June 2020 Medical Policy Announcements
Posted: June 2020
New and revised policies: Effective September 2020 (for variable effective dates see table below)
Clarified policies: Posted June 2020 (for variable posted dates see table below)
Retired policies: Effective June 2020

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

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

A full draft version of each policy is available **only by request, to ordering participating clinician providers, one month prior to the effective date of the policy**. To request draft policies, contact Medical Policy Administration at ebr@bcbsma.com.

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None

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AIM Specialty Health

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

REVISED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Conditions	120	Policy criteria on high frequency chest compression device revised based on expert opinion. New medically necessary indications added for chronic neuromuscular disorder.	September 1, 2020	Commercial	Pulmonology
Phototherapy: PUVA, UV-B and Targeted Phototherapy	059	Medically necessary and investigational indications described for home narrow band UV-B phototherapy system (handheld units) for moderate-to-severe localized psoriasis. The policy is also clarified stating coverage for either the home UV-B booth or the home narrow band UV-B handheld unit. We will not cover both devices simultaneously.	June 1, 2020	Commercial	Dermatology

Genetic Testing
Effective for dates of service on and after **September 1, 2020** the following updates will apply to the AIM Genetic Testing Clinical Appropriateness Guidelines. You may access and download a copy of the current guidelines here.
For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com.

AIM Guideline	Contains updates to the following:	Effective Date	Products Affected	Policy Type
Genetic Testing for Single-Gene and Multifactorial Conditions	▪ Updates were made to text in the Germline Genetic Testing and Multifactorial (Non-Mendelian) Genetic Testing criteria. ▪ Post-transplant rejection monitoring and RNA gene expression profiles information was added to the background.	September 1, 2020	Commercial	Genetic Testing
Genetic Testing for Hereditary Cancer Susceptibility	▪ Multi-Gene Panel Testing criteria was updated by removing MSH3 from the gene list lacking established clinical validity. ▪ Retirement and removal of CHEK2/PALB2 and Prostate Cancer criteria with reliance on Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic guidelines (v1.2020) for determining eligibility for testing.	September 1, 2020	Commercial	Genetic Testing
Genetic Testing for Reproductive Carrier	No criteria changes	September 1, 2020	Commercial	Genetic Testing

Screening and Prenatal Diagnosis				
Molecular Testing of Solid and Hematologic Tumors and Malignancies	▪ General coverage criteria for somatic multi-gene panels was updated to include criteria for FDA companion diagnostics. ▪ The following updates were made to Table 1. Solid tumor markers that are medically necessary when general coverage criteria are met: o TP53 was added to genes allowed in molecular studies for Brain/Central Nervous System cancers. o Coverage criteria was clarified for Primary Myelofibrosis to allow targeted multi-gene panels when performed on bone marrow. o Coverage criteria was added for Multiple Myeloma to allow chromosomal microarray analysis (CMA) when cytogenetic (karyotype) and/or FISH analysis is uninformative. ▪ Criteria for gene expression classifier testing in breast cancer were updated to include: o Clarification of coverage in males. o An expansion in coverage to include Breast Cancer Index. o An expansion in coverage for Prosigna™ PAM50 and EndoPredict®to include tumor size >0.5 cm to ≤1.0 cm. o An expansion in coverage for Oncotype DX testing to include tumor size >0.5 cm to ≤1.0 cm plus unfavorable histological features, defined as an intermediate or high nuclear and/or histologic grade (Grade 2 or 3), or lymphovascular invasion OR tumor size 1.1-5.0 cm, any grade. ▪ Prostate Cancer (symptomatic cancer screening) criteria was clarified with examples of clinical suspicion of prostate cancer (e.g. abnormal digital rectal exam, prostate specific antigen (PSA) of greater than 3). ▪ Please note for contracting purposes, 0037U (FoundationOne CDx) is now	September 1, 2020	Commercial	Genetic Testing

	considered medically necessary for certain indications.			
Genetic Testing for Hereditary Cardiac Disease	Criteria was clarified for Non-Covered Tests to include genetic testing for isolated LVNC (left ventricular noncompaction).	September 1, 2020	Commercial	Genetic Testing
Genetic Testing for Pharmacogenomics and Thrombophilia	Criteria was added for CYP2C9 and VKORC1 genotyping in individuals being treated with warfarin.	September 1, 2020	Commercial	Genetic Testing
Genetic Testing for Whole Exome and Whole Genome Sequencing	Whole Exome Sequencing criteria was expanded to include coverage for fetal testing, individuals in the NICU/PICU, and those with hearing loss.	September 1, 2020	Commercial	Genetic Testing

