MASSACHUSETTS

MEDICAL POLICY ANNOUNCEMENTS

Posted November 2023

This document announces new medical policy changes that take effect February 1, 2024. Changes affect these specialties:

Genetic Testing; Obstetrics Gynecology
Hematology
Orthopedics; Neurology
Transplantation; Endocrinology

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

GENETIC TESTING; OBSTETRICS GYNECOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Carelon Genetic Testing Management Program CPT and HCPCS Codes	957	**Policy revised** to remove CPT 81420. This code is no longer in-scope under the Carelon Genetic Testing Program. PA is no longer required from Carelon or Blue Cross. CPT 81420: Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21	February 1, 2024	Commercial	No action required.

HEMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Gene Therapies for	168	**New policy** describing medically necessary and investigational	November 1, 2023	Commercial Medicare	Prior authorization is required.

Hemophilia A or B		indications for Roctavian added. Title updated to include gene therapies for Hemophilia A. Hemgenix policy criteria #3 **clarified** to replace "AND" with "OR."			

ORTHOPEDICS; NEUROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, Biacuplasty	482	**Policy revised.** Investigational policy statement on Intraosseous Basivertebral Nerve Ablation removed from MP 482. See new MP 485 Intraosseous Basivertebral Nerve Ablation describing medically necessary indications.	February 1, 2024	Commercial Medicare	No action required.
Intraosseous Basivertebral Nerve Ablation	485	**New medical policy** describing medically necessary indications.	February 1, 2024	Commercial Medicare	Prior authorization is required.

TRANSPLANTATION; ENDOCRINOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Islet Transplantation for Chronic Pancreatitis and Donislecel-jujn for Type 1 Diabetes	324	**Policy revised.** Investigational statement added for use of donislecel-jujn in type 1 diabetes. Policy title updated.	February 1, 2024	Commercial	No action required.

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.

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