic cancer At least two blood relatives with pancreatic cancer FDR and at least one other blood relative with pancreatic cancer, starting at age 50 or 10 years earlier than the youngest affected relative <p>Explanation of change</p> <ul style="list-style-type: none"> Addition of age threshold specification by scenario from CAPS Consortium Restructure of indicated scenarios for operational clarification <p>MRI pelvis Surveillance: Indicated for rectal cancer treated with transanal local excision alone only Explanation of change</p> <ul style="list-style-type: none"> MRI Pelvis - NCCN evidence block alignment for surveillance of rectal cancer (2A recommendation) <p>Esophageal and Gastroesophageal Junction Cancers FDG-PET/CT Management: Indicated in ANY of the following scenarios:</p> <ul style="list-style-type: none"> Radiation planning for preoperative or definitive treatment only Single assessment of response to chemoradiation (as definitive treatment or prior to surgery) when performed at least 5 weeks after completion of therapy Standard imaging cannot be performed or is nondiagnostic for recurrent or progressive disease <p>Explanation of change</p> <ul style="list-style-type: none"> PET clarification: Post chemoradiation imaging limited to single treatment response assessment (not ongoing) <p>Hepatobiliary Cancer MRI abdomen with or without MRCP Diagnostic Workup and Diagnosis: Indicated for EITHER of the following scenarios:</p> <ul style="list-style-type: none"> Known cirrhosis or hepatitis B, with positive or rising serum alpha fetoprotein (AFP)* Documented hepatobiliary cancer <p>Explanation of change</p> <ul style="list-style-type: none"> MRI Abdomen +/- MRCP – NCCN alignment for positive or rising AFP in patients undergoing HCC screening (2A recommendation) <p>Gastrointestinal stromal tumors (GIST) FDG-PET/CT Management: Indicated in EITHER of the following scenarios:</p> <ul style="list-style-type: none"> Assess treatment response following completion of neoadjuvant chemotherapy Standard imaging cannot be performed or is nondiagnostic for recurrent or progressive disease <p>Explanation of change</p> <ul style="list-style-type: none"> Addition of management scenario in alignment with NCCN (use of PET for ambiguous standard imaging findings) <p>Effective November 7th 2021: Transplant-related imaging</p>
--	--

	<p>Advanced imaging is considered medically necessary in the following scenarios:</p> <ul style="list-style-type: none"> • For living donors, a single pre-transplant evaluation • For patients on the transplant waiting list for liver transplantation, annual surveillance • Evaluation of suspected post-transplant complications Note: For patients on the transplant list but who have not undergone transplantation and who have a change in clinical condition, please refer to the applicable sign- or symptom-based indication. <p>IMAGING STUDY</p> <ul style="list-style-type: none"> • CT abdomen or CT abdomen/pelvis • MRI abdomen as an alternative to CT abdomen for surveillance in patients on the waiting list for liver transplantation <p>Explanation of change New indication for transplant-related imaging</p>
--	--

Policies with Coverage Updates in the Past 12 Months	
Ostomy Supplies (369)	<p>Effective October 1, 2021:</p> <ul style="list-style-type: none"> • New medical policy describing medically necessary and not medically necessary ostomy supplies.
Immune Modulating Drugs (004)	<p>Effective 8/2021: Updated criteria for Crohn's Disease and clarified criteria for Psoriasis.</p> <p>Effective 7/2021: Updated to add nonpreferred language to Cosentyx, also new age for Humira in UC and a new indication for Actemra.</p> <p>Effective 1/1/2021: Updated to move Cosentyx and Actemra to non-preferred. Plus Tremfya, Taltz, Enbrel, Stelara, Xeljanz to preferred. A new indication was added to the policy with Cimzia as preferred.</p>
Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon (185)	<p>Effective 5/2021: BCBSA National medical policy review. Added lower GI bleeding and major risks for colonoscopy or moderate sedation and incomplete colonoscopy to investigational policy statement. Effective 5/1/2021.</p>
Fecal Microbiota Transplantation (682)	<p>Effective 4/2021: BCBSA National medical policy review. First policy statement updated with information from 2017 Infectious Diseases Society of America guidelines for C.diff regarding the number of prior C diff infections before fecal microbiota transplantation is considered (ie, "There have been at least 2 recurrences that are refractory to standard antibiotic treatment"). Effective 4/1/2021.</p>
Medical and Surgical Management of Obesity including Anorexians (379)	<p>Effective 4/2021: BCBSA National medical policy review. Policy statement for adolescent bariatric surgery clarified due to updated weight-based criteria used for adults issued by the American Academy of Pediatrics.</p> <p>Effective 1/1/2021:</p>

