MASSACHUSETTS

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Medical Policy

Medicare Advantage Management

Policy Number: 132

Effective Date: 10/1/2020

Related Policies

Outpatient Prior Authorization Code List, #072
Medical Technology Assessment Non-Covered Services List, #400
Musculoskeletal Services Management, #220
Musculoskeletal Services Management CPT and HCPCS Codes, #221

Table of Contents

Outpatient Prior Authorization Code List for Commercial #072: This document represents medical policies with specific procedure codes. These procedure codes require prior authorization for Commercial plans when they are performed in the outpatient setting.

Benefits, Eligibility, and Claims	Prior Authorization Questions
Provider Services 1-800-882-2060 (Physicians) 1-800-451-8123 (Hospitals) 1-800-451-8124 (Ancillary Providers)	1-800-222-7620

Medicare Advantage Administrative Guidelines

As a third party that administers Medicare Advantage products, Blue Cross Blue Shield of Massachusetts uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations. Coverage determinations are based on National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). In addition, available CMS Medicare-related manuals are used to guide medical policy for Medicare Advantage members.

National Coverage Determinations (NCD)

BCBSMA is required to make coverage determinations for services through the CMS National Coverage Determination policies and benefit manuals. **When there is no NCD, BCBSMA medical policies are followed for Medicare Advantage members**.

To review the specific NCDs, please click "accept" on the CMS licensing agreement at the bottom of the CMS webpage. Click here to see the NCDs alphabetical index

Local Coverage Determinations (LCD) Massachusetts Jurisdiction

BCBSMA is required to make coverage determinations for services that each Medicare Administrative Contractor (MAC)* publishes as the Local Coverage Determination. The LCDs utilized for coverage determinations are based on the jurisdiction of the member's residency (unless otherwise specified by CMS). **When there is no LCD or benefit statement that addresses the service/procedure, BCBSMA medical policies are followed for Medicare Advantage members.**

To review the specific LCDs, please click "accept" on the CMS licensing agreement at the bottom of the CMS webpage. Click here to see the LCDs alphabetical index

*Medicare Administrative Contractors (MACs) are private health care insurers that have been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims or Durable Medical Equipment claims for Medicare Fee-For-Service beneficiaries.

Local Coverage Determinations (LCD) Molecular Diagnostic Tests (MolDX) Program by Palmetto GBA

BCBSMA is required to make coverage determinations for services that each Medicare Administrative Contractor (MAC)* publishes as the Local Coverage Determination. When there is no MolDX LCD on the jurisdiction of the member's residency, Palmetto GBA MolDX LCDs are followed for Medicare Advantage members. Click here to see Palmetto GBA MolDX LCDs

*Medicare Administrative Contractors (MACs) are private health care insurers that have been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims or Durable Medical Equipment claims for Medicare Fee-For-Service beneficiaries.

High Technology Radiology and Sleep Disorder for Medicare Advantage Products

Please use the following steps to determine the appropriate clinical guidance for High Technology Radiology and Sleep Disorder Management medical policies for **Medicare Advantage only:**

1. Determine if Prior Authorization is required for the member through Carelon's website – see Prior Authorization Information.

If prior authorization IS required through Carelon

1. Request prior authorization from Carelon or call 1-866-745-1783.
2. Follow steps outlined by Carelon

If prior authorization IS NOT required through Carelon

1. Determine if there is National Coverage Determination (NCD) or Local Coverage Determination (LCD) on the technology. To view the Centers for Medicare and Medicaid Services website, click CMS.gov. **Exception:** For Magnetic Resonance Imaging (MRI) Breast (#774), we follow Carelon clinical guidelines.
2. When there is no NCD or LCD guidance, go to Carelon guidelines for clinical review criteria.
3. If member meets clinical criteria, order test.
4. If member does not meet clinical criteria but requires a clinical exception, follow the Clinical Exception Process.

Prior Authorization Information: Medicare HMO Blue℠ and Medicare PPO Blue℠

The requirements of BCBSMA Radiology Management Program may require a precertification/prior authorization via Carelon

These requirements are member-specific: please verify member eligibility and requirements through **Online Services** by logging onto Provider Central.

Refer to our Authorization Quick Tip for an overview of pre-certification and prior authorization requirements.

Ordering clinicians should request pre-certification from Carelon or call 1-866-745-1783 (when applicable).

Genetic Testing for Medicare Advantage Products

Prior authorization through Carelon **is not required** for Medicare Advantage products. Please see the appropriate National Coverage Determination (NCD) or Local Coverage Determination (LCD) through the CMS website for specific genetic testing guidelines.

Commercial and Medicare Policy Directory and Outpatient Prior Authorization Information for Medicare Advantage

Policy #	BCBSMA Medical Policy	Medicare Advantage Local Coverage Determination (LCD) National Coverage Determination (NCD) Click here for Palmetto GBA MolDX LCD
N/A	Chiropractic Services	CMS IOM Publication 100-2 Medicare Benefit Policy Manual Chapter 15, Sections 30.5 – Chiropractor's Services and 240 – Chiropractic Services – General CMS IOM Publication 100-4 Medicare Claims Processing Manual Chapter 12, Section 220 – Chiropractic Services Article: Chiropractic Services – Medical Policy Article (A57889) Article: Billing and Coding: Chiropractic Services (A58412)
MP 003	Transcutaneous Electrical Nerve Stimulation	NCD: Transcutaneous Electrical Nerve Stimulation for Acute Post-Operative Pain (10.2) NCD: Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1) NCD: Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation and Neuromuscular Electrical Stimulation (160.13) NCD: Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (160.27) LCD: Transcutaneous Electrical Nerve Stimulators (TENS) (L33802) **Outpatient Prior Authorization** Prior authorization is not required
MP 007	Obstetrical Ultrasound & Ultrasound for Family Planning	NCD: Ultrasound Diagnostic Procedures (220.5) **Outpatient Prior Authorization** Prior authorization is not required
MP 008	Zolgensma (onasemnogene abeparvovec-xioi) for Spinal Muscular Atrophy (SMA)	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** C9399, J3399, J3490, J3590: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *085 Prior Authorization Request Form for Zolgensma*

MP 009	Elzonris (tagraxofusp-erzs) for the Treatment of Blastic Plasmacytoid Dendritic Cell Neoplasm	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** J9269: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *928 Prior Authorization Request Form for Elzonris*
MP 015	Lung and Lobar Lung Transplant	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This procedure is performed in the inpatient setting
MP 016	Homocysteine Testing in the Screening, Diagnosis, and Management of Cardiovascular Disease and Venous Thromboembolic Disease	LCD: MolDX: Biomarkers in Cardiovascular Risk Assessment (L36523) **Outpatient Prior Authorization** Prior authorization is not required
MP 018	Balloon Dilation of the Eustachian Tube	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 020	Medicare Advantage Part B Step Therapy	Click here for additional coverage information: Medicare Advantage Part B Step Therapy LCD: Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L33394) LCD: Off-label Use of Rituximab and Rituximab Biosimilars (L39297) NCD: Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (110.21) NCD: Anti-Cancer Chemotherapy for Colorectal Cancer (110.17) **Outpatient Prior Authorization** C9257; J0178; J0179; J0881; J0882; J0885; J0887; J0888; J0897; J1442; J1447; J1745; J2503; (deleted 01.01.22); J2778; J7318; J7320; J7321; J7322; J7323; J7324; J7325; J7326; J7327; J7328; J7329; J7332; J9035; J9312; J9355; Q4081; Q5103; Q5104; Q5105; Q5106; Q5107; Q5108; Q5110; Q5111; Q5112; Q5113; Q5114; Q5115; Q5116; Q5117; Q5118; Q5119; Q5120; Q5121 Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Standard Form for Medication Prior Authorization Requests (eForm*
MP 022	Gene Therapies for Duchenne Muscular Dystrophy	No LCD or NCD BCBSMA medical policy is followed Outpatient Prior Authorization Prior authorization is required

		Prior Authorization Request Form for Elevidys (delandistrogene moxparvovec-rokl), #025
MP 024	Vestibular Function Testing	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 026	Sphenopalatine Ganglion Block for Headache	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 028	Omidubicel as Adjunct Treatment for Hematologic Malignancies	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is required
MP 029	Molecular Testing in the Management of Pulmonary Nodules	LCD: MolDX: BDX-XL2 (L37054) LCD: MolDX: Percepta® Bronchial Genomic Classifier (L36886) **Outpatient Prior Authorization** Prior authorization is not required
MP 031	Suture Button Suspensionplasty Fixation System for Thumb Carpometacarpal Osteoarthritis added.	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 032	High-Sensitivity C-Reactive Protein	LCD: MolDX: Biomarkers in Cardiovascular Risk Assessment (L36358) **Outpatient Prior Authorization** Prior authorization is not required
MP 035	Temporomandibular Joint Disorder	BCBSMA medical policy is followed LCD: Transcutaneous Electrical Nerve Stimulators (TENS) (L33802)*reference for non-surgical treatment **Outpatient Prior Authorization** 21010, 21050, 21060, 21073, 21116, 21240, 21242, 21243, 29800, 29804: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 037	Surgical and Debulking Treatments for Lymphedema	No LCD or NCD BCBSMA medical policy is followed

		Outpatient Prior Authorization Prior authorization is not required
MP038	Leadless Cardiac Pacemakers	NCD: Leadless Pacemakers (20.8.4) **Outpatient Prior Authorization** Prior authorization is not required
MP 042	Wearable Cardioverter Defibrillators	LCD: Automatic External Defibrillators (L33690) **Outpatient Prior Authorization** Prior authorization is not required
MP 043	Suction Lipectomy for Lipedema	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is required
MP 045	Pathogen Panel Testing	LCD: MolDX: Molecular Diagnostic Tests (MDT) (L35160) LCD: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (L39044) **Outpatient Prior Authorization** Prior authorization is not required
MP 046	Hip Resurfacing	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This procedure is performed in the inpatient setting
MP 048	Hyperthermic Intraperitoneal Chemotherapy for Select Intra-Abdominal and Pelvic Malignancies	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 053	Ophthalmologic Techniques That Evaluate the Posterior Segment for Glaucoma	LCD: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) (L34380) **Outpatient Prior Authorization** Prior authorization is not required
MP 050	Gene Therapies for Sickle Cell Disease	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *055 Prior Authorization Request Form for Gene Therapies for Sickle Cell Disease.pdf*
MP 059	Phototherapy: PUVA, UV-B and Targeted Phototherapy	NCD: Treatment of Psoriasis (250.1) **Outpatient Prior Authorization** Prior authorization is not required

