

October 2018 Medical Policy Announcements

Posted: October 2018

New and revised policies: Effective January 2019 (for variable effective dates see table below)

Clarified policies: Posted October 2018 (for variable posted dates see table below)

Retired policies: Effective October 2018

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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[Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer](#)

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[Prostatic Urethral Lift](#)

Hematopoietic Cell Transplantation - Effective January 1, 2019

Prior Authorization will be **required** for all products including Medicare Advantage if the following procedures are performed in the outpatient setting:

[Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias](#)

[Allogeneic Hematopoietic Cell transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms](#)

[Autologous Hematopoietic Stem Cell Transplantation for Malignant Astrocytomas and Gliomas](#)

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[List of Retired BCBSMA Genetic Testing Medical Policies](#)

To access the current version of the AIM guidelines, go to <http://www.aimspecialtyhealth.com>.

[Genetic Testing for Heredity Cancer Susceptibility](#)

[Genetic Testing for Pharmacogenetic and Thrombophilia](#)

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None

NEW MEDICAL POLICIES					
New Medical Policy Title	Policy Number	Policy Summary	Effective Date	Products Affected	Policy Type
None	NA	NA	NA	NA	NA

REVISED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Bioengineered Skin and Soft Tissue Substitutes	663	Policy statements on breast reconstructive surgery following cancer treatment using allogeneic acellular dermal matrix products revised.	October 1, 2018	Commercial Medicare	Dermatology Plastic Surgery
Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer	336	Ongoing investigational indications described. For coverage information on the following tests, see medical policy #954, AIM Genetic Testing Management Program and medical policy #957, AIM Genetic Testing Management Program CPT and HCPCS Codes: <ul style="list-style-type: none"> Genetic Testing (using PCR) for TMPRSS Fusion Genes in Prostate Cancer Genetic Testing for Mitochondrial DNA 	January 1, 2019	Commercial	Urology Oncology

		<p>Mutation Testing (eg, Prostate Core Mitomics Test™)</p> <ul style="list-style-type: none"> • Candidate Gene Panels • Gene Hypermethylation Testing (eg, ConfirmMDx®). 			
Medical Technology Assessment Non-Covered Services	400	<p>CPT codes 20696 and 20697 were removed. These codes are covered.</p> <p>Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer- assisted adjustment (eg, spatial frame)</p>	September 21, 2018	Commercial Medicare	Orthopedics
Prostatic Urethral Lift	744	The first policy statement revised to indicate that the eligible patient should either be unable to tolerate/failed medical management or not a surgical candidate for TURP.	January 1, 2019	Commercial Medicare	Urology

Hematopoietic Cell Transplantation					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias	190	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Allogeneic Hematopoietic Cell transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms	155	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Autologous Hematopoietic Stem Cell Transplantation for Malignant Astrocytomas and Gliomas	159	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia	076	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Hematopoietic Cell Transplantation for Autoimmune Diseases	192	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology

Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma	074	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia	212	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma	205	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer	204	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults	191	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas	143	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Hematopoietic Cell Transplantation for Plasma Cell Dyscracias, Including Multiple Myeloma and POEMS Syndrome	075	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Hematopoietic Cell Transplantation for Primary Amyloidosis	181	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Hematopoietic Cell Transplantation for Solid Tumors of Childhood	208	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Hematopoietic Cell Transplantation in the Treatment of Germ-Cell Tumors	247	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
Hematopoietic Stem-Cell Transplantation for Hodgkin Lymphoma	207	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology

Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia	322	Outpatient prior authorization will be required for all Commercial products including Medicare Advantage.	January 1, 2019	Commercial Medicare	Hematology Oncology
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Genetic Testing					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Genetic Testing Management Program	954	<p><u>For Commercial Products</u></p> <p>Prior authorization program for genetic testing and molecular diagnostics will be implemented.</p> <p>Prior authorization for commercial HMO/POS and PPO plans will be required.</p> <p>Prior authorization will not be required for genetic testing associated with organ transplantation.</p> <p>For medical necessity criteria, see AIM Clinical Appropriateness Guidelines.</p> <p>Click here for additional information about the Genetic Testing Program</p> <p><u>For Medicare Advantage Products</u></p> <p>Prior authorization through AIM Specialty Health is not required for Medicare Advantage products.</p> <p>For specific genetic testing guidelines, see the appropriate National Coverage Determination (NCD) or Local Coverage Determination (LCD) through the CMS website.</p>	January 1, 2019	Commercial	Oncology Cardiology Obstetrics
Genetic Testing Management Program CPT and HCPCS Codes	957	<p><u>For Commercial Products</u></p> <p>In-scope CPT and HCPCS codes under the AIM Genetic Testing Management Program for Commercial products described.</p>	January 1, 2019	Commercial	Oncology Cardiology Obstetrics