	Policy clarified to include the following criteria: Has failed other non-surgical approaches to long-term weight loss. These approaches (i.e., diet and exercise plans, behavioral changes, etc.) and duration are up to the surgeon's discretion.
Special Foods: Special Infant Formula, Enteral Formula, Ketogenic Diet for Seizures and Formula Infusion Pumps (304)	Effective 2/2021: Updated to add coverage for Relizorb® to the policy.
AIM guideline: Abdomen and Pelvic Imaging (930)	Effective February 9, 2020: <ul style="list-style-type: none"> • Foreign body (Pediatric only), Gastrointestinal bleeding, Henoch-Schonlein purpura, Hematoma or hemorrhage – intracranial or extracranial, Perianal fistula/abscess (fistula in ano), Ascites, Biliary tract dilatation or obstruction, Cholecystitis, Choledocholithiasis, Focal liver lesion, Hepatomegaly, Jaundice, Azotemia, Adrenal mass, indeterminate, Hematuria, Renal mass, Urinary tract calculi, Adrenal hemorrhage, Adrenal mass, Lymphadenopathy, Splenic hematoma, Undescended testicle (cryptorchidism) • Abdominal and/or pelvic pain • Combined pelvic pain with abdominal pain criteria in new “abdominal and/or pelvic pain” indication • Required ultrasound or colonoscopy for select adult patients based on clinical scenario • Ultrasound-first approach for pediatric abdominal and pelvic pain • Added requirement to exclude DVT prior to abdominopelvic imaging • Added new indications for diagnosis, management, and surveillance of splenic incidentalomas following the ACR White Paper (previously reviewed against “tumor, not otherwise specified”) • Separated criteria for solid and cystic pancreatic masses • Defined follow up intervals for cystic pancreatic masses • Added criteria for MR elastography • Limited requirement for upper endoscopy to patients with relevant symptoms • New requirement for fecal calprotectin or CRP to differentiate IBS from IBD • Incorporated Intussusception (pediatric only), and Ischemic bowel • Moved this indication to Oncologic Imaging Guideline
Retired policies:	Effective January 1, 2021: Ingestible pH and Pressure Capsule (045) Effective January 1, 2021: Transanal Radiofrequency Treatment of Fecal Incontinence (309) Effective May 1, 2021: Vagus Nerve Blocking Therapy for Treatment of Obesity (644) Effective October 1, 2021: Alpha-Fetoprotein-L3 for Detection of Liver Cancer (504)

Policies with No Coverage Updates	
<ol style="list-style-type: none"> 1. Allogeneic Pancreas Transplant (328) 2. Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening (557) 3. Biofeedback as a Treatment of Fecal Incontinence or Constipation (308) 4. Chromoendoscopy as an Adjunct to Colonoscopy (904) 5. Confocal Laser Endomicroscopy (618) 6. Cryosurgical Ablation of Primary or Metastatic Liver Tumors (633) 	