MP 060	Uterus Transplantation for Absolute Uterine Factor Infertility	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 061	Vitamin B12 Testing	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 065	Retinal Telescreening for Diabetic Retinopathy	LCD: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) (L33567) **Outpatient Prior Authorization** Prior authorization is not required
MP 066	Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) **Outpatient Prior Authorization** C9076; Q2041, Q2042, Q2053; Q2054: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue • *924 Prior Authorization Request Form for CAR T-Cell Therapy Services for Treatment of Diffuse Large B-cell Lymphoma* • *925 Prior Authorization Request Form for CAR T-Cell Therapy Services for B-cell Acute Lymphoblastic Leukemia (tisagenlecleucel)* • *940 Prior Authorization Request Form for CAR T-Cell Therapy Services for Mantle Cell Lymphoma (Brexucabtagene Autoleucel) MP 066.pdf* • *941 Prior Authorization Request Form for CAR T-Cell Therapy Services for Non-Hodgkin Lymphoma (Lisocabtagene Maraleucel).pdf* • *944 Prior Authorization Request Form for CAR T-Cell Therapy Services for Follicular Lymphoma (Axicabtagene Ciloleucel).pdf*
MP 068	Plastic Surgery	NCD: Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (250.5) LCD: Cosmetic and Reconstructive Surgery (L39051) BCBSMA Commercial policy is followed for other indications **Outpatient Prior Authorization** Prior authorization is required for **Medicare HMO Blue** and **Medicare PPO Blue** for the following codes: 15780, 15781, 15782, 15783, 15830, 30400, 30410, 30420, 30430, 30435, 30450 Prior authorization is required for **Medicare HMO Blue** for the following codes: 11900,11901, 21120, 21121, 21122,

		21123, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21208, 21209 *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 069	Esophageal pH Monitoring	NCD: 24-Hour Ambulatory Esophageal pH Monitoring (100.3) **Outpatient Prior Authorization** Prior authorization is not required
MP 070	Implantable Cardioverter Defibrillator	NCD: Implantable Automatic Defibrillators (20.4) **Outpatient Prior Authorization** Prior authorization is not required
MP 072	Outpatient Prior Authorization Code List	This document includes all codes that require prior authorization for Commercial plans
MP 073	Intracellular Micronutrient Analysis	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 074	Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma	NCD: Stem Cell Transplantation (Formerly 110.8.1) (110.23) **Outpatient Prior Authorization** 38240, S2142, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 075	Hematopoietic Cell Transplantation for Plasma Cell Dyscracias, Including Multiple Myeloma and POEMS Syndrome	NCD: Stem Cell Transplantation (Formerly 110.8.1) (110.23) **Outpatient Prior Authorization** 38241, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 076	Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia	NCD: Stem Cell Transplantation (Formerly 110.8.1) (110.23) **Outpatient Prior Authorization** 38240, 38241, S2142, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification*

		Request Form
MP 077	Scenesse (afamelanotide) for Treatment of Erythropoietic Protoporphyria (EPP)	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** J7352: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *160 Prior Authorization Request Form for Scenesse (afamelanotide) for Treatment of Erythropoietic Protoporphyria (EPP)*
MP 078	Sexual Dysfunction Diagnosis and Therapy	NCD: Diagnosis and Treatment of Impotence (230.4) LCD: Vacuum Erection Devices (VED) (L34824) **Outpatient Prior Authorization** Prior authorization is not required
MP 080	Radiofrequency Coblation Tenotomy for Musculoskeletal Conditions	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 081	Extracorporeal Shock Wave Treatment for Plantar Fasciitis and Other Musculoskeletal Conditions	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 084	Optical Coherence Tomography of the Anterior Eye Segment	LCD: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) (L34380) **Outpatient Prior Authorization** Prior authorization is not required
MP 086	Assisted Reproductive Services	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 087	Esketamine Nasal Spray (Spravato) and Intravenous Ketamine for Treatment-Resistant Depression	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** G2082, G2083: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *094 Prior Authorization Request Form for Esketamine Nasal Spray (Spravato) and Intravenous Ketamine*
MP 088	Preimplantation Genetic Testing	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required

MP 091	Applied Behavioral Analysis (ABA)	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 095	Iontophoresis and Phonophoresis as a Transdermal Technique for Drug Delivery	LCD: Outpatient Physical and Occupational Therapy Services (L33631) **Outpatient Prior Authorization** Prior authorization is not required
MP 097	Bone Morphogenetic Protein	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 098	Endovascular Stent Grafts for Abdominal Aortic Aneurysms	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This procedure is performed in the inpatient setting
MP 100	Inhaled Nitric Oxide	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 101	Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 107	Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Artificial Pancreas Device Systems	LCD: Glucose Monitors (L33822) LCD: External Infusion Pumps (L33794) LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38623) **Outpatient Prior Authorization** A4238, A4239, A9277: Prior authorization is required for Medicare HMO Blue and Medicare PPO for Type 2 diabetics only. Individuals who have Type 1 diabetes do not need prior authorization. *845 Prior Authorization Request Form*
MP 110	Meniscal Allografts and Other Meniscal Implants	NCD: Collagen Meniscus Implant (150.12) **Outpatient Prior Authorization** Prior authorization is not required
MP 111	Autografts and Allografts in the Treatment of Focal Articular	No LCD or NCD BCBSMA medical policy is followed

	Cartilage Lesions	**Outpatient Prior Authorization** 27415, 27416, 28446, 29866, 29867: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 112	Myocardial Strain Imaging	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 120	Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Conditions	LCD: High Frequency Chest Wall Oscillation Devices (L33785) LCD: Intrapulmonary Percussive Ventilation System (L33786) **Outpatient Prior Authorization** Prior authorization is not required Intrapulmonary Percussive Ventilation (IPV) System is not a covered device
MP 121	Closure Devices for Patent Foramen Ovale and Atrial Septal Defects	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** 93580: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 122	Chelation Therapy	NCD: Chelation Therapy for Treatment of Atherosclerosis (20.21) NCD: Ethylenediamine-Tetra-Acetic (EDTA) Chelation Therapy for Treatment of Atherosclerosis (20.22) **Outpatient Prior Authorization** Prior authorization is not required
MP 124	Multicancer Early Detection Testing	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 125	Medicare Advantage Part B Medical Utilization Management	Click here for additional coverage information: Medicare Advantage Part B Medical Utilization Management Medical necessity criteria will follow CMS NCD/LCD/Article guidance. In the absence of CMS guidance, criteria will follow the medically accepted indication that is supported by the Food and Drug Administration (FDA) labeling of the drug and/or medical references approved by Medicare.

		Outpatient Prior Authorization J0585; J0586; J0587; J0588; J2357; J2182; J0517; J2786; J2350; J0897; J3380; J2796; J0129; J1602; J3357; J3358; J7686; J0840; J0850; J1459; J1460; J1554; J1555; J1556; J1557; J1558; J1559; J1560; J1561; J1562; J1568; J1569; J1571; J1572; J1573; J1575; J1599; J1670; J1566; J2791: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Standard Form for Medication Prior Authorization Requests (eForm)*
MP 130	Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome	LCD: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38387) LCD: Suction Pumps (L33612) **Outpatient Prior Authorization** 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21685, 42145: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 133	Microprocessor-Controlled Prostheses for the Lower Limb	LCD: Lower Limb Prostheses (L33787) **Outpatient Prior Authorization** Prior authorization is not required
MP 134	Signal-Averaged Electrocardiography (SAECG)	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 136	Outpatient Pulmonary Rehabilitation	NCD: Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (20.35) **Outpatient Prior Authorization** Prior authorization is not required
MP 138	Serological Diagnosis of Celiac Disease	LCD: Molecular Pathology Procedures (L35000) for HLA-DQ2 and HLA-DQ8 testing BCBSMA medical policy is followed for other services **Outpatient Prior Authorization** Prior authorization is not required
MP 139	Diagnostic Laboratory Services	NCD: Blood Counts (190.15) NCD: Thyroid Testing (190.22) NCD: Urine Culture, Bacterial (190.12) NCD: Prothrombin Time (PT) (190.17) NCD: Serum Iron Studies (190.18) NCD: Hepatitis Panel/Acute Hepatitis Panel (190.33)

		Outpatient Prior Authorization Prior authorization is not required
MP 141	Catheter Ablation as Treatment for Atrial Fibrillation	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 142	Air Ambulance Transport	CMS Medicare Benefit Policy Manual, Chapter 10-Ambulance Services, section 10.4 Air Ambulance Services **Outpatient Prior Authorization for Medicare HMO Blue** Prior authorization **is required** for air ambulance transport Note: As air ambulance transport is normally of an urgent or emergency nature, a retrospective review of documentation will be performed prior to payment authorization. **Outpatient Prior Authorization for Medicare PPO Blue** Prior authorization **is not required**. However, all air ambulance transport claims must be submitted with supporting documentation and reviewed for medical necessity. Note: As air ambulance transport is normally of an urgent or emergency nature, a retrospective review of documentation will be performed prior to payment authorization. We recommend submitting authorization requests electronically. For more information, please refer to the Utilization Management section of our Blue Cross Blue Book. Claims payment is based on eligibility at the time of service, availability of benefits at the time of claim receipt, and medical necessity. All covered services, even those that don't require authorization, are subject to the plan's medical necessity requirements and may be subject to audit or review, including after the service was rendered or after the claim has been paid. *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 143	Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas	NCD: Stem Cell Transplantation (Formerly 110.8.1) (110.23) LCD: Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin and Non-Hodgkin Lymphoma with B-cell or T-cell Origin (L39513) **Outpatient Prior Authorization** 38240, 38241, S2142, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue

		Massachusetts Collaborative Prior Authorization Form ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 146	Ground Ambulance	CMS Medicare Benefit Policy Manual, Chapter 10- Ambulance Services **Outpatient Prior Authorization for Medicare HMO Blue** Prior authorization is **required**. • All non-emergent ambulance transports from a member's home or residence[1] to a contracted facility or provider • Chair car/van Prior authorization is **not required for:** • Emergency transports • Non-emergency ambulance transports between facilities when the patient is an inpatient • Involuntary transport to a psychiatric facility [1] A member's "residence" is defined as the place where he or she makes their home and dwells permanently, or for an extended period of time. **Outpatient Prior Authorization for Medicare PPO Blue** **Prior authorization is not required for:** • Any ground ambulance services • Involuntary transport to a psychiatric facility • Air ambulances Note: all air ambulance claims must be submitted with supporting documentation and will be reviewed for medical necessity. *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 147	ZulressoTM (Brexanolone) for the Treatment of Post-Partum Depression	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization **is required** for Medicare HMO Blue and Medicare PPO Blue; see policy and form for CPT codes *148 Prior Authorization Request Form for Zulresso (Brexanalone) for the Treatment of Postpartum Depression prn.pdf*
MP 149	Whole Gland Cryoablation of the Prostate	NCD: Cryosurgery of Prostate (230.9) **Outpatient Prior Authorization** Prior authorization **is not required**
MP 150	Hematopoietic Cell Transplantation for Acute Myeloid Leukemia	NCD: Stem Cell Transplantation (Formerly 110.8.1) (110.23) **Outpatient Prior Authorization**

		38240, 38241, S2142, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 151	Neuropsychological and Psychological Testing	LCD: Psychological and Neuropsychological Testing (L34646) LCD: Psychiatry and Psychology Services (L33632) **Outpatient Prior Authorization** Prior authorization is not required
MP 152	Biofeedback as a Treatment of Headache	NCD: Biofeedback Therapy (30.1) LCD: Psychiatry and Psychology Services (L33632) **Outpatient Prior Authorization** Prior authorization is not required
MP 153	Sacral Nerve Neuromodulation/Stimulation	NCD: Sacral Nerve Stimulation for Urinary Incontinence (230.18) **Outpatient Prior Authorization** Prior authorization is not required
MP 154	Monitored Anesthesia Care (MAC)	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 155	Allogeneic Hematopoietic Cell transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms	NCD: Stem Cell Transplantation Formerly 110.8.1 (110.23) **Outpatient Prior Authorization** 38240, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 156	Shoulder Resurfacing	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 157	Electrical Stimulation Devices for Psychiatric and Neurological Conditions	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 158	Outpatient Pediatric Pain Rehabilitation Centers	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization**

		Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 159	Gene Therapies for Bladder Cancer	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is required. *Prior Authorization Request Form for Adstiladrin (nadofaragene firadenovec-vncg), #193*
MP 164	Dry Hydrotherapy for Chronic Pain Conditions	LCD: Outpatient Physical and Occupational Therapy Services (L33631) **Outpatient Prior Authorization** This is not a covered service
MP 165	Laboratory Testing Investigational Services	LCD only for ▪ Codes 0112U: Biomarkers Overview (L35062) ▪ Codes 0371U; 0372U; 0373U; 0374U; 0377U: MolDX: Molecular Diagnostic Tests (L35025) All other tests follow BCBSMA medical policy **Outpatient Prior Authorization** This is not a covered service
MP 163	Maternal Serum Biomarkers for Prediction of Adverse Obstetric Outcomes	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 167	Tumor Markers for Diagnosis and Management of Cancer	LCD: Multimarker Serum Tests Related to Ovarian Cancer Testing (L38371) NCD: Colorectal Cancer Screening Tests (210.3) For other markers BCBSMA Commercial policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 168	Gene Therapies for Hemophilia A or B	No LCD or NCD BCBSMA medical policy is followed Outpatient Prior Authorization Prior authorization is required. Prior Authorization Request Form for Gene Therapies for Hemophilia B Hemgenix® (Etranacogene dezaparvovec), #169 Prior Authorization Request Form Gene Therapies for

		Hemophilia A Roctavian® (Valoctocogene roxaparvovec-rvox), #166
MP 171	Intravenous Antibiotic Therapy and Associated Diagnostic Testing for Lyme Disease	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 172	Percutaneous Electrical Nerve Stimulation and Percutaneous Neuromodulation Therapy	NCD: Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1) **Outpatient Prior Authorization** Prior authorization is not required
MP 173	Biofeedback as a Treatment of Urinary Incontinence in Adults	NCD: Biofeedback Therapy for the Treatment of Urinary Incontinence (30.1.1) **Outpatient Prior Authorization** Prior authorization is not required
MP 174	Facet Arthroplasty	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 175	Digital Health Technologies: Diagnostic Applications	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 176	Surgical Left Atrial Appendage Occlusion Devices for Stroke Prevention in Atrial Fibrillation	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 178	Complementary Medicine	NCD: Colonic Irrigation (100.7) LCD: Psychiatry and Psychology Services (L33632) BCBSMA Commercial policy is followed for services listed **Outpatient Prior Authorization** This is not a covered service
MP 179	Orthognathic Surgery	No LCD or NCD BCBSMA medical policy is followed Outpatient Prior Authorization Prior authorization is required
MP 180	Endothelial Keratoplasty	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required

MP 181	Hematopoietic Cell Transplantation for Primary Amyloidosis	NCD: Stem Cell Transplantation (Formerly 110.8.1) (110.23) **Outpatient Prior Authorization** 38241, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 182	Immune Cell Function Assay	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 183	Prolotherapy	NCD: Prolotherapy, Joint Sclerotherapy, and Ligamentous Injections with Sclerosing Agents (150.7) LCD: Facet Joint Interventions for Pain Management (L35936) **Outpatient Prior Authorization** This is not a covered service
MP184	Axillary Reverse Mapping for Prevention of Breast Cancer-Related Lymphedema	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 185	Wireless Capsule Endoscopy to Diagnose Disorders of the Small Bowel, Esophagus, and Colon	LCD: Colon Capsule Endoscopy (L38571) **Outpatient Prior Authorization** Prior authorization is not required
MP 186	Absorbable Nasal Implant for Treatment of Nasal Valve Collapse	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 187	Biofeedback for Miscellaneous Indications	NCD: Biofeedback Therapy (30.1) **Outpatient Prior Authorization** Prior authorization is not required
MP 189	Gender Affirming Services (Transgender Services)	NCD: Gender Dysphoria and Gender Reassignment Surgery (140.9) BCBSMA medical policy is followed **Outpatient Prior Authorization** Click here for CPT codes Prior authorization is required for Medicare HMO Blue for surgical services, speech therapy and/or voice training services only

		Prior authorization is not required for Medicare PPO Blue *901 Prior Authorization Request Form for Gender Affirming Services (Transgender Services)* ***OR*** *902 Prior Authorization Request Form for Electrolysis for Gender Affirming Services*
MP 190	Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias	NCD: Stem Cell Transplantation Formerly 110.8.1 (110.23) **Outpatient Prior Authorization** 38240, S2142, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 191	Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 192	Hematopoietic Cell Transplantation for Autoimmune Diseases	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** 38241, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue
MP 195	Dynamic Spinal Visualization and Vertebral Motion Analysis	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 196	Kidney Transplant	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This procedure is performed in the inpatient setting.
MP 197	Heart Transplant	NCD: Heart Transplants (260.9) **Outpatient Prior Authorization** This procedure is performed in the inpatient setting.
MP 198	Liver Transplant and Combined Liver-Kidney Transplant	NCD: Adult Liver Transplantation (260.1) NCD: Pediatric Liver Transplantation (260.2) **Outpatient Prior Authorization** This procedure is performed in the inpatient setting.
MP 199	Stationary Ultrasonic Diathermy Devices	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service

MP 200	Transanal Endoscopic Microsurgery	No LCD or NCD BCBSMA Commercial policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 201	Functional Neuromuscular Electrical Stimulation	NCD: Neuromuscular Electrical Stimulation (NMES) (160.12) **Outpatient Prior Authorization** Prior authorization is not required
MP 203	Electromagnetic Navigation Bronchoscopy	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 204	Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 205	Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 206	Automated Ambulatory Blood Pressure Monitoring for the Diagnosis of Hypertension in Patients with Elevated Office Blood Pressure	NCD: Ambulatory Blood Pressure Monitoring (20.19) **Outpatient Prior Authorization** Prior authorization is not required
MP 207	Hematopoietic Cell Transplantation for Hodgkin Lymphoma	NCD: Stem Cell Transplantation Formerly 110.8.1 (110.23) LCD: Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin and Non-Hodgkin Lymphoma with B-cell or T-cell Origin (L39513) **Outpatient Prior Authorization** 38241, S2142, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 208	Hematopoietic Cell Transplantation for Solid Tumors of Childhood	NCD: Stem Cell Transplantation Formerly 110.8.1 (110.23) **Outpatient Prior Authorization** 38241, S2150: Prior authorization is required for Medicare

		HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 210	Biofeedback as a Treatment of Chronic Pain	NCD: Biofeedback Therapy (30.1) **Outpatient Prior Authorization** Prior authorization is not required
MP 211	Intraoperative Neurophysiologic Monitoring Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring	LCD: Visual Electrophysiology Testing (L36831) LCD: Intraoperative Neurophysiological Testing (L34623) LCD: Nerve Conduction Studies and Electromyography (L35098) BCBSMA Commercial policy is followed ▪ Somatosensory Evoked Potential Testing ▪ Motor Evoked Potential Testing **Outpatient Prior Authorization** 95940, 95941, G0453: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 212	Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia	NCD: Stem Cell Transplantation (Formerly 110.8.1) (110.23) **Outpatient Prior Authorization** 38240, S2142, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 215	Gene Therapies for Thalassemia	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) **Outpatient Prior Authorization** Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue. See policy for additional information *#216 Prior Authorization Request Form for Zynteglo® (Betibeglogene autotemcel)*
MP 218	Endoscopic Radiofrequency Ablation or Cryoablation for Barrett Esophagus	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 219	Carotid Stent Placement	NCD: Percutaneous Transluminal Angioplasty (PTA) (20.7) **Outpatient Prior Authorization** Prior authorization is not required

MP 220	Musculoskeletal Services Management	BCBSMA medical policy is followed when there is not an applicable LCD or NCD **Outpatient Prior Authorization** Prior authorization is required
MP 221	Musculoskeletal Services Management CPT and HCPCS Codes	BCBSMA medical policy is followed when there is not an applicable LCD or NCD **Outpatient Prior Authorization** Prior authorization is required
MP 223	Aqueous Shunts and Stents for Glaucoma	LCD: Micro-Invasive Glaucoma Surgery (MIGS) (L37244) **Outpatient Prior Authorization** Prior authorization is not required
MP 224	Home Cardiorespiratory Monitoring	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 227	Myoelectric Prosthetic and Orthotic Components for the Upper Limb	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 231	Automated Percutaneous and Percutaneous Discectomy	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 233	Endovascular Stent Grafts for Disorders of the Thoracic Aorta	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 237	Occipital Nerve Stimulation	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 238	Treatment of Varicose Veins/Venous Insufficiency	LCD: Varicose Veins of the Lower Extremity, Treatment of (L33575) **Outpatient Prior Authorization** 36465, 36466, 36470, 36471, 36475, 36476, 36478, 36479, 36482, 36843, 37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, S2202: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue

		Massachusetts Collaborative Prior Authorization Form ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 240	Image-Guided Minimally Invasive Decompression for Spinal Stenosis	NCD: Percutaneous image-guided lumbar decompression for lumbar spinal stenosis (150.13) **Outpatient Prior Authorization** Prior authorization is not required
MP 241	Gene Therapies for Cerebral Adrenoleukodystrophy	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is required *Gene Therapy for Cerebral Adrenoleukodystrophy Skysona® (Elivaldogene autotemcel) Prior Authorization Request Form #242*
MP 243	Magnetic Resonance–Guided Focused Ultrasound	LCD: Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor (L37421) **Outpatient Prior Authorization** Prior authorization is not required
MP 244	Laparoscopic and Transcervical Techniques for the Myolysis of Uterine Fibroids	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 247	Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** 38241, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 248	Extracorporeal Photopheresis	NCD: Extracorporeal Photopheresis (110.4) **Outpatient Prior Authorization** Prior authorization is not required
MP 249	Multimarker Serum Testing Related to Ovarian Cancer	LCD: Multimarker Serum Tests Related to Ovarian Cancer Testing (L38371) **Outpatient Prior Authorization** This is not a covered service
MP 250	Systems Pathology in Prostate Cancer	No LCD or NCD BCBSMA medical policy is followed

		Outpatient Prior Authorization This is not a covered service
MP 254	Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow)	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 258	Quantitative Sensory Testing	NCD: Sensory Nerve Conduction Threshold Tests (sNCTs) (160.23) LCD: Nerve Conduction Studies and Electromyography (L35098) **Outpatient Prior Authorization** This is not a covered service
MP 259	Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 260	Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 261	Bioimpedance Devices for the Detection of Lymphedema	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 263	Dynamic Posturography	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 264	Diagnosis and Management of Idiopathic Environmental Intolerance or Clinical Ecology	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 266	Ovarian and Internal Iliac Vein Endovascular Occlusion as a Treatment of Pelvic Congestion Syndrome	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 267	Treatment of Tinnitus	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required

