Mass General Brigham
Health Plan

Medicare Advantage Administration Guidelines

Policy Number: 063

Contents

Overview
The purpose of this document is to describe how Mass General Brigham Health Plan manages its Medicare Advantage medical policies.

Coverage Guidelines
Mass General Brigham Health Plan uses Centers for Medicare & Medicaid Services (CMS) guidelines for medical necessity and coverage determinations for its Medicare Advantage members. This guidance includes but is not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), and information available in CMS Medicare-related manuals. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plans' commercial medical policies will be followed to determine the medical necessity of the service.

The Mass General Brigham Health Plan Medical Policy Committee creates medical policies outlining medical necessity criteria that are evidence based, include input from experts in our network as needed, and reflect the standards of care in our practice area. Medical Policies are created to address services not covered by InterQual Criteria, or in the event that the Medical Policy Committee believes an InterQual Criteria set does not reflect these requirements.

Mass General Brigham Health Plan utilizes Change Health Care InterQual® criteria. InterQual® criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from independent panel of clinical experts.

To access medical necessity criteria, the following links can be used:

1. InterQual criteria (all lines of business including CMS guidelines): Mass General Brigham Health Plan Provider Portal
2. Mass General Brigham Medical Policies: Medical Policies (massgeneralbrighamhealthplan.org)

National Coverage Determinations (NCD)
National Coverage Determinations (NCDs) are created by CMS to define the circumstances for Medicare

coverage nationwide for a specific medical service, procedure, or device. When there is no NCD, Mass General Brigham Health Plan commercial medical policies are used for Medicare Advantage members.

Local Coverage Determination (LCD)
An LCD is a decision delivered by an insurer or fiscal intermediary regarding coverage of a particular service, procedure, or device. Mass General Brigham Health Plan is required to make coverage determinations for services that each Medicare Administrative Contractor (MAC)[1] publishes as the Local Coverage Determination. The LCDs used 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 specifically addresses the service, procedure, or device Mass General Brigham Health Plan commercial medical policies are used for Medicare Advantage members.

Medicare and Commercial Policies – Table 1
The following table outlines Mass General Brigham Health Plan' medical policies and corresponding CMS Medical Policies[2]. Mass General Brigham Health Plan medical necessity guidelines do not replace Medicare coverage guidelines, unless explicitly specified below by Mass General Brigham Health Plan. Please refer to the Medicare Coverage Database to access complete Medicare guidelines and medical necessity criteria.

Policy Number	Mass General Brigham Health Plan Medical Policy	Medicare Advantage
01	Abecma	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24).
02	Absorbent Products for Incontinence	This is not a covered service.
03	Acupuncture	NCD: Acupuncture for Chronic Lower Back Pain (cLBP) (30.3.3)
04	Acute Inpatient	Mass General Brigham Health Plan utilizes InterQual® criteria in reviewing medical necessity for level of care criteria, Acute Care Adult, Acute Care Pediatric, Rehabilitation Adult and Pediatric, Sub acute and Skilled Nursing Facilities Adult and Pediatric.
05	Arthrodesis for Sacroiliac Joint Pain	LCD: Minimally invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint (L36406). Local Coverage Article: Billing and Coding: Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint (A57431)
06	Artificial Pancreas Device System	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
07	Autologous Chondrocyte Implantation in the Knee	No NCD or LCD

[1] 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.

[2] Mass General Brigham Health Plan identified these policies at the time of the Plan's most recent policy review.

		Please follow the Mass General Brigham Health Plan Commercial policy.
08	Bariatric Surgery	NCD: Bariatric Surgery for the Treatment of Morbid Obesity (100.1). LCD: Laparoscopic Sleeve Gastrectomy (LSG) – Medical Policy Article (A52447).
09	Bone Growth Stimulators	NCD: Osteogenic Stimulators (150.2) LCD: Osteogenesis Stimulators (L33796). Local Coverage Article: (A52513).
010	Breast Surgeries	LCD: Reduction Mammaplasty (L35001). For Reconstructive Breast Surgery/Management of Breast Implants please follow Mass General Brigham Health Plan commercial policy. For Breast Reconstruction related to Gender Affirming Procedures please follow Mass General Brigham Health Plan Gender Affirming Procedures policy.
011	Breyanzi	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24).
012	Bronchial Thermoplasty	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
013	Chiropractic Services	LCD: Outpatient Physical and Occupational Therapy Services (L33631). LCD: Billing and Coding: Outpatient Physical and Occupational Therapy Services (A56566).
014	Continuous Glucose Monitors	LCD: Glucose Monitors (L33822) Local Coverage Article: (A52464) Prior authorization is not required.
015	Corneal Collagen Crosslinking	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
016	Definition of Skilled Care	CMS Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services.
017	Dental Treatment Setting	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
018	Durable Medical Equipment	Mass General Brigham Health Plan utilizes InterQual® Medicare criteria in reviewing medical necessity for Durable Medical Equipment.[3]

[3] InterQual Medicare Durable Medical Equipment criteria includes Local Coverage Determinations (LCDs) for Noridian Healthcare Solutions, LLC.