		<p>For medical necessity criteria, see AIM Clinical Appropriateness Guidelines.</p> <p>Click here for additional information about the Genetic Testing Program.</p> <p><u>For Medicare Advantage Products</u></p> <p>Prior authorization through AIM Specialty Health is not required for Medicare Advantage products.</p> <p>For specific genetic testing guidelines, see the appropriate National Coverage Determination (NCD) or Local Coverage Determination (LCD) through the CMS website.</p>			
Genetic Testing: To access the current version of AIM guidelines, go to http://www.aimspecialtyhealth.com					
Genetic Testing for Heredity Cancer Susceptibility	See AIM Specialty Health Guidelines	Criteria added to allow germline testing (BRCA 1/2, ATM and PALB2) of prostate cancer when an individual has localized stage III, regional or metastatic disease.	January 1, 2019	Commercial Medicare	Oncology
Genetic Testing for Pharmacogenetic and Thrombophilia	See AIM Specialty Health Guidelines	F2/F5 criteria expanded to allow additional management changes for unprovoked VTE and estrogen changes with significant family history.	January 1, 2019	Commercial Medicare	Non-oncology
Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis	See AIM Specialty Health Guidelines	<p>Criteria deleted requiring 10 week gestational age limit and vanishing twin exclusion for non-invasive prenatal testing (NIPT).</p> <p>Criteria expanded for carrier screening to include additional rare genetic variants for conditions common in other ethnicities.</p>	January 1, 2019	Commercial Medicare	Obstetrics Gynecology
Genetic Testing for Single-Gene and Multifactorial Conditions	See AIM Specialty Health Guidelines	Criteria deleted requiring evaluation by a board certified medical geneticist, genetic counselor or other specialist with specific expertise in the condition/genes associated with multi-gene panels.	January 1, 2019	Commercial Medicare	Non-oncology

Molecular Testing of Solid and Hematologic Tumors and Malignancies	See AIM Specialty Health Guidelines	Criteria expanded to include genetic testing for uveal melanoma when an individual meets NCCN guidelines. Exclusion criteria added for prostate cancer screening. Criteria revised for Mammaprint.	January 1, 2019	Commercial Medicare	Hematology
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High Technology Radiology					
Computed Tomographic Angiography Coronary arteries (CCTA)	831	Medically necessary indications revised.	January 28, 2019	Commercial	Cardiology
Magnetic Resonance Imaging (MRI) Cardiac	835	Medically necessary indications revised.	January 28, 2019	Commercial	Cardiology
Nuclear Cardiology Myocardial Perfusion Imaging	836	Medically necessary indications revised.	January 28, 2019	Commercial	Cardiology
Positron Emission Tomography (PET) Myocardial Imaging	837	Medically necessary indications revised.	January 28, 2019	Commercial	Cardiology

Sleep Management					
Management of Obstructive Sleep Apnea - OSA using Auto-Titrating Positive Airway Pressure - APAP and Continuous Positive Airway Pressure - CPAP Devices	526	HCPCS code A7047 (oral interface used with respiratory suction pump) removed. The ApniCure Winx device as a treatment for obstructive sleep apnea is no longer available for purchase/use.	January 28, 2019	Commercial	Pulmonology

CLARIFICATIONS TO MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Posted Date	Products Affected	Policy Type
BCR-ABL1 Testing in Chronic Myelogenous Leukemia and Acute Lymphoblastic Leukemia	612	Local Coverage Determination (LCD): Molecular Pathology Procedures (L35000) added.	September 1, 2018	Medicare	Hematology
Gene Therapy for Inherited Retinal Dystrophy	911	Policy criteria clarified. Gene Therapy for Inherited Retinal Dystrophy Prior authorization request form, #926 clarified.	September 13, 2018	Commercial Medicare	Ophthalmology
Genetic Testing for Lynch Syndrome and Other	226	Local Coverage Determination (LCD): Molecular Pathology Procedures (L35000) added.	September 1, 2018	Medicare	Gastroenterology

