



BlueCross BlueShield  
of North Carolina

# MEDICARE

March 2024

## **Medical Policies and Clinical Utilization Management Guidelines Update**

**Please note**, this communication applies to *Healthy Blue + Medicare<sup>SM</sup> (HMO-POS D-SNP)* offered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC).

The *Medical Policies, Clinical Utilization Management (UM) Guidelines, and Third-Party Criteria* below were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed.

Please share this notice with other providers in your practice and office staff.

To view a guideline, visit [bluecrossnc.com/providers](https://www.bluecrossnc.com/providers) and select **Medical Policies and Clinical UM Guidelines** under *Resources*.

### **Notes/updates:**

Updates marked with an asterisk (\*) notate that the criteria may be perceived as more restrictive:

- ANC.00009 - Cosmetic and Reconstructive Services of the Trunk, Groin, and Extremities;
- Previously titled: Cosmetic and Reconstructive Services of the Trunk and Groin:
  - Revised title to include "Extremities"
  - Revised Position Statement regarding lipectomy or liposuction for lymphedema and lipedema
- DME.00011 - Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices:
  - Reformatted bullet points to letters
  - Added lines to Investigational & Not Medically Necessary statement on electrical stimulation wound treatment device, electromagnetic wound treatment devices and pulsed electromagnetic field stimulation
- LAB.00011 - Selected Protein Biomarker Algorithmic Assays:
  - Reformatted bullet points to letters
  - Added IMMray® PanCan-d test to the Investigational & Not Medically Necessary statement
- LAB.00028 - Blood-based Biomarker Tests for Multiple Sclerosis, Previously titled: Serum Biomarker Tests for Multiple Sclerosis:
  - Revised title

<https://www.bluecrossnc.com/providers/networks-programs/blue-medicare/healthy-blue-medicare>

Blue Cross and Blue Shield of North Carolina Senior Health, DBA Blue Cross and Blue Shield of North Carolina, is an HMO-POS D-SNP plan with a Medicare contract and a NC State Medicaid Agency Contract (SMAC). Enrollment in Blue Cross and Blue Shield of North Carolina Senior Health depends upon contract renewal.

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- Expanded scope of document from serum to blood-based biomarker testing for multiple sclerosis (MS)
- Revised Position Statement to indicate blood-based biomarker tests for multiple sclerosis are considered Investigational & Not Medically Necessary for all uses
- MED.00140 - Lentiviral Gene Therapy for Beta Thalassemia and Sickle Cell Disease; Previously Titled: Gene Therapy for Beta Thalassemia:
  - Revised title
  - Added Investigational & Not Medically Necessary statement on lovetibeglogene autotemcel
- MED.00144 - Gene Therapy for Duchenne Muscular Dystrophy:
  - Outlines the Medically Necessary and Investigational & Not Medically Necessary criteria for the infusion of Delandistrogene moxeparvovec-rokl (ELEVIDYS)
- MED.00147 - Cellular Therapy Products for Allogeneic Stem Cell Transplantation:
  - Outlines the Medically Necessary and Investigational & Not Medically Necessary criteria for the use of ex-vivo expansion of cord blood stem cell products
- SURG.00129 - Percutaneous Vertebral Disc and Vertebral Endplate Procedures:
  - Removed the criteria examples for failed CPAP treatment
  - Added definition for failed CPAP treatment
- SURG.00144 - Occipital and Sphenopalatine Ganglion Nerve Block Therapy for the Treatment of Headache and Neuralgia; Previously titled: Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia:
  - Revised title
  - Added Investigational & Not Medically Necessary statement for sphenopalatine ganglion nerve blocks
- TRANS.00041 - Histological Analysis using Microarray Gene Expression Profiling for Kidney Allograft Injury or Rejection:
  - Histological analysis using microarray gene expression profiling is considered Investigational & Not Medically Necessary for detection of allograft injury or rejection in kidney transplant recipients
- CG-MED-39 - Bone Mineral Density Testing Measurement:
  - Added phrase “using Dual-X-Ray Absorptiometry” to bullets I and III of Medically Necessary criteria and to bullets I and IV of Not Medically Necessary criteria
  - Added Not Medically Necessary position statement for bone strength and fracture risk assessment using imaging scans other than DXA
- CG-MED-95 - Transanal Irrigation:
  - Outlines the Medically Necessary and Not Medically Necessary criteria for transanal irrigation
- CG-OR-PR-05 - Myoelectric Upper Extremity Prosthetic Devices:
  - Revised formatting of Medically Necessary section
  - Added Repair and Replacement criteria to Clinical Indications section
  - Added new Not Medically Necessary statement regarding enhanced dexterity prosthetic arm myoelectric upper extremity prosthetic devices
  - Added new Medically Necessary and Not Medically Necessary criteria for device repair and replacement.