		Local Coverage Determinations (LCDs) for Noridian Healthcare Solutions, LLC. NCD: Durable Medical Equipment Reference List (280.1).
020	Enteral Nutrition Formulas and Supplements	LCD: Enteral Nutrition (L38955). Local Coverage Article: Enteral Nutrition – Policy Article (A58833). LCD: Parenteral Nutrition (L38953). Local Coverage Article: Parenteral Nutrition (A58836).
021	Experimental and Investigational	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy. Mass General Brigham Health Plan covers services, procedures, devices, biologic products, and drugs (collectively "treatment") when there is sufficient scientific evidence (including published peer reviewed literature and clinical guidelines) to support their use or when the treatment is required by regulation. We also use guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations.
022	Extended Care Facility	CMS Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance.
024	Gender Affirming Procedures	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
025	Hearing Devices	For Cochlear Implant please use NCD: Cochlear Implantation (50.3). For other hearing devices, please follow Mass General Brigham Health Plan Commercial policy.
026	HIV-Associated Lipodystrophy Syndrome	For facial dermal injection please use NCD: Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (250.5). For other procedures please follow the Mass General Brigham Health Plan Commercial policy.
027	Home Health Care	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.[4]

[4] Mass General Brigham Health Plan utilizes Change Health Care InterQual® criteria in reviewing medical necessity for Home Health care. This criteria aligns with CMS Medicare Benefit Policy Manual Chapter 7- Home Health Services.

028	Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea	LCD: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38387).
029	Assisted Reproductive Services/Infertility Services	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
030	Insulin Pumps	LCD: External Infusion Pumps (L33794). Prior authorization is not required.
031	Intravenous Ketamine for Treatment Resistant Depression	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
032	Kymriah	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24).
033	Luthathera (Lutetium Lu 177 Dotate)	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
034	Luxturna	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
035	Mobile Cardiac Outpatient Telemetry	NCD: Electrocardiographic Services (20.15).
036	Neuromodulation for Overactive Bladder and Fecal Incontinence	LCD: Posterior Tibial Nerve Stimulation for Voiding Dysfunction (L33396) NCD: Sacral Nerve Stimulation for Urinary Incontinence (230.18). For Fecal Incontinence, please follow the Mass General Brigham Health Plan Commercial policy.
037	Non-Emergency Medical Necessary Ground Transportation	CMS Medicare Benefit Policy Manual, Chapter 10 Ambulance Services. No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
038	Oral and Maxillofacial Surgery and Procedures	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
040	Outpatient Chest Physical Therapy	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
041	Outpatient Drug Screening and Testing	LCD: Urine Drug Testing (L36037).
042	Phototherapeutic Keratectomy	NCD: Refractive Keratoplasty (80.7).
043	Phototherapy and Photochemotherapy for Dermatologic Conditions	NCD for Treatment of Psoriasis (250.1) For other procedures please follow the Mass

		General Brigham Health Plan Commercial policy.
044	Preimplantation Genetic Testing	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
045	Prostatic Urethral Lift	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
046	Prostheses - Lower Limb	LCD: Lower Limb Prostheses (L33787).
047	Prostheses - Upper Limb	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
048	Provenge	NCD: Autologous Cellular Immunotherapy Treatment (110.22).
049	Pylarify and Gallium Ga-68 PSMA for Imaging for Patients for Prostate Cancer	NCD: Positron Emission Tomography (FDG) for Oncologic Conditions (220.6.17).
050	Radiofrequency Ablation to Treat Uterine Fibroids	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
051	Reconstructive and Cosmetic Procedures	NCD: Treatment of Actinic Keratosis (250.4). LCD: Varicose Veins of the Lower Extremity, Treatment of (L33575). LCD: Blepharoplasty, Blepharoptosis and Brow Lift (L34528). Local Coverage Article: Billing and Coding: Blepharoplasty, Blepharoptosis and Brow Lift (A56908). Local Coverage Article: Blepharoplasty - Medical Policy Article (A52837). CMS Medicare Benefit Policy Manual Chapter 16- General Exclusions from Coverage.
053	Speech Generating Devices	LCD: Speech Generating Devices (SGD) (L33739). Local Coverage Article: Speech Generating Devices (SGD) – Policy Article (A52469).
054	Tecartus	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24).
055	Therapeutic Lens	LCD: Eye Prostheses (L33737). Local Coverage Article: Eye Prostheses (A52462).
056	Tumor Treating Fields	LCD: Tumor Treatment Field Therapy (TTFT) (L34823).

		Local Coverage Article: Tumor Treatment Field Therapy (TTFT) (A52711) .
057	UVB Home Phototherapy for Skin Disease	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
058	Vitamin D Screening and Testing in Adults	LCD: Vitamin D Assay Testing (L37535).
059	Yescarta	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24).
060	Zolgensma	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
061	Carvykti	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24).
062	Pluvicto	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
063	Zynteglo	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24).
065	Skysona	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24).
066	Transurethral Waterjet Ablation of the Prostate	LCD: Fluid Jet System Treatment for LUTS/BPH (38367). Local Coverage Article: Billing and Coding: Fluid Jet System Treatments for LUTS/BPH (A56797)
067	Hemgenix	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
068	Adstiladrin	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
070	Roctavian	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.
071	Balloon Dilation of the Eustachian Tube	No NCD or LCD Please follow the Mass General Brigham Health Plan Commercial policy.

Effective Date

January 2024: Annual Update. Administrative changes made to the coverage guidelines section. Added language regarding Medical Policy Committee. Intent unchanged. Changes made to Table 1 to reflect updated hyperlinks. High-tech radiology section removed. References updated.

December 2023: Off-cycle Update. Roctavian added to Table 1.

September 2023: Off-cycle Update. Adstiladrin added to Table 1.
August 2023: Off-Cycle Update. Transurethral Waterjet Ablation of Prostate and Hemgenix policies added to Table 1.
May 2023: Off-Cycle Update. Zynteglo and Skysona policies added to Table 1.
April 2023. Off-Cycle Update: Prior authorization removed from External Counterpulsation (Policy #23). Policy retired.
March 2023. Off-Cycle Update: Prior authorization removed for Continuous Glucose Monitors (Policy # 14).
January 2023. Effective Date

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