MP 269	Heart/Lung Transplant	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This procedure is performed in the inpatient setting
MP 271	Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty)	NCD: Thermal Intradiscal Procedures (TIPs) (150.11) **Outpatient Prior Authorization** This is not a covered service
MP 272	Intravitreal and Punctum Corticosteroid Implants	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 274	Methadone Treatment for Opioid Use Disorder	MLN Matters Number: SE1604 Medicare Coverage of Substance Abuse Services Medicare Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements **Outpatient Prior Authorization** Prior authorization is not required
MP 280	Total Artificial Hearts and Implantable Ventricular Assist Devices	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This procedure is performed in the inpatient setting NCD: Artificial Hearts and Related Devices (20.9) **retired December 1, 2020**
MP 283	Biomarker Testing in Risk Assessment and Management of Cardiovascular Disease	NCD: Lipid Testing (190.23) LCD: B-type Natriuretic Peptide (BNP) Testing (L33573) LCD: MolDX: Biomarkers in Cardiovascular Risk Assessment (L36358) **Outpatient Prior Authorization** Prior authorization is not required
MP 284	Bronchial Thermoplasty	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** 31660, 31661: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 287	Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting	NCD: Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB) 20.16

		Outpatient Prior Authorization Prior authorization is not required
MP 290	Serum Biomarker Human Epididymis Protein 4 - HE4	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 291	Intravenous Anesthetics for the Treatment of Chronic Pain	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 292	Radioembolization for Primary and Metastatic Tumors of the Liver	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 297	Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders	LCD: Transcranial Magnetic Stimulation (L33398) **Outpatient Prior Authorization** 90867, 90868, 90869: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 299	Subtalar Arthroereisis	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 302	Electrical Stimulation for the Treatment of Arthritis	LCD: Transcutaneous Electrical Joint Stimulation Devices (TEJSD) (L34821) **Outpatient Prior Authorization** This is not a covered service
MP 303	Ultrasonographic Evaluation of Skin Lesions	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 305	Vertical Expandable Prosthetic Titanium Rib	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 306	Wireless Pressure Sensors in Endovascular Aneurysm Repair	No LCD or NCD BCBSMA medical policy is followed

		Outpatient Prior Authorization This is not a covered service
MP 307	Saturation Biopsy for Diagnosis, Staging and Management of Prostate Cancer	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 308	Biofeedback as a Treatment of Fecal Incontinence or Constipation	NCD: Biofeedback Therapy (30.1) **Outpatient Prior Authorization** Prior authorization is not required
MP 313	Bronchial Valves	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 320	Diagnosis and Treatment of Sacroiliac Joint Pain	LCD: Minimally invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint (L36406) LCD: Sacroiliac Joint Injections and Procedures (L39455) **Outpatient Prior Authorization** Prior authorization is required
MP 321	Threshold Electrical Stimulation as a Treatment of Motor Disorders	NCD: Treatment of Motor Function Disorders with Electric Nerve Stimulation (160.2) **Outpatient Prior Authorization** This is not a covered service
MP 322	Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia	NCD: Stem Cell Transplantation Formerly 110.8.1 (110.23) **Outpatient Prior Authorization** 38241, S2150: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 323	Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)	NCD: Percutaneous Transluminal Angioplasty (PTA) (20.7) **Outpatient Prior Authorization** Prior authorization is not required
MP 324	Islet Transplantation	NCD: Islet Cell Transplantation in the Context of a Clinical Trial (260.3.1) NCD: Pancreas Transplants (260.3) **Outpatient Prior Authorization** This procedure is performed in the inpatient setting
MP 328	Allogeneic Pancreas Transplant	NCD: Pancreas Transplants (260.3) **Outpatient Prior Authorization**

		This procedure is performed in the inpatient setting
MP 329	Fecal Calprotectin Testing	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 332	Insulin Delivery Devices	NCD: Infusion Pumps (280.14) NCD: Durable Medical Equipment Reference List (280.1) LCD: External Infusion Pumps (L33794) **Outpatient Prior Authorization** Prior authorization is not required
MP 334	Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation	NCD: Percutaneous Left Atrial Appendage Closure (LAAC) (20.34) **Outpatient Prior Authorization** Prior authorization is not required
MP 336	Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer	LCD: MolDX-CDD: ConfirmMDx Epigenetic Molecular Assay (L35632) Billing and Coding Article: Biomarker Testing for Prostate Cancer Diagnosis A56609 is followed in lieu of retired LCD L37733. **Outpatient Prior Authorization** Prior authorization is not required
MP 341	Flow Cytometry for Cell Analysis	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 342	Thermography	NCD: Thermography (220.11) **Outpatient Prior Authorization** This is not a covered service
MP 347	Ambulatory Event Monitors and Mobile Cardiac Outpatient Telemetry	NCD: Electrocardiographic Services (20.15) **Outpatient Prior Authorization** Prior authorization is not required
MP 348	Stem Cell Therapy for Peripheral Arterial Disease	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 352	Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis	LCD: Venous Angioplasty with or without Stent Placement for the Treatment of Chronic Cerebrospinal Venous Insufficiency (L35028) **Outpatient Prior Authorization**

		This is not a covered service
MP 354	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers	NCD: Pneumatic Compression Devices (280.6) **Outpatient Prior Authorization** Prior authorization is not required
MP 356	Open and Thoracoscopic Approaches to Treat Atrial Fibrillation and Atrial Flutter (Maze and Related Procedures)	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 362	Cranial Electrotherapy Stimulation and Auricular Electrostimulation	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 364	Lung Volume Reduction Surgery for Severe Emphysema	NCD: Lung Volume Reduction Surgery (Reduction Pneumoplasty) (100-3/240.1) **Outpatient Prior Authorization** This procedure is performed in the inpatient setting
MP 365	Manual and Power Operated Wheelchairs	LCD: Manual Wheelchair Bases (L33788) LCD: Power Mobility Devices (L33789) LCD: Wheelchair Options/Accessories (L33792) LCD: Wheelchair Seating (L33312) NCD: Seat Elevation Equipment (Power Operated) on Power Wheelchairs (280.16) **Outpatient Prior Authorization** Prior authorization is required K0813;K0814;K0815;K0816;K0820; K0821;K0822;K0823 K0824;K0825;K0826;K0827;K0828;K0829;K0830;K0831; K0835;K0836;K0837;K0838;K0839;K0840; K0841;K0842 K0843; K0848;K0849;K0850;K0851;K0852; K0853;K0854 K0855; K0856;K0857;K0858;K0859;K0860;K0861;K0862 K0863;K0864; K0890;K0891; K0898 Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue.
MP 369	Ostomy Supplies	LCD: Ostomy Supplies (L33828) Local Coverage Article: Ostomy Supplies - Policy Article A52487 **Outpatient Prior Authorization** Prior authorization is not required
MP 370	Urological Supplies	LCD: Urological Supplies (L33803) Local Coverage Article: Urological Supplies - Policy Article A52521 **Outpatient Prior Authorization** Prior authorization is not required
MP 371	Gas Permeable Scleral Contact Lens	LCD: Refractive Lenses (L33793)

		Outpatient Prior Authorization Prior authorization is not required
MP 372	Viscocanalostomy and Canaloplasty	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 379	Medical and Surgical Management of Obesity including Anorexiants	NCD: Intensive Behavioral Therapy for Obesity (210.12) NCD: Bariatric Surgery for the Treatment of Morbid Obesity (100.1) **Outpatient Prior Authorization** 43644; 43770, 43775, 43845, 43846;43847: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *047 Preauthorization Request Form for 379 Surgical Management of Obesity*
MP 385	Routine Foot Care and Debridement of Nails	LCD: Routine Foot Care and Debridement of Nails (L33636) NCD: Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy) (70.2.1) CMS Publication 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 290 – Foot Care **Outpatient Prior Authorization** Prior authorization is not required
MP 392	Transcatheter Aortic Valve Implantation for Aortic Stenosis	NCD: Transcatheter Aortic Valve Replacement (TAVR) (20.32) **Outpatient Prior Authorization** This procedure is performed in the inpatient setting
MP 393	Nerve Fiber Density Measurement	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 403	Transcatheter Pulmonary Valve Implantation	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 404	Axial Lumbosacral Interbody Fusion	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 406	Treatment of Hyperhidrosis	LCD: Botulinum Toxins (L33646) LCD: Outpatient Physical and Occupational Therapy

		Services (L33631) (Iontophoresis) BCBSMA medical policy is followed for CPT 32664 **Outpatient Prior Authorization** Prior authorization is not required
MP 407	Continuous Passive Motion in the Home Setting	NCD: Durable Medical Equipment Reference List (280.1) **Outpatient Prior Authorization** Prior authorization is not required
MP 423	Outpatient Psychotherapy	LCD: Psychiatry and Psychology Services (L33632) LCD: Psychiatric Partial Hospitalization Programs (L33626) **Outpatient Prior Authorization** Prior authorization is not required
MP 428	Reconstructive Breast Surgery/Management of Breast Implants	NCD: Breast Reconstruction Following Mastectomy (140.2) LCD: Reduction Mammaplasty (L35001) **Outpatient Prior Authorization** 11970, 11971, 19316, 19318, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19367, 19368, 19369, 19371, 19380, 19396, S2066, S2067: Prior authorization is required Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 436	Interspinous Fixation - Fusion Devices	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 445	Ultrasound for the Evaluation of Paranasal Sinuses	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 447	Whole-Body Computed Tomography Scan as a Screening Test	NCD: Computed Tomography (220.1) **Outpatient Prior Authorization** Prior authorization is not required
MP 449	Vertebral Fracture Assessment with Densitometry	Medicare Benefit Policy Manual - Pub 100-02 Medicare Benefit Policy **Outpatient Prior Authorization** Prior authorization is not required; 77085 is covered when criteria are met.
MP 450	Bone Mineral Density Studies	NCD: Bone (Mineral) Density Studies (150.3) Medicare Benefit Policy Manual - Pub 100-02 Medicare

		Benefit Policy **Outpatient Prior Authorization** Prior authorization is not required
MP 451	Peroral Endoscopic Myotomy for Treatment of Esophageal Achalasia	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 453	Melanoma Vaccines	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 454	Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 455	Adoptive Immunotherapy	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 461	Laser Treatment of Active Acne	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 462	Nonpharmacologic Treatment of Rosacea	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 463	Dermatologic Applications of Photodynamic Therapy	NCD: Treatment of Actinic Keratosis (250.4) **Outpatient Prior Authorization** Prior authorization is not required
MP 465	Lipid Apheresis	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 466	Plasma Exchange	NCD: Apheresis (Therapeutic Pheresis) (110.14) **Outpatient Prior Authorization** Prior authorization is not required