7. Difidid ([700](#))
8. Endoscopic Retrograde Cholangiopancreatography - ECRP - with Laser or Electrohydraulic Lithotripsy ([209](#))
9. Erythropoietin, Recombinant Human, Epoetin Alpha (Epogen® & Procrit®), Darbepoetin Alpha (Aranesp®) ([262](#))
10. Esophageal pH Monitoring ([069](#))
11. Extracorporeal Photopheresis ([248](#))
12. Fecal Analysis in the Diagnosis of Intestinal Dysbiosis ([556](#))
13. Fecal Calprotectin Testing ([329](#))
14. Gastric Electrical Stimulation ([636](#))
15. Heart-Lung Transplantation ([269](#))
16. Home Total Parenteral Nutrition (TPN) ([296](#))
17. Hyperbaric Oxygen Pressurization (HBO) ([653](#))
18. Immune cell Function Assay in Solid Organ transplantation ([182](#))
19. In Vivo Analysis of Colorectal Polyps ([521](#))
20. Interferons Alpha and Gamma ([052](#))
21. Islet Transplantation ([324](#))
22. Isolated Small Bowel Transplant ([631](#))
23. Liver Transplant and Combined Liver-Kidney Transplant ([198](#))
24. Lung and Lobar Lung Transplantation ([015](#))
25. Medical and Surgical Management of Obesity including Anorexiant ([379](#))
26. Monitored Anesthesia Care (MAC) ([154](#))
27. Noninvasive Techniques for the Evaluation and Monitoring of Patients with Chronic Liver Disease ([921](#))
28. Noninvasive Vascular Studies –Duplex Scans ([691](#))
29. Nutrient/Nutritional Panel Testing ([745](#))
30. Oncologic Applications of Photodynamic Therapy, Including Barrett's Esophagus ([454](#))
31. Peroral Endoscopic Myotomy for Treatment of Esophageal Achalasia ([451](#))
32. Plasma Exchange ([466](#))
33. Plugs for Fistula Repair ([528](#))
34. Proton Pump Inhibitors ([030](#))
35. Renal (Kidney) Transplantation ([196](#))
36. Serological Diagnosis of Celiac Disease ([138](#))
37. Serum Antibodies for the Diagnosis of Inflammatory Bowel Disease ([551](#))
38. Special Foods: Special Infant Formula, Enteral Formula, Ketogenic Diet for Seizures and Formula Infusion Pumps ([304](#))
39. Surgical and Transesophageal Endoscopic Procedures to Treat Gastroesophageal Reflux Disease ([920](#))
40. Small Bowel-Liver and Multivisceral Transplant ([632](#))
41. Transanal Endoscopic Microsurgery (TEMS) ([200](#))
42. Transanal Radiofrequency Treatment of Fecal Incontinence ([309](#))
43. Transcatheter Arterial Chemoembolization to Treat Primary or Metastatic Liver Malignancies ([634](#))
44. Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon ([185](#))
45. Whole Body Computed Tomography Scan as a Screening Test ([447](#))
46. Medical Technology Assessment Investigational (Non-Covered) Services List ([400](#))

Reference Policies	
Outpatient Prior Authorization Code List (072)	New policy outlining procedure codes that require prior authorization when performed in the outpatient setting.
Compound Drug List (704)	Pharmacy Compound Inclusion List for MP 579 Compounded Medications
Compound Exclusion List (705)	Compounded Exclusion List of Bulk Chemicals for MP 579 Compounded Medications
MED UM Drug List (034)	Medications requiring Prior Authorization when covered under the member's medical benefits and administered in the outpatient setting.
Medicare Advantage Management (132)	BCBSMA is required to make coverage determinations for services that each Medicare Administrative Contractor (MAC)* publishes as the Local Coverage

	Determination. The LCDs utilized for coverage determinations are based on the jurisdiction of the member's residency (unless otherwise specified by CMS). When there is no LCD or benefit statement that addresses the service/procedure, BCBSMA Commercial medical policies are followed for Medicare Advantage members.
AIM Specialty Health Guidelines	https://aimspecialtyhealth.com/

For questions: ebr@bcbsma.com