**October 2019 Medical Policy Announcements**
**Posted: October 2019**
**New and revised policies: Effective January 2020 (for variable effective dates see table below)**
**Clarified policies: Posted October 2019 (for variable posted dates see table below)**
**Retired policies: Effective October 2019**

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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**NEW MEDICAL POLICIES:**
None

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**REVISED MEDICAL POLICIES:**


**Advanced Specialty Health (AIM)**
**Genetic Testing - Effective for dates of service on and after December 12, 2019**


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**CLARIFICATIONS TO MEDICAL POLICIES:**


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**RETIRED MEDICAL POLICIES:**
None

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**NEW PHARMACY MEDICAL POLICIES:**


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**REVISED PHARMACY MEDICAL POLICIES**


| NEW MEDICAL POLICIES | | | | | |
|---|---|---|---|---|---|
| New Medical Policy Title | Policy Number | Policy Summary | Effective Date | Products Affected | Policy Type |
| N/A | 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 |
| Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Artificial Pancreas Device Systems | 107 | Medically necessary criteria for artificial pancreas were transferred to policy #107 from policy #720. Title changed.<br><br>Prior authorization is required for Commercial and Medicare HMO.<br><br>**Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid**<br>• Medically necessary indications described for use of short-term or long-term CGM in specific T2DM patients with criteria.<br><br>**Artificial Pancreas Device Systems**<br>• Medical policy statements revised. The age criterion changed.<br>• Medically necessary statement added on FDA-approved automated insulin delivery system (artificial pancreas device system) designated as hybrid closed loop insulin delivery system in patients with type 1 diabetes who meet specified criteria.<br>• New investigational statement added on use of an automated insulin delivery system (artificial pancreas device system) for individuals who have not met specified criteria. | January 1, 2020 | Commercial Medicare | Endocrinology |
| Methadone Treatment for Opioid Use Disorder | 274 | New medically necessary criteria for Medicare Advantage added. | January 1, 2020 | Medicare | Psychiatry |
| Prostatic Urethral Lift | 744 | Medically necessary statement was updated to remove: Patient does not have prostate-specific antigen level ≥3 ng/mL. | January 1, 2020 | Commercial Medicare | Urology |

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|---|---|---|---|---|---|
| | | Medically necessary criterion regarding nickel allergy was expanded to include titanium and stainless steel. | | | |
| Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders | 297 | Prior authorization is required for Medicare Advantage. | January 1, 2020 | Medicare | Psychiatry |

**Genetic Testing**
Effective for dates of service on and after December 12, 2019, the following updates will apply to the AIM Genetic Clinical Appropriateness Guidelines. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. You may access and download a copy of the current guidelines here.

| AIM Guideline | Contains updates to the following: | Effective Date | Products Affected | Policy Type |
|---|---|---|---|---|
| Molecular Testing of Solid and Hematologic Tumors and Malignancies | ▪ Coverage Criteria expanded for NTRK fusion testing to cover FDA approved medications.<br>▪ Coverage Criteria added to include testing criteria for minimal residual disease (MRD) testing.<br>○ Relevant text was incorporated into the following sections to account for the added coverage criteria: Background, CPT Codes, Professional Society Guidelines, References and Revision History. | December 12, 2019 | Commercial | Hematology Oncology |

| CLARIFICATIONS TO MEDICAL POLICIES | | | | | |
|---|---|---|---|---|---|
| Medical Policy Title | Policy Number | Policy Change Summary | Posted Date | Products Affected | Policy Type |
| Artificial Pancreas Device Systems | 720 | Medically necessary criteria for Artificial Pancreas Device Systems were transferred to policy #107, Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Artificial Pancreas Device Systems.<br><br>Policy #720 will be retired. | January 1, 2020 | Commercial Medicare | Endocrinology |
| Assisted Reproductive Services | 086 | Overview of covered services added. | October 1, 2019 | Commercial Medicare | Obstetrics Gynecology |
| Intraoperative Neurophysiologic Monitoring | 211 | Policy clarified to remove the note indicating that training of four monitoring is considered integral to intraoperative | October 1, 2019 | Commercial Medicare | Neurology Neurosurgery |

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|---|---|---|---|---|---|
| Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring | | monitoring and/or administration of anesthesia. | | | |
| Neuropsychological and Psychological Testing | 151 | Local Coverage Determination (LCD): Psychiatry and Psychology Services (L33632) added. | October 1, 2019 | Commercial Medicare | Psychiatry |
| Ovarian and Internal Iliac Vein Endovascular Occlusion as a Treatment of Pelvic Congestion Syndrome | 266 | Policy title and language clarified from embolization to endovascular occlusion to clarify policy inclusion of both embolization and sclerotherapy treatment strategies. Policy statement otherwise unchanged. | October 1, 2019 | Commercial Medicare | Obstetrics Gynecology |
| Zulresso™ (Brexanalone) for the Treatment of Post-Partum Depression | 147 | Policy clarified to state that Zulresso™ must be administered in the inpatient setting. | October 1, 2019 | Commercial Medicare | Psychiatry Obstetrics Gynecology |

| RETIRED MEDICAL POLICIES | | | | | |
|---|---|---|---|---|---|
| Medical Policy Title | Policy Number | Policy Change Summary | Effective Date | Products Affected | Policy Type |
| N/A | N/A | N/A | N/A | N/A | N/A |

| | | NEW PHARMACY MEDICAL POLICIES | |
|---|---|---|---|
| Medical Policy Title | Policy Number | Policy Summary | Effective Date |
| Entresto Step Therapy | 063 | Implement new Step therapy policy requiring ACE, ARB, or Beta-Blocker use before the use of Entresto. | January 1, 2020 |
| Mupirocin Step Therapy | 062 | Implement new Step therapy policy requiring ointment use before the use of cream. | January 1, 2020 |

| | | REVISED PHARMACY MEDICAL POLICIES | |
|---|---|---|---|
| Medical Policy Title | Policy Number | Policy Change Summary | Effective Date |
| Immune Modulating Drugs | 004 | Updating Xeljanz and Xeljanz XR use for the Ulcerative Colitis diagnosis to a non-preferred category because of the newly identified safety issues in this population.<br><br>BCBSMA will also add an extra step before approving Taltz. | January 1, 2020 |

**New 2019 Category III CPT Codes**
**All** category III CPT Codes, including new 2019 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*.**