MP 470	Pelvic Floor Stimulation as a Treatment of Urinary Incontinence and Fecal Incontinence	NCD: Non-Implantable Pelvic Floor Electrical Stimulator (230.8) **Outpatient Prior Authorization** Prior authorization is not required
MP 471	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	NCD: Incontinence Control Devices (230.10) **Outpatient Prior Authorization** Prior authorization is not required
MP 473	Deep Brain Stimulation	NCD: Deep Brain Stimulation for Essential Tremor and Parkinson Disease (160.24) NCD: Electrical Nerve Stimulators (160.7) **Outpatient Prior Authorization** This procedure is performed in the inpatient setting
MP 474	Vagus Nerve Stimulation	NCD: Vagus Nerve Stimulation (VNS) (160.18) **Outpatient Prior Authorization** Prior authorization is not required
MP 478	Cochlear Implant	NCD: Cochlear Implantation (50.3) **Outpatient Prior Authorization** Prior authorization is not required
MP 479	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 480	Semi-Implantable and Fully Implantable Middle Ear Hearing Aid	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 481	Auditory Brainstem Implant	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 482	Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, Biacuplasty and Intraosseous Basivertebral Nerve Ablation	NCD: Thermal Intradiscal Procedures (TIPs) (150.11) **Outpatient Prior Authorization** This is not a covered service
MP 483	Manipulation under Anesthesia	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required

MP 485	Intraosseous Basivertebral Nerve Ablation (Intracept® system)	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is required
MP 492	Epithelial Cell Cytology in Breast Cancer Risk Assessment and High-Risk Patient Management - Ductal Lavage and Suction Collection Systems	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 493	Breast Duct Endoscopy	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 494	Scintimammography and Gamma Imaging of the Breast and Axilla	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 497	Ultrasound Accelerated Fracture Healing Device	LCD: Osteogenesis Stimulators (L33796) **Outpatient Prior Authorization** Prior authorization is not required
MP 498	Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures	LCD: Osteogenesis Stimulators (L33796) **Outpatient Prior Authorization** Prior authorization is not required
MP 499	Electrical Bone Growth Stimulation of the Appendicular Skeleton	LCD: Osteogenesis Stimulators (L33796) **Outpatient Prior Authorization** Prior authorization is not required
MP 503	CA 125	NCD: Tumor Antigen by Immunoassay - CA 125 (190.28) **Outpatient Prior Authorization** Prior authorization is not required
MP 509	Interferential Current Stimulation	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 510	Cooling Devices Used in the Outpatient Setting	LCD: Cold Therapy (L33735) **Outpatient Prior Authorization** This is not a covered service
MP 513	Peripheral Subcutaneous Field Stimulation	No LCD or NCD BCBSMA medical policy is followed

		Outpatient Prior Authorization This is not a covered service
MP 515	Neurofeedback	LCD: Psychiatry and Psychology Services (L33632) **Outpatient Prior Authorization** This is not a covered service
MP 517	Paraspinal Surface Electromyography to Evaluate and Monitor Back Pain	LCD: Nerve Conduction Studies and Electromyography (L35098) **Outpatient Prior Authorization** This is not a covered service
MP 521	In Vivo Analysis of Colorectal Polyps	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 522	Low-Level Laser Therapy	NCD: Laser Procedures (140.5) LCD: Outpatient Physical and Occupational Therapy Services (L33631) **Outpatient Prior Authorization** Prior authorization is not required
MP 523	Transvaginal and Transurethral Radiofrequency Tissue Remodeling for Urinary Stress Incontinence	LCD: Non-covered Services (L33629) **Outpatient Prior Authorization** This is not a covered service
MP 524	Measurement of Exhaled Nitric Oxide and Exhaled Breath Condensate in the Diagnosis and Management of Respiratory Disorders	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 528	Plugs for Anal Fistula Repair	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 530	ST2 Assay for Chronic Heart Failure	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 532	Insulin Potentiation Therapy	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service

MP 533	Actigraphy	NCD: Sleep Testing for Obstructive Sleep Apnea (OSA) (240.4.1) **Outpatient Prior Authorization** Prior authorization is not required
MP 536	Analysis of Proteomic Patterns for Early Detection of Cancer	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 538	Serum Tumor Markers for Breast and Gastrointestinal Malignancies	NCD: Carcinoembryonic Antigen (190.26) NCD: Tumor Antigen by Immunoassay - CA 15-3/CA 27.29 (190.29) NCD: Tumor Antigen by Immunoassay - CA 19-9 (190.30) **Outpatient Prior Authorization** Prior authorization is not required
MP 541	Postsurgical Home Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	LCD: Pneumatic Compression Devices (L33829) **Outpatient Prior Authorization** Prior authorization is not required
MP 543	Negative Pressure Wound Therapy in the Outpatient Setting	LCD: Negative Pressure Wound Therapy Pumps (L33821) Negative Pressure Wound Therapy Interpretive Guidelines Negative Pressure Wound Therapy Interpretive Guidelines March 2012 LCD: Outpatient Physical and Occupational Therapy Services (L33631) **Outpatient Prior Authorization** 97605, 97606: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 544	Surgical Ventricular Restoration	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 546	Handheld Radiofrequency Spectroscopy for Intraoperative Assessment of Surgical Margins during Breast-Conserving Surgery	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 547	Ultrasonographic Measurement of Carotid Intima-Medial Thickness as an Assessment of Subclinical Atherosclerosis	NCD: Ultrasound Diagnostic Procedures (220.5) **Outpatient Prior Authorization** This is not a covered service
MP 549	Bone Turnover Markers for	NCD: Collagen Crosslinks, any Method (190.19)

	Diagnosis and Management of Osteoporosis and Diseases Associated with High Bone Turnover	**Outpatient Prior Authorization** Prior authorization is not required
MP 550	Orthotics for Progressive Scoliosis	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 551	Serum Antibodies for the Diagnosis of Inflammatory Bowel Disease	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 554	Quantitative Electroencephalography as a Diagnostic Aid for Attention-Deficit/Hyperactivity Disorder	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 555	Identification of Microorganisms Using Nucleic Acid Probes	LCD only for resipiratory panels and gastrointestinal services panels, all other tests follow the BCBSMA medical policy LCD: Respiratory Pathogen Panel Testing (L39027) LCD: Multiplex Gastrointestinal Pathogen Panel (GPP) Tests for Acute Gastroenteritis (AGE) (L39226) **Outpatient Prior Authorization** Prior authorization is not required
MP 556	Fecal Analysis in the Diagnosis of Intestinal Dysbiosis	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 557	Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening	NCD: Colorectal Cancer Screening Tests (210.3) **Outpatient Prior Authorization** Prior authorization is not required
MP 560	Hippotherapy	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 562	Laser Treatment of Onychomycosis	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 570	Surgical Interruption of Pelvic	No LCD or NCD

	Nerve Pathways for Primary and Secondary Dysmenorrhea	BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 576	Myocardial Sympathetic Innervation Imaging in Patients with Heart Failure	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 577	Whole Body Dual X-Ray Absorptiometry to Determine Body Composition	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 581	Cerebrospinal Fluid and Urinary Biomarkers of Alzheimer Disease	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 582	Balloon Sinuplasty for Treatment of Chronic Sinusitis	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 583	Percutaneous Tibial Nerve Stimulation for Voiding Dysfunction	LCD: Posterior Tibial Nerve Stimulation for Voiding Dysfunction (L33396) **Outpatient Prior Authorization** Prior authorization is not required
MP 584	Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers)	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 586	Rhinomanometry and Acoustic/Optical Rhinometry	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 589	Leukocyte Histamine Release Test	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 590	Nerve Graft with Radical Prostatectomy	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service

MP 592	Artificial Intervertebral Disc: Lumbar Spine	NCD: Lumbar Artificial Disc Replacement (LADR) (150.10) **Outpatient Prior Authorization** This is not a covered service
MP 593	Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems	NCD: Phrenic Nerve Stimulator (160.19) **Outpatient Prior Authorization** Prior authorization is not required
MP 594	Computer-Assisted Navigation for Orthopedic Procedure	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 595	Baroreflex Stimulation Devices	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 596	Navigated Transcranial Magnetic Stimulation	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 599	Photodynamic Therapy for Choroidal Neovascularization	NCD: Photodynamic Therapy (80.2) NCD: Ocular Photodynamic Therapy (OPT) (80.2.1) NCD: Photosensitive Drugs (80.3) NCD: Verteporfin (80.3.1) **Outpatient Prior Authorization** Prior authorization is not required
MP 600	Transpupillary Thermotherapy for Treatment of Choroidal Neovascularization	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 603	Vertebral Axial Decompression	NCD: Vertebral Axial Decompression (VAX-D) (160.16) **Outpatient Prior Authorization** This is not a covered service
MP 604	Trigger Point and Tender Point Injections	LCD: L39662 Trigger Point Injections (TPI) **Outpatient Prior Authorization** Prior authorization is not required
MP 606	Retinal Prosthesis	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization**

		Prior authorization is not required
MP 607	Photocoagulation of Macular Drusen	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 609	Suprachoroidal Delivery of Pharmacologic Agents	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 610	Intraocular Radiotherapy for Age-Related Macular Degeneration	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 611	Orthoptic Training for the Treatment of Vision or Learning Disabilities	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 613	Eyelid Thermal Pulsation for the Treatment of Dry Eye Syndrome	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 618	Confocal Laser Endomicroscopy	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 631	Isolated Small Bowel Transplant	NCD: Intestinal and Multi-Visceral Transplantation (260.5) **Outpatient Prior Authorization** This procedure is performed in the inpatient setting
MP 632	Small Bowel/Liver and Multivisceral Transplant	NCD: Intestinal and Multi-Visceral Transplant (260.5) **Outpatient Prior Authorization** This procedure is performed in the inpatient setting
MP 633	Cryosurgical Ablation of Primary or Metastatic Liver Tumors	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 636	Gastric Electrical Stimulation	No LCD or NCD BCBSMA medical policy is followed

		Outpatient Prior Authorization This is not a covered service
MP 643	Amniotic Membrane and Amniotic Fluid	LCD: Amniotic and Placental-Derived Product Injections and/or Applications for Musculoskeletal Indications, Non-Wound (L39139) BCBSMA Commercial policy is followed for other indications **Outpatient Prior Authorization** Prior authorization is not required
MP 648	End-Diastolic Pneumatic Compression Boot as a Treatment of Peripheral Vascular Disease or Lymphedema	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 649	Enhanced External Counterpulsation (EECP) for Chronic Stable Angina or Congestive Heart Failure	NCD: External Counterpulsation (ECP) Therapy for Severe Angina (20.20) **Outpatient Prior Authorization** Prior authorization is not required
MP 651	Transmyocardial Revascularization	NCD: Transmyocardial Revascularization (TMR) (20.6) **Outpatient Prior Authorization** This procedure is performed in the inpatient setting
MP 652	Progenitor Cell Therapy for the Treatment of Damaged Myocardium Due to Ischemia	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 653	Hyperbaric Oxygen Therapy	NCD: Hyperbaric Oxygen Therapy (20.29) **Outpatient Prior Authorization** Prior authorization is not required
MP 655	Electrostimulation and Electromagnetic Therapy for Treating Wounds	NCD: Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds (270.1) LCD: Outpatient Physical and Occupational Therapy Services (L33631) **Outpatient Prior Authorization** Prior authorization is not required
MP 657	Noncontact Ultrasound Treatment for Wounds	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 659	Sensory Integration Therapy and Auditory Integration Therapy	LCD: Outpatient Physical and Occupational Therapy Services (L33631) LCD: Speech-Language Pathology (L33580)