Inherited Colon Cancer Syndromes					
Pharmacogenomic and Metabolite Markers for Patients Treated with Thiopurines	096	Local Coverage Determination (LCD): Molecular Pathology Procedures (L35000) added.	September 1, 2018	Medicare	Gastro- enterology
Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases	702	Clinical criteria in Table 1 for synovitis clarified under the description section. Summary and references updated.	October 1, 2018	Commercial Medicare	Neurology

RETIRED MEDICAL POLICIES

Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
NA	NA	NA	NA	NA	NA

List of Retired BCBSMA Genetic Testing Medical Policies:

The following BCBSMA Genetic Testing Medical Policies will be retired effective January 1, 2019.

Note: These policies will no longer be available on the BCBSMA website as of this date. For medically necessary indications, see the [AIM Clinical Appropriateness Guidelines for non-oncologic and oncologic conditions](#).

Medical Policy Title	Policy Number
Cardiology	
Gene Expression Testing in the Evaluation of Patients with Stable Ischemic Heart Disease	349
Genetic Testing for Congenital Long QT Syndrome	082
Genetic Testing for Dilated Cardiomyopathy	601
Genetic Testing for Marfan Syndrome, Thoracic Aortic Aneurysms and Dissections, and Related Disorders	729
Genetic Testing for Predisposition to Inherited Hypertrophic Cardiomyopathy	909
Genotyping for 9p21 Genetic Polymorphisms to Predict Cardiovascular Disease Risk	340
ST2 Assay for Chronic Heart Failure	723
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Genetic Testing for CHARGE Syndrome	540
Genetic Testing for Facioscapulohumeral Muscular Dystrophy	535
Genetic Testing for Familial Alzheimer's Disease	580
Genetic Testing for Helicobacter Pylori Treatment	288
Genetic Testing for Hereditary Hemochromatosis	908
Genetic Testing for Hereditary Pancreatitis	516
Genetic Testing for Heterozygous Familial Hypercholesterolemia	796
Genetic Testing for Inherited Thrombophilia	802
Genetic Testing for Lactase Insufficiency	565
Genetic Testing for Macular Degeneration	665
Genetic Testing for Muscular Dystrophies	828
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Genetic Testing for Cutaneous Malignant Melanoma	300
Genetic Testing for Fanconi Anemia	714
Genetic Testing for Hereditary Breast and Ovarian Cancer	245
Genetic Testing for Inherited Susceptibility to Colon Cancer, Including Microsatellite Instability Testing	226
Genetic Testing for Li-Fraumeni Syndrome	684
Genetic Testing for PTEN Hamartoma Tumor Syndrome	615
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Genetic Testing for Limb-Girdle Muscular Dystrophies	738
Genetic Testing for Mitochondrial Disorders	685
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Genetic Testing for FMR1 mutations (including Fragile X Syndrome)	907
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Genetic Testing for Neurofibromatosis	793
Genetic Testing for Nonsyndromic Hearing Loss	452
Genetic Testing for Rett Syndrome	803
Genetic Testing for the Diagnosis of Inherited Peripheral Neuropathies	569
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Gene Expression Profiling for Cutaneous Melanoma	056
Gene Expression Profiling for Uveal Melanoma	683
Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer: TMPRSS Fusion Genes in Prostate Cancer (using PCR); Mitochondrial DNA Mutation Testing (eg, Prostate Core Mitomics Test™); Candidate Gene Panels; Gene Hypermethylation Testing (eg, ConfirmMDx®)	333
Genetic Testing for CHEK2 Mutations for Breast Cancer	741
Genetic Testing for FLT3 and NPM1 Mutations in Acute Myeloid Leukemia	693
Genetic Testing for Germline Mutations of the RET Proto-Oncogene in Medullary Carcinoma of the Thyroid	564
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Microarray-Based Gene Expression Profile Testing for Multiple Myeloma Risk Stratification	477
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Multigene Expression Assay for Predicting Recurrence in Colon Cancer	239
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New 2018 Category III CPT Codes

All category III CPT Codes, including new 2018 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.***