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- CG-SURG-61 - Cryosurgical, Radiofrequency, Microwave or Laser Ablation to Treat Solid Tumors Outside the Liver; Previously titled: Cryosurgical, Radiofrequency or Laser Ablation to Treat Solid Tumors Outside the Liver:
  - Revised title
  - Added microwave ablation to the Clinical Indications
  - Added cryoablation and microwave ablation to the Medically Necessary indications for NSCLC and malignant tumors that have metastasized to the lung
  - Added Not Medically Necessary statements regarding focal cryoablation of the prostate and microwave ablation for all other indications
  - Revised Medically Necessary indication for cryoablation of the prostate to whole gland cryoablation of the prostate
  - Reordered clinical indications to be based on clinical condition rather than ablative technique

***Medical Policies***

On August 10, 2023, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Blue Cross NC. These medical policies take effect May 27, 2024.

<b>Publish Date</b>	<b>Medical Policy Number</b>	<b>Medical Policy Title</b>	<b>New or Revised</b>
9/27/2023	*ANC.00009	Cosmetic and Reconstructive Services of the Trunk, Groin, and Extremities Previously titled: Cosmetic and Reconstructive Services of the Trunk and Groin	Revised
9/27/2023	*DME.00011	Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices	Revised
9/27/2023	*LAB.00011	Selected Protein Biomarker Algorithmic Assays	Revised
9/27/2023	*LAB.00028	Blood-based Biomarker Tests for Multiple Sclerosis Previously titled: Serum Biomarker Tests for Multiple Sclerosis	Revised
9/27/2023	*MED.00140	Lentiviral Gene Therapy for Beta Thalassemia and Sickle Cell Disease Previously Titled: Gene Therapy for Beta Thalassemia	Revised
9/27/2023	*MED.00144	Gene Therapy for Duchenne Muscular Dystrophy	New

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9/27/2023	*MED.00147	Cellular Therapy Products for Allogeneic Stem Cell Transplantation	New
9/27/2023	SURG.00052	Percutaneous Vertebral Disc and Vertebral Endplate Procedures	Revised
9/27/2023	*SURG.00129	Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring	Revised
9/27/2023	*SURG.00144	Occipital and Sphenopalatine Ganglion Nerve Block Therapy for the Treatment of Headache and Neuralgia Previously titled: Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia	Revised
9/27/2023	TRANS.00039	Portable Normothermic Organ Perfusion Systems	Revised
9/27/2023	*TRANS.00041	Histological Analysis using Microarray Gene Expression Profiling for Kidney Allograft Injury or Rejection	New

***Clinical UM Guidelines***

On August 10, 2023, the MPTAC approved the following *Clinical UM Guidelines* applicable to Blue Cross NC. These guidelines were adopted by the medical operations committee for Medicare Advantage members on September 28, 2023. These guidelines take effect May 27, 2024.

<b>Publish Date</b>	<b>Clinical UM Guideline Number</b>	<b>Clinical UM Guideline Title</b>	<b>New or Revised</b>
9/27/2023	*CG-MED-39	Bone Mineral Density Testing Measurement	Revised
9/27/2023	CG-MED-83	Site of Care: Specialty Pharmaceuticals	Revised
9/27/2023	*CG-MED-95	Transanal Irrigation	New
9/27/2023	*CG-OR-PR-05	Myoelectric Upper Extremity Prosthetic Devices	Revised
9/27/2023	CG-OR-PR-08	Microprocessor Controlled Lower Limb Prosthesis	Conversion New
9/27/2023	CG-OR-PR-09	Microprocessor Controlled Knee-Ankle-Foot Orthosis	Conversion New

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<b>Publish Date</b>	<b>Clinical UM Guideline Number</b>	<b>Clinical UM Guideline Title</b>	<b>New or Revised</b>
9/27/2023	CG-SURG-01	Colonoscopy	Revised
9/27/2023	*CG-SURG-61	Cryosurgical, Radiofrequency, Microwave or Laser Ablation to Treat Solid Tumors Outside the Liver Previously titled: Cryosurgical, Radiofrequency or Laser Ablation to Treat Solid Tumors Outside the Liver	Revised
9/27/2023	CG-SURG-79	Implantable Infusion Pumps	Revised
9/27/2023	CG-SURG-83	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	Revised