		Outpatient Prior Authorization Prior authorization is not required
MP 660	Cognitive Rehabilitation	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 661	Surgical and Non-surgical Treatment of Gynecomastia	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 662	Composite Tissue Allotransplantation of the Hand and Face	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 663	Bioengineered Skin and Soft Tissue Substitutes	NCD: Porcine Skin and Gradient Pressure Dressings (270.5) BCBSMA Commercial policy is followed for other indications **Outpatient Prior Authorization** Prior authorization is not required
MP 673	Antigen Leukocyte Antibody Test	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 674	Drug Testing in Pain Management and Substance Use Disorder Treatment	LCD: Urine Drug Testing (L39611) **Outpatient Prior Authorization** Prior authorization is not required
MP 675	Vision Services	NCD: Refractive Keratoplasty (80.7) **Outpatient Prior Authorization** Prior authorization is not required
MP 677	Multibiomarker Disease Activity Blood Test for Rheumatoid Arthritis	Local Coverage Article: MolDX: Vectra™ DA Coding and Billing Guidelines (A53110) LCD: MolDX: Molecular Diagnostic Tests (MDT) (L35160) **Outpatient Prior Authorization** Prior authorization is not required
MP 682	Fecal Microbiota Transplantation	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization**

		Prior authorization is not required
MP 691	Non-Invasive Vascular Studies - Duplex Scans	LCD: Non-Invasive Vascular Studies (L33627) **Outpatient Prior Authorization** Prior authorization is not required
MP 692	Transcatheter Mitral Valve Repair	NCD: Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation (20.33) **Outpatient Prior Authorization** Prior authorization is not required
MP 695	Surgery for Groin Pain in Athletes	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 701	Electromyography and Nerve Conduction Studies	LCD: Nerve Conduction Studies and Electromyography (L35098) **Outpatient Prior Authorization** Prior authorization is not required
MP 702	Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 703	Reduction Mammaplasty for Breast-Related Symptoms	LCD: Reduction Mammaplasty (L35001) **Outpatient Prior Authorization** 19318: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 706	Patient-Specific Instrumentation (eg, Cutting Guides) for Joint Arthroplasty	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 707	Benign Skin Lesions	LCD: Removal of Benign Skin Lesions (L35498) LCA: Billing and Coding: Removal of Benign Skin Lesions (A54602) LCA: Billing and Coding: Removal of Benign Skin Lesions (A57482) **Outpatient Prior Authorization** Prior authorization is not required
MP 709	Proteomic Testing for Systemic Therapy in Non-Small-Cell Lung	LCD: Molecular Pathology Procedures (L35000)

	Cancer	**Outpatient Prior Authorization** This is not a covered service
MP 711	Multitarget Polymerase Chain Reaction Testing for Diagnosis of Bacterial Vaginosis	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 713	Autonomic Nervous System Testing	LCD: Autonomic Function Testing (L36236) **Outpatient Prior Authorization** Prior authorization is not required
MP 715	Endobronchial Ultrasound for Diagnosis and Staging of Lung Cancer	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 716	Responsive Neurostimulation for the Treatment of Refractory Focal Epilepsy	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 718	Powered Exoskeleton for Ambulation in Patients with Lower Limb Disabilities	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 719	Minimally Invasive Ablation Procedures for Morton and Other Peripheral Neuromas	LCD: Peripheral Nerve Blocks (L36850) **Outpatient Prior Authorization** This is not a covered service
MP 721	Patient-Controlled End of Range Motion Stretching Devices	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 726	Extracorporeal Membrane Oxygenation	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This procedure is performed in the inpatient setting
MP 730	Endovascular Therapies for Extracranial Vertebral Artery Disease	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 732	Chemical Peels	NCD: Treatment of Actinic Keratosis (250.4)

		Outpatient Prior Authorization Prior authorization is not required
MP 733	Focal Treatments for Prostate Cancer	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 737	Orthopedic Applications of Platelet-Rich Plasma	LCD: Platelet Rich Plasma (L38937) **Outpatient Prior Authorization** This is not a covered service
MP 740	Blepharoplasty, Blepharoptosis Repair and Brow Ptosis Repair	LCD: Blepharoplasty, Blepharoptosis and Brow Lift (L34528) **Outpatient Prior Authorization** 15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908: Prior authorization is required for Medicare HMO Blue and for Medicare PPO Blue *Massachusetts Collaborative Prior Authorization Form* ***OR*** *Blue Cross Blue Shield of Massachusetts Pre-certification Request Form*
MP 742	Urinary Metabolite Tests for Adherence to Direct-Acting Antiviral Medications for Hepatitis C	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 744	Minimally Invasive and Surgical Treatment Options for Benign Prostatic Hyperplasia (BPH)	LCD: Fluid Jet System Treatment for LUTS/BPH (L38367) BCBSMA medical policy is followed for other services **Outpatient Prior Authorization** Prior authorization is not required
MP 745	Nutrient/Nutritional Panel Testing	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 746	Vitamin D Assay Testing	LCD: Vitamin D Assay Testing (L37535) **Outpatient Prior Authorization** Prior authorization is not required
MP 748	Multispectral Digital Skin Lesion Analysis	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 792	Dry Needling of Trigger Points for	NCD: Acupuncture for Chronic Lower Back Pain (cLBP)

	Myofascial Pain	(30.3.3) LCD: Pain Management (L33622) LCD: Peripheral Nerve Blocks (L36850) **Outpatient Prior Authorization** Prior authorization is not required
MP 794	Ablation of Peripheral Nerves to Treat Pain	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 800	Steroid-Eluting Sinus Stents	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 801	Surgical Deactivation of Headache Trigger Sites	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 838	Allograft Injection for Degenerative Disc Disease	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 841	Adjunctive Techniques for Screening and Surveillance of Barrett Esophagus and Esophageal Dysplasia	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 842	Durable Medical Equipment	Local Coverage Determinations (LCDs) for Noridian Healthcare Solutions, LLC (19003, DME MAC, J-D) **Outpatient Prior Authorization** Prior authorization requirements are variable on DME services
MP 900	Advanced Imaging/Radiology CPT and HCPCS Codes	**Outpatient Prior Authorization** Prior authorization through Carelon **is required** for Medicare Advantage products.
MP 904	Chromoendoscopy as an Adjunct to Colonoscopy	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 905	Corneal Collagen Cross-linking	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization**

		Prior authorization is not required
MP 911	Gene Therapy for Inherited Retinal Dystrophy	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** J3398: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *Gene Therapy for Inherited Retinal Dystrophy Preauthorization Request Form #926*
MP 912	Microwave Tumor Ablation	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 914	Neural Therapy	LCD: Pain Management (L33622) **Outpatient Prior Authorization** This is not a covered service
MP 915	Optical Coherence Tomography for Imaging of Coronary Arteries	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 916	Cardiac Rehabilitation in the Outpatient Setting	NCD: Cardiac Rehabilitation Programs (20.10) NCD: Cardiac Rehabilitation Programs for Chronic Heart Failure (20.10.1) NCD: Intensive Cardiac Rehabilitation (ICR) Programs (20.31) NCD: The Pritikin Program (20.31.1) NCD: Ornish Program for Reversing Heart Disease (20.31.2) **Outpatient Prior Authorization** Prior authorization is not required
MP 917	Measurement of Serum Antibodies to Selected Biologic Agents	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 918	Dopamine Transporter Imaging with Single Photon Emission Computed Tomography	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 919	Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service

MP 920	Surgical and Transesophageal Endoscopic Procedures to Treat Gastroesophageal Reflux Disease	LCD: Select Minimally Invasive GERD Procedures (L35080) **Outpatient Prior Authorization** 43210, 43284: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue *956 Prior Authorization Request Form for Surgical and Transesophageal Endoscopic Procedures to Treat Gastroesophageal Reflux Disease*
MP 921	Noninvasive Techniques for the Evaluation and Monitoring of Patients with Chronic Liver Disease	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 922	Percutaneous Electrical Nerve Field Stimulation for Functional Abdominal Pain Disorders	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** Prior authorization is not required
MP 923	Medical Policy for Medicare Advantage Products Advanced Imaging/Radiology and Sleep Disorder Management	**Outpatient Prior Authorization** Prior authorization through Carelon is required for Medicare Advantage products.
MP 937	Quality Care Cancer Program (Radiation Oncology)	**Outpatient Prior Authorization** Prior authorization through Carelon is required for Medicare Advantage products.
MP 938	Quality Care Cancer Program (Radiation Oncology) CPT and HCPCS Codes	**Outpatient Prior Authorization** Prior authorization through Carelon is required for Medicare Advantage products.
MP 942	Chimeric Antigen Receptor Therapy for Multiple Myeloma	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) **Outpatient Prior Authorization** Q2055: Prior authorization is required for Medicare HMO Blue and Medicare PPO Blue. See policy for additional information *943 Prior Authorization Request Form for CAR T-Cell Therapy Services for Multiple Myeloma (Idecabtagene vicleucel)*
MP 946	Aducanumab for Alzheimer Disease	NCD: Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (200.3) **Outpatient Prior Authorization** J0172: Injection, aducanumab-avwa, 2 mg. Prior authorization is required. Effective 1.12.2023
MP 947	Digital Health Therapies for Attention Deficit /Hyperactivity	No LCD or NCD BCBSMA medical policy is followed

	Disorder	**Outpatient Prior Authorization** This is not a covered service
MP 948	Laser Interstitial Thermal Therapy for Neurological Conditions	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 955	Phrenic Nerve Stimulation for Central Sleep Apnea	No LCD or NCD BCBSMA medical policy is followed **Outpatient Prior Authorization** This is not a covered service
MP 957	AIM Genetic Testing Management Program CPT and HCPCS Codes	**Outpatient Prior Authorization** Prior authorization through Carelon **is not required** for Medicare Advantage products. Please see the appropriate NCD or LCD through the CMS website for specific genetic testing guidelines.