CLARIFICATIONS TO MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Posted Date	Products Affected	Policy Type
Artificial Intervertebral Disc: Cervical Spine	585	Terminology clarified from artificial intervertebral disc arthroplasty of the cervical spine to cervical disc arthroplasty.	June 1, 2020	Commercial Medicare	Neurosurgery Orthopedics
Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty	219	Policy clarified to remove duplicate statement on percutaneous intracranial artery stent placement with or without angioplasty. For coverage information, see medical policy #323.	June 1, 2020	Commercial	Neurosurgery
Circulating Tumor DNA and Circulating Tumor Cells for Cancer Management (Liquid Biopsy)	797	Policy reactivated. Prior authorization information section clarified. Prior authorization is required through AIM Specialty Health.	June 8, 2020	Commercial	Hematology Oncology
Dry Needling of Myofascial Trigger Points	792	National Coverage Determination (NCD) for Acupuncture for Chronic Lower Back Pain (cLBP) (30.3.3) added. Local Coverage Determination (LCD): Pain Management (L33622) removed.	June 1, 2020	Medicare	Orthopedics
Electrical Bone Growth Stimulation of the Appendicular Skeleton	499	Pseudarthrosis added to the policy; statements otherwise unchanged.	June 1, 2020	Commercial	Orthopedics

Genetic Testing Management Program	954	Updated to include information pertaining to #797 Circulating Tumor DNA and Circulating Tumor Cells for Cancer Management (Liquid Biopsy): • BCBSMA policy #797 will be used instead of the AIM guideline on solid and hematologic tumors and malignancies. • Policy #797 is only available on the BCBSMA medical policy website. • Prior authorization is required through AIM Specialty Health.	June 8, 2020	Commercial	Hematology Oncology
Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	247	Policy clarified to include the definition of favorable and unfavorable prognostic factors.	May 13, 2020	Commercial Medicare	Hematology Oncology
Medical Technology Assessment Investigational (Non-Covered) Services List	400	The following codes were added to the non-covered list: ▪ A4639 Replacement pad for infrared heating pad system, each ▪ E0221 Infrared heating pad system. The following narratives were added to the non-covered list: ▪ Skin Contact Monochromatic Infrared Energy (MIRE) ▪ VIVAER Radiofrequency Ablation for Treatment of Nasal Obstruction.	June 1, 2020	Commercial Medicare	Dermatology ENT/Oto-laryngology
Percutaneous Balloon Kyphoplasty, Radiofrequency Kyphoplasty, and Mechanical Vertebral Augmentation	485	Policy statements clarified that the medically necessary statements on compression fractures apply to the thoracolumbar spine. The tradename "Kiva" was removed from policy statements.	June 1, 2020	Commercial	Neurosurgery Orthopedics
Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation	334	Medically necessary policy statement clarified to include non-valvular terminology.	May 1, 2020	Commercial	Cardiology

Sacral Nerve Neuromodulation/ Stimulation	153	Minor edits to the Policy section; statements unchanged.	June 1, 2020	Commercial Medicare	Urology

RETIRED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Skin Contact Monochromatic Infrared Energy (MIRE)	507	Policy is retired. There is no specific code for MIRE. MIRE is added to MP #400 Medical Technology Assessment Investigational (Non-Covered) Services List.	June 1, 2020	Commercial Medicare	Dermatology

New 2020 Category III CPT Codes
All category III CPT Codes, including new 2020 codes, are **non-covered** unless they are explicitly described as "medically necessary" in a BCBSMA medical policy. To search for a particular code, click the following link: https://www.bluecrossma.com/common/en_US/medical_policies/medcat.htm and type the code in the search box on the page. Consult the coverage statement of any associated medical policy. ***If there is no associated policy, the code is non-covered*.**