Mass General Brigham
Health Plan

Medical Policy
Medicare Advantage Administration Guidelines

Policy Number: 063

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

Coverage Guidelines
Medicare Advantage plan members
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), local coverage articles (LCAs), 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)

OneCare and Senior Care Options (SCO) plan members

Mass General Brigham Health Plan uses CMS guidelines for medical necessity and coverage determinations for its OneCare and SCO members. This guidance includes but is not limited to NCDs, LCDs, LCAs, and information available in CMS Medicare-related manuals. When there is no guidance from CMS for the requested service, or the guidance is insufficient or very restrictive, Mass General Brigham Health Plan uses guidance from MassHealth for the requested service. When there is no guidance from CMS or MassHealth, or the guidance for the requested service is very restrictive or insufficient, Mass General Brigham Health Plans' commercial medical policies will be followed to determine the medical necessity of the service. The commercial medical policies created by Mass General Brigham Health Plan are developed as described above.

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	OneCare and SCO
01	Abecma	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services The NCD lacks sufficient specificity to ensure consistent medical review and coverage	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.

[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.

		decisions. Please follow the Mass General Brigham Health Plan commercial policy.	
03	Acupuncture	NCD - Acupuncture (30.3) NCD: Acupuncture for Chronic Lower Back Pain (cLBP) (30.3.3) NCD - Acupuncture for Fibromyalgia (30.3.1) NCD - Acupuncture for Osteoarthritis (30.3.2)	When member does not meet CMS criteria, follow MassHealth criteria.
07	Autologous Chondrocyte Implantation in the Knee	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS or MassHealth criteria. 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 - Bariatric Surgical Management of Morbid Obesity (L35022)	When member does not meet CMS criteria, follow MassHealth criteria.
09	Bone Growth Stimulators	NCD: Osteogenic Stimulators (150.2) LCD: Osteogenesis Stimulators (L33796). Local Coverage Article: (A52513).	NCD: Osteogenic Stimulators (150.2) LCD: Osteogenesis Stimulators (L33796). Local Coverage Article: (A52513).
010	Breast Surgeries	NCD - Breast Reconstruction Following Mastectomy (140.2) LCD - Reduction Mammaplasty (L35001) LCD - Cosmetic and Reconstructive Surgery (L39506) LCD - Cosmetic and Reconstructive Surgery (L38914) LCD - Cosmetic and Reconstructive Surgery (L35090) LCD - Cosmetic and Reconstructive Surgery (L33428)	NCD - Breast Reconstruction Following Mastectomy (140.2) LCD - Reduction Mammaplasty (L35001) LCD - Cosmetic and Reconstructive Surgery (L39506) LCD - Cosmetic and Reconstructive Surgery (L38914) LCD - Cosmetic and Reconstructive Surgery (L35090) LCD - Cosmetic and Reconstructive Surgery (L33428)

		LCD - Cosmetic and Reconstructive Surgery (L39051) LCD - Plastic Surgery (L35163) LCD - Plastic Surgery (L37020)	LCD - Cosmetic and Reconstructive Surgery (L39051) LCD - Plastic Surgery (L35163) LCD - Plastic Surgery (L37020) When member does not meet CMS criteria, follow MassHealth criteria.
011	Breyanzi	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services The NCD lacks sufficient specificity to ensure consistent medical review and coverage decisions. Please follow the Mass General Brigham Health Plan commercial policy.	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services When the member does not meet CMS criteria, follow MassHealth criteria.
013	Chiropractic Services	Medicare Policy Benefit Manual, Chapter 15, section 240.1 "Coverage of Chiropractic Services." LCD - Chiropractic Services (L37254) LCD - Chiropractic Services (L37387)	Medicare Policy Benefit Manual, Chapter 15, section 240.1 "Coverage of Chiropractic Services." LCD - Chiropractic Services (L37254) LCD - Chiropractic Services (L37387) When the member does not meet CMS criteria, follow MassHealth criteria.
014	Continuous Glucose Monitors	LCD: Glucose Monitors (L33822) LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38664) LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38623)	LCD: Glucose Monitors (L33822) LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38664) LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38623)

		LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38657) LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38617) LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38743) LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38686) LCD: Glucose Monitors (L33822) Prior authorization is not required.	LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38657) LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38617) LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38743) LCD: Implantable Continuous Glucose Monitors (I-CGM) (L38686) LCD: Glucose Monitors (L33822) Prior authorization is not required.
015	Corneal Collagen Crosslinking	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS or MassHealth criteria. Please follow the Mass General Brigham Health Plan Commercial policy.
016	Definition of Skilled Care	Medicare Benefit Policy Manual Chapter 7 - Home Health Services Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance	Medicare Benefit Policy Manual Chapter 7 - Home Health Services Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance
017	Dental Treatment Setting	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS or MassHealth criteria. 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]	Mass General Brigham Health Plan utilizes InterQual® Medicare criteria in reviewing medical necessity for

[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) NCD - Home Use of Oxygen (240.2) NCD - Hospital Beds (280.7) NCD - INDEPENDENCE iBOT 4000 Mobility System (280.15) NCD - Infrared Therapy Devices (270.6) NCD - Mobility Assistive Equipment (MAE) (280.3) NCD - Neuromuscular Electrical Stimulation (NMES) (160.12) NCD - Seat Elevation Equipment (Power Operated) on Power Wheelchairs (280.16) NCD - Seat Lift (280.4)	Durable Medical Equipment.[4] Local Coverage Determinations (LCDs) for Noridian Healthcare Solutions, LLC. NCD: Durable Medical Equipment Reference List (280.1) NCD - Home Use of Oxygen (240.2) NCD - Hospital Beds (280.7) NCD - INDEPENDENCE iBOT 4000 Mobility System (280.15) NCD - Infrared Therapy Devices (270.6) NCD - Mobility Assistive Equipment (MAE) (280.3) NCD - Neuromuscular Electrical Stimulation (NMES) (160.12) NCD - Seat Elevation Equipment (Power Operated) on Power Wheelchairs (280.16) NCD - Seat Lift (280.4)
020	Enteral Nutrition Formulas and Supplements	LCD: Enteral Nutrition (L38955). LCD: Parenteral Nutrition (L38953).	LCD: Enteral Nutrition (L38955). LCD: Parenteral Nutrition (L38953).
021	Experimental and Investigational	No CMS criteria. 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	No CMS or MassHealth criteria. 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

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

		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.	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) and MassHealth 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.	CMS Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance. When the member does not meet CMS criteria, follow MassHealth criteria.
024	Gender Affirming Procedures	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS criteria. Please follow MassHealth criteria.
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.	For Cochlear Implant please use NCD: Cochlear Implantation (50.3). When the member does not meet medical necessity, follow MassHealth criteria. There are no CMS or MassHealth criteria 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.	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	Mass General Brigham Health Plan utilizes InterQual® Medicare criteria in reviewing medical necessity for Home Health Care.[5] NCD - Home Health Nurses' Visits to Patients Requiring Heparin Injection (290.2) NCD - Home Health Visits to a Blind Diabetic (290.1) LCD - Home Health - Psychiatric Care (L34561) LCD - Home Health Occupational Therapy (L34560) LCD - Home Health Physical Therapy (L34564) LCD - Home Health Plans of Care: Monitoring Glucose Control in the Medicare Home Health Population with Type II Diabetes Mellitus (L35132) LCD - Home Health Skilled Nursing Care-Teaching and Training: Alzheimer's Disease and Behavioral Disturbances (L34562) LCD - Home Health Speech-Language Pathology (L34563) LCD - Home Health-Surface Electrical Stimulation in the Treatment of Dysphagia (L34565) LCD - Physical Therapy - Home Health (L33942)	Mass General Brigham Health Plan utilizes InterQual® Medicare criteria in reviewing medical necessity for Home Health Care. NCD - Home Health Nurses' Visits to Patients Requiring Heparin Injection (290.2) NCD - Home Health Visits to a Blind Diabetic (290.1) LCD - Home Health - Psychiatric Care (L34561) LCD - Home Health Occupational Therapy (L34560) LCD - Home Health Physical Therapy (L34564) LCD - Home Health Plans of Care: Monitoring Glucose Control in the Medicare Home Health Population with Type II Diabetes Mellitus (L35132) LCD - Home Health Skilled Nursing Care-Teaching and Training: Alzheimer's Disease and Behavioral Disturbances (L34562) LCD - Home Health Speech-Language Pathology (L34563) LCD - Home Health-Surface Electrical Stimulation in the Treatment of Dysphagia (L34565) LCD - Physical Therapy - Home Health (L33942)

[5] 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). Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea (L38276) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38307) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38310) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38398) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38312) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38385) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38528)	LCD: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38387). Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea (L38276) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38307) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38310) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38398) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38312) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38385) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38528)
029	Infertility Services/Assisted Reproductive Services	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS criteria. Noncovered by MassHealth. Please follow the Mass General Brigham Health Plan Commercial policy.
030	Insulin Pumps	LCD: External Infusion Pumps (L33794). Prior authorization is not required.	LCD: External Infusion Pumps (L33794). Prior authorization is not required.
031	Intravenous Ketamine for Treatment Resistant Depression	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services CMS criteria are nonspecific. Please follow	When member does not meet CMS criteria, follow MassHealth criteria.

		the Mass General Brigham Health Plan Commercial policy.	
032	Kymriah	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services The NCD lacks sufficient specificity to ensure consistent medical review and coverage decisions. Please follow the Mass General Brigham Health Plan commercial policy.	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.
033	Lutathera (Lutetium Lu 177 Dotate)	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services CMS criteria are nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services CMS criteria are nonspecific and there are no MassHealth criteria. Please follow the Mass General Brigham Health Plan Commercial policy.
034	Luxturna	LCD: Voretigene Neparvovec-rzyl (Luxturna) (L37863) If member is outside MAC jurisdiction, follow the Mass General Brigham medical policy.	LCD: Voretigene Neparvovec-rzyl (Luxturna) (L37863) If member is outside MAC jurisdiction, use MassHealth criteria.
036	Neuromodulation for Overactive Bladder and Fecal Incontinence	LCD: Posterior Tibial Nerve Stimulation for Voiding Dysfunction (L33396) LCD: Sacral Nerve Stimulation for the Treatment of Urinary and Fecal Incontinence (L39543) NCD: Sacral Nerve Stimulation for Urinary Incontinence (230.18).	LCD: Posterior Tibial Nerve Stimulation for Voiding Dysfunction (L33396) LCD: Sacral Nerve Stimulation for the Treatment of Urinary and Fecal Incontinence (L39543) NCD: Sacral Nerve Stimulation for Urinary Incontinence (230.18).

		For Fecal Incontinence outside of the Palmetto MAC area, please follow the Mass General Brigham Health Plan Commercial policy.	For Fecal Incontinence outside of the Palmetto MAC area, 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.	CMS Medicare Benefit Policy Manual, Chapter 10 Ambulance Services. When member does not meet CMS criteria or there are no CMS criteria, follow MassHealth criteria.
038	Oral and Maxillofacial Surgery and Procedures	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS criteria. For orthognathic surgery, follow the MassHealth criteria. For other services, follow the Mass General Brigham Health Plan Commercial policy.
040	Outpatient Chest Physical Therapy	LCD - Respiratory Care (L34149) LCD - Respiratory Care (L37293) LCD - Respiratory Therapy (Respiratory Care) (L34430) For members living outside the MAC jurisdictions, please follow the Mass General Brigham Health Plan Commercial policy.	LCD - Respiratory Care (L34149) LCD - Respiratory Care (L37293) LCD - Respiratory Therapy (Respiratory Care) (L34430) For members living outside the MAC jurisdictions, please follow