Prior authorization is required for the following Gender Affirming Transgender codes for Medicare HMO Blue: and Medicare PPO Blue:

Male to Female Surgery	
17380	Electrolysis epilation, each 30 minutes
19325	Mammaplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19380	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
54120	Amputation of penis; partial
54125	Amputation of penis; complete
54300	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchiectomy
55970	Intersex surgery; male to female
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
Facial Feminization/ Masculinization	
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
Brow Lift	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
Blepharoplasty	

15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
Rhinoplasty	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
Cheek Augmentation	
21270	Malar augmentation, prosthetic material
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
Jaw Reconstruction	
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
Chin Reconstruction	
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
Face Lift: These codes are covered when required as part of medically necessary facial feminization procedure	
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
Liposuction: These codes are covered when required as part of medically necessary facial feminization procedure	
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
Trachea Shave/Thyroid Cartilage Reduction	
31599	Unlisted procedure, larynx
Chest and Genital Surgery for Feminization Surgery	
17380	Electrolysis epilation, each 30 minutes
19325	Mammaplasty, augmentation; with prosthetic implant
19350	Nipple/areola reconstruction
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19380	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
54120	Amputation of penis; partial
54125	Amputation of penis; complete
54300	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra
54125	Amputation of penis; complete
54300	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization

	of urethra
55970	Intersex surgery; male to female
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state
Chest and Genital Surgery for Masculinization Surgery	
19303	Mastectomy, simple, complete
19316	Mastopexy
19350	Nipple/areola reconstruction
53430	Urethroplasty, reconstruction of female urethra
54660	Insertion testicular prosthesis
55175	Scrotoplasty; simple
55180	Scrotoplasty; complex
55980	Intersex surgery; female to male
56620	Vulvectomy; simple
56625	Vulvectomy; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical
57110	Vaginectomy; complete removal of vaginal wall
57111	Vaginectomy; with removal of paravaginal tissue (radical vaginectomy)

Policy History

Date	Action
5/2024	MP 043 Suction Lipectomy for Lipedema added. LCD: Amniotic and Placental-Derived Product Injections and/or Applications for Musculoskeletal Indications, Non-Wound (L39139) added to MP 643.
4/2024	Pain Management (L33622) removed from MP 604. Trigger Point Injections (TPI) (L39662) added to MP 604. LCD: Peripheral Nerve Blocks (L36850) removed from MP 794 Ablation of Peripheral Nerves to Treat Pain. LCD: Peripheral Nerve Blocks (L36850) added to MP 792 Dry Needling of Trigger Points for Myofascial Pain.
3/2024	LCD: Biomarker Testing for Prostate Cancer Diagnosis (L37733) removed from MP 336. LCD L37733 Biomarker Testing for Prostate Cancer Diagnosis retired effective 3/1/2024. Billing and Coding Article: Biomarker Testing for Prostate Cancer Diagnosis A56609 is followed in lieu of retired LCD L37733.
4/2024	MP 028 Omidubicel as Adjunct Treatment for Hematologic Malignancies. Prior authorization is required. Effective 4/1/2024. MP 097 Bone Morphogenetic Protein. Prior authorization is not required. Effective 4/1/2024. MP 664 Cardiovascular Risk Panels retired. Transferred to MP 283 Biomarker Testing in Risk Assessment and Management of Cardiovascular Disease. Effective 4/1/2024. MP 558 Measurement of Lipoprotein-Associated Phospholipase A2 - Lp-PLA2 - in the Assessment of Cardiovascular Risk retired. Transferred to MP 283 Biomarker Testing in Risk Assessment and Management of Cardiovascular Disease. Effective 4/1/2024.
3/2024	MP 374 Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions retired effective 3/1/2024. The policy will no longer be available on the Blue Cross website. To submit authorization requests through InterQual use Authorization Manager. MP 050 Gene Therapies for Sickle Cell Disease added. Effective 1/1/2024. MP 055 Gene Therapies for Sickle Cell Disease Prior Authorization Request Form for Casgevy ™ (Exagamglogene autotemcel) added. Effective 1/1/2024. MP 031 Suture Button Suspensionplasty Fixation System for Thumb Carpometacarpal Osteoarthritis added. Effective 3/1/2024. LCD L37808 Water Vapor Thermal Therapy for LUTS/BPH removed from MP #744.

	NCD: Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB) 20.16 added to MP #287.
2/2024	MP #485 Intraosseous Basivertebral Nerve Ablation added. Removed LCD L36037 and added LCD L39611 to MP #674. Added Chiropractic Services. Added LCD L39051 to MP #068.
1/2024	MP #028 Omidubicel as Adjunct Treatment for Hematologic Malignancies added.
12/2023	Policy revised to remove orchiectomy and hysterectomy procedure codes from MP 189. Prior authorization is not required for the following codes: Orchiectomy codes: 54520; 54690. Hysterectomy codes: 58150; 58180; 58260 58262; 58275; 58290 58291; 58541; 58542; 58543; 58544; 58550 58552; 58553; 58554; 58570; 58571; 58572; 58573. Effective 12/1/2023.
12/2023	MP 061 Vitamin B12 Testing added. Effective 12/1/2023. MP #165 Laboratory Testing Investigational Services clarified.
11/2023	MP #124 Multicancer Early Detection Testing added. Effective 11/1/2023.
9/2023	MP #022 Gene Therapies for Duchenne Muscular Dystrophy added. 8/15/2023. NCD 280.16 added to MP #365 section.
8/2023	Added LCD L39513 to MP #143 and MP #207.
8/2023	MP #165 Laboratory Testing Investigational Services. Ongoing investigational codes: 0112U; 0365U, 0366U, 0367U from MP #400 and transferred to MP #165.
7/2023	MP #159 Gene Therapies for Bladder Cancer added. Effective 6/8/2023.
5/2023	Removed LCD L33622 and added LCD L39455 to MP #320.
5/2023	MP #320 Diagnosis and Treatment of Sacroiliac Joint Pain reinstated and added. Revised policy title for MP 482.
4/2023	MP #168 Gene Therapies for Hemophilia B added. Effective 4/3/2023. Clarified LCD language in MP#555.
4/2023	Added LCD L39044 to MP 045.
4/2023	The following were added. Effective 4/1/2023. MP #220 InterQual Musculoskeletal Services Management MP #221 InterQual Musculoskeletal Services Management CPT and HCPCS Codes. MP #184 Axillary Reverse Mapping for Prevention of Breast Cancer-Related Lymphedema Musculoskeletal medical policies retired effective 4/1/2023. These policies will no longer be available on the Blue Cross website. To submit authorization requests through InterQual use Authorization Manager. MP #585 Artificial Intervertebral Disc - Cervical Spine MP #320 Diagnosis and Treatment of Sacroiliac Joint Pain MP #690 Epidural Steroid Injections MP #140 Facet Joint Denervation MP #485 Percutaneous Balloon Kyphoplasty, Radiofrequency Kyphoplasty and Mechanical Vertebral Augmentation MP #484 Percutaneous Vertebroplasty and Sacroplasty MP #472 Spinal Cord and Dorsal Root Ganglion Stimulation MP #193 Total Ankle Replacement.
3/2023	The following were added: MP #179 Orthognathic Surgery MP #199 Stationary Ultrasonic Diathermy Devices MP #241 Gene Therapies for Cerebral Adrenoleukodystrophy MP #107 Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Artificial Pancreas Device Systems. Added A4238 effective 3/1/2023.
1/2023	Clarified MP #138, #189, and #744.
1/2023	The following were added: CMS Publication 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 290 – Foot Care added under MP #385. LCD: Botulinum Toxins (L33646) added under MP #406. LCD: Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L33394) added under MP #020. LCD: External Infusion Pumps (L33794) added under MP #107 and #332. LCD: Facet Joint Interventions for Pain Management (L35936) added under #183. LCD: Fluid Jet System Treatment for LUTS/BPH (L38367) added under MP #744.

	LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38623) added under MP #107. LCD: MolDX: BDX-XL2 (L37054) added under MP #029. LCD: MolDX: Biomarkers in Cardiovascular Risk Assessment (L36358) added under MP #032, #558, and #664. LCD: MolDX: Molecular Diagnostic Tests (MDT) (L35160) added under MP #045 and #677. LCD: MolDX: Percepta® Bronchial Genomic Classifier (L36886) added under MP #029. LCD: Molecular Pathology Procedures (L35000) added under MP #138. LCD: Multimarker Serum Tests Related to Ovarian Cancer Testing (L38371) added under MP #167. LCD: Nerve Conduction Studies and Electromyography (L35098) added under MP #211, #258, and #517. LCD: Off-label Use of Rituximab and Rituximab Biosimilars (L39297) added under MP #020. LCD: Osteogenesis Stimulators (L33796) added under MP #498. LCD: Outpatient Physical and Occupational Therapy Services (L33631) added under MP #095, #164, #406, #522, #543 and #655. LCD: Pain Management (L33622) added under MP #792 and #914. LCD: Peripheral Nerve Blocks (L36850) added under MP #719 and #794. LCD: Psychiatric Partial Hospitalization Programs (L33626) added under MP #423. LCD: Psychiatry and Psychology Services (L33632) added under MP #152, #178, and #515. LCD: Reduction Mammaplasty (L35001) added under MP #428. LCD: Refractive Lenses (L33793) added under MP #371. LCD: Suction Pumps (L33612) added under MP #130. LCD: Transcutaneous Electrical Joint Stimulation Devices (TEJSD) (L34821) added under MP #302. LCD: Transcutaneous Electrical Nerve Stimulators (TENS) (L33802) added under MP #003 and #035. LCD: Vacuum Erection Devices (VED) (L34824) added under MP #078. LCD: Venous Angioplasty with or without Stent Placement for the Treatment of Chronic Cerebrospinal Venous Insufficiency (L35028) added under MP #352. LCD: Water Vapor Thermal Therapy for LUTS/BPH (L37808) added under MP #744. NCD: 24-Hour Ambulatory ESOPHAGEAL pH Monitoring (100.3) added under MP #069. NCD: Anti-Cancer Chemotherapy for Colorectal Cancer (110.17) added under MP #020. NCD: Biofeedback Therapy (30.1) added under MP #152. NCD: Bone (Mineral) Density Studies (150.3) added under MP #450. NCD: Breast Reconstruction Following Mastectomy (140.2) added under MP #428. NCD: CHELATION Therapy for Treatment of Atherosclerosis (20.21) added under MP #122. NCD: Colonic Irrigation (100.7) added under MP #178. NCD: Colorectal Cancer Screening Tests (210.3) added under MP #167 and #557. NCD: Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (250.5) added under MP #068. NCD: Diagnosis and Treatment of Impotence (230.4) added under MP #078. NCD: Durable Medical Equipment Reference List (280.1) added under MP #332. NCD: Electrical Nerve Stimulators (160.7) added under MP #473. NCD: Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (110.21) added under MP #020. NCD: Ethylenediamine-Tetra-Acetic (EDTA) CHELATION Therapy for Treatment of Atherosclerosis (20.22) added under MP #122. NCD: Heart Transplants (260.9) added under MP #197. NCD: Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (200.3) added under MP #946. NCD: Ocular Photodynamic Therapy (OPT) (80.2.1) added under MP #599. NCD: Pancreas Transplants (260.3) added under MP #324. NCD: Pediatric Liver Transplantation (260.2) added under MP #198. NCD: Photodynamic Therapy (80.2) added under MP #599. NCD: Photosensitive Drugs (80.3) added under MP #599. NCD: Porcine Skin and Gradient Pressure Dressings (270.5) added under MP #663. NCD: Refractive Keratoplasty (80.7) added under MP #675. NCD: Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with

	Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy) (70.2.1) added under MP #385. NCD: Sleep Testing for Obstructive Sleep Apnea (OSA) (240.4.1) added under MP #533. NCD: Stem Cell Transplantation (Formerly 110.8.1) (110.23) added under MP #143, #150, #208, #212, and #322. NCD: Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (160.27) added under MP #003. NCD: Treatment of Actinic Keratosis (250.4) added under MP #732. NCD: Tumor Antigen by Immunoassay - CA 15-3/CA 27.29 (190.29) added under MP #538. NCD: Tumor Antigen by Immunoassay - CA 19-9 (190.30) added under MP #538. NCD: Ultrasound Diagnostic Procedures (220.5) added under MP #007. NCD: Verteporfin (80.3.1) added under MP #599. MP #020 added J0897, J9312, J9355, Q5112, Q5113, Q5114, Q5115, Q5116, Q5117, Q5119, and Q5121 to prior authorization section and removed J2505. MP #068 removed LCD L3468. MP #074, #075, and #076 updated NCD title. MP #077 added J7352 to prior authorization section. MP #125 added J3380; J2796; J0129; J1602; J3357; J3358; J7686; J0840; J0850; J1459; J1460; J1554; J1555; J1556; J1557; J1558; J1559; J1560; J1561; J1562; J1568; J1569; J1571; J1572; J1573; J1575; J1599; J1670; J1566; J2791 added to prior authorization section. MP #134 removed LCD L7171. MP #176 Surgical Left Atrial Appendage Occlusion Devices for Stroke Prevention in Atrial Fibrillation added. MP #200 removed LCD L33392 and LCA A56195. MP #208 updated NCD title. MP #209 removed policy, retired April 2022. MP #268 removed policy, retired October 2021. MP #283 updated LCD from L36523 to L36358. MP #336 removed LCA A53107 and title updated on LCD L37733. MP #450, #594, #595, #606, #610, #613, #730, #737, and #905 removed LCD L33392. MP #484 and #485 updated title for LCD L33569. MP #530 removed NCD 260.10, LCD's L33629, L38255, L38355 and Allomap link. MP #557 removed Decision Memo for Screening for Colorectal Cancer Stool DNA Testing (CAG-00440N). MP #642 removed policy as language moved to MP #719. MP #657 removed LCD L37228. MP #661 removed LCD L34628. MP #692 updated NCD title. MP #719 updated title. MP #733 removed LCD L38262. MP #946 added J0172 to prior authorization section effective 1/12/2023. MP #955 removed LCD L37929.
1/2023	Clarified prior authorization for policy 107. Effective 1/1/2023.
12/2022	Clarified prior authorization for policy 107. Policy 175 Digital Health Technologies: Diagnostic Applications added. Clarified coverage for policy 449. Effective 12/1/2022.
11/2022	MP 215 Gene Therapies for Thalassemia added. Effective 10/13/2022. MP 164 Dry Hydrotherapy for Chronic Pain Conditions added. Effective 11/1/2022.
10/6/2022	NCD: Artificial Hearts and Related Devices (20.9) removed under MP#280. NCD 20.9 retired effective 12/1/2020.
10/2022	The following policies were retired. Effective 10/1/2022. MP #591 Thermal Capsulorrhaphy as a Treatment of Joint Instability MP #043 Home Uterine Activity Monitoring MP #625 Embryonic Mesencephalic Transplantation for the Treatment of Parkinsons Disease MP #626 Stereotactic Radiofrequency Pallidotomy for the Treatment of Parkinsons Disease MP #627 Adrenal-to-Brain Transplantation MP #553 Minimally Invasive Coronary Artery Bypass Graft Surgery MP #124 Isolated Limb Perfusion or Infusion for Malignant Melanoma MP #028Therapeutic Radiopharmaceuticals in Oncology. Effective 10/8/2022.
9/2022	The following policies were added: MP #045 Pathogen Panel Testing MP #060 Uterus Transplantation for Absolute Uterine Factor Infertility. MP 790 Expanded Molecular Panel Testing of Cancers to Identify Targeted Therapies was retired. Effective 9/4/2022.
8/2022	LCD: Multiplex Gastrointestinal Pathogen Panel (GPP) Tests for Acute Gastroenteritis (AGE) (L39226) added under MP #555. Effective 8/1/2022.
5/2022	MP #948 Laser Interstitial Thermal Therapy for Neurological Conditions added.
4/2022	MP #465 Policy updated to indicate prior authorization is not required. MP #163 Maternal Serum Biomarkers for Prediction of Adverse Obstetric Outcomes added.

3/2022	The following policies were added: MP #091 Applied Behavioral Analysis MP #922 Percutaneous Electrical Nerve Field Stimulation for Functional Abdominal Pain Disorders
2/2022	MP #842 Durable Medical Equipment added. LCD: Colon Capsule Endoscopy (L38571) added under MP #185. Effective 2/15/2022.
1/2022	Policy updated to include prior authorization requirements for Medicare PPO. Effective 1/1/2022. The following policies were added: MP #365 Manual and Power Operated Wheelchairs MP #369 Ostomy Supplies MP #370 Urological Supplies.
1/2022	MP #841 Adjunctive Techniques for Screening and Surveillance of Barrett Esophagus and Esophageal Dysplasia added.
12/2021	LCD: Respiratory Pathogen Panel Testing (L39027) added under MP #555 Identification of Microorganisms Using Nucleic Acid Probe. LCD: Epidural Steroid Injections for Pain Management (L39036) added under MP #690 Epidural Steroid Injections for Neck and Back Pain. Commercial MP #797 Circulating Tumor DNA and Circulating Tumor Cells for Cancer Management (Liquid Biopsy) retired 1/4/2021. The following policies were added: MP #947 Digital Health Therapies for Attention Deficit /Hyperactivity Disorder MP #946 Aducanumab for Alzheimer Disease MP #838 Allograft Injection for Degenerative Disc Disease.
10/2021	HCPCS codes C9081 & Q2054 added. Commercial MP #253 InVitro Chemoresistance and Chemosensitivity Assays retired. Removed LCD information from MP:112 as there is no longer an LCD. The medical policy is followed.
9/2021	Medicare Billing and Coding Article A54602 added under MP #707 Benign Skin Lesions
8/2021	Commercial MP 542 Ultrafiltration in Decompensated Heart Failure was retired. LCD: Platelet Rich Plasma (L38937) added under MP #737 Orthopedic Applications of Platelet-Rich Plasma.
7/2021	The following radiation oncology commercial policies were retired: MP #090 Intensity-Modulated Radiotherapy of the Prostate MP #091 Endobronchial Brachytherapy MP #163 Intensity-Modulated Radiotherapy of the Breast and Lung MP #164 Intensity-Modulated Radiation Therapy Cancer of the Head and Neck or Thyroid MP #165 Intensity-Modulated Radiation Therapy Abdomen and Pelvis MP #175 Brachytherapy for Clinically Localized Prostate Cancer Using Permanently Implanted Seeds MP #277 Stereotactic Radiosurgery and Stereotactic Body Radiotherapy MP #278 Intraoperative Radiotherapy; MP 326 Accelerated Breast Irradiation and Brachytherapy Boost after Breast-Conserving Surgery for Early-Stage Breast Cancer MP #353 High-Dose Rate Temporary Prostate Brachytherapy MP #437 Charged-Particle (Proton or Helium Ion) Radiotherapy for Neoplastic Conditions MP #602 Intracavitary Balloon Catheter Brain Brachytherapy for Malignant Gliomas or Metastasis to the Brain MP #739 Electronic Brachytherapy for Nonmelanoma Skin Cancer MP #743 Hydrogel Spacer use During Radiotherapy for Prostate Cancer MP #910 Intensity Modulated Radiotherapy (IMRT) Central Nervous System Tumors.
6/2021	MP #942 Chimeric Antigen Receptor Therapy for Multiple Myeloma added 6/4/2021.
6/2021	Prior authorization requirements on MP #313 Bronchial Valves clarified. The following policies were added: MP #937Quality Care Cancer Program (Radiation Oncology); MP #938 Quality Care Cancer Program (Radiation Oncology) CPT and HCPCS Codes.
5/2021	The following commercial policies were retired: MP #221 Keratoprosthesis; MP #644 Vagus Nerve Blocking Therapy for Treatment of Obesity; MP #235 Implantation of Intrastromal Corneal Ring Segments.
4/2021	LCD: Pneumatic Compression Devices (L33829) added under MP #541 Postsurgical Home Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis.

4/2021	The following policies were added: MP #142 Air Ambulance Transport; MP #146 Ground Ambulance; MP #158 Outpatient Pediatric Pain Rehabilitation Centers; MP #139 Diagnostic Laboratory Services. The following commercial policies were retired: MP #060 Transurethral Water Vapor Thermal Therapy for Benign Prostatic Hyperplasia retired. For coverage information see MP #744 Minimally Invasive and Surgical Treatment Options for Benign Prostatic Hyperplasia (BPH); MP #145 Surgical Treatment of Femoroacetabular Impingement. MP #464 Implantable Miniature Telescope (IMT). LCD: Select Minimally Invasive GERD Procedures (L35080) added. LCD: Fluid Jet System Treatment for LUTS/BPH (L38367) added.
3/2021	The following commercial policies were retired: MP #285 Placental/Umbilical Cord Blood as a Source of Stem Cells; MP #448 Computed Tomography Perfusion Imaging of the Brain.
2/2021	Outpatient prior authorization is required for Medicare Advantage for #077 Scenesse (afamelanotide) for Treatment of Erythropoietic Protoporphyria. Effective 2/1/2021. The following commercial policies were retired: MP #050 Endothelial Microscopy; MP #397 Quantitative Assay for Measurement of HER2 Total Protein Expression and HER2 Dimers; MP #469 Radioactive Seed Localization of Nonpalpable Breast Lesions.
1/2021	Outpatient prior authorization information for Medicare Advantage added from #072 Outpatient Prior Authorization Code List for Commercial plans. The following pharmacy medical policies were added: #020 Medicare Advantage Part B Step Therapy and #125 Medicare Advantage Part B Medical Utilization Management. The following commercial policies were retired: MP #598 Lysis of Epidural Adhesions MP #222 Automated Point of Care Nerve Conduction Tests MP #045 Ingestible pH and Pressure Capsule MP #309 Transanal Radiofrequency Treatment of Fecal Incontinence MP #597 Phototherapeutic Keratectomy.
12/2020	The following commercial policies were retired: MP #137Magnetoencephalography/ Magnetic Source Imaging retired. MP #639 Radioimmunoscintigraphy Imaging (Monoclonal Antibody Imaging) with Indium-111 Capromab Pendetide for Prostate Cancer retired. Investigational HCPCS code A9507 added to MP #400. MP #723 ST2 Assay for Chronic Heart Failure and Heart Transplant Rejection retired; merged into policy #530 Laboratory Tests Post Transplant and for Heart Failure.
11/2020	The following commercial policies were retired: MP #343 Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions MP #401 Intravitreal Angiogenesis Inhibitors for Retinal Vascular Conditions MP #638 Radioimmunoscintigraphy Imaging and Monoclonal Antibody Imaging Using In-111 Satumomab Pendetide (OncoScint) or Tc-99m Arcitumomab IMMU-4, CEA-Scan MP #640 Radioimmunoscintigraphy Imaging and Monoclonal Antibody Imaging Using Technetium-99m Nofetumomab Merpentan (Verluma) MP #654 Multianalyte Assays with Algorithmic Analyses for Predicting Risk of Type 2 Diabetes
10/2020	The following commercial policies were retired: MP #242 Occlusion of Uterine Arteries Using Transcatheter Embolization MP #679 Transrectal Ultrasound for Staging Rectal Cancer MP #680 Transrectal Ultrasound of the Prostate MP #519 Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy MP #504 Alpha-Fetoprotein-L3 for Detection of Hepatocellular (Liver) Cancer.
10/2020	New document. Effective 10/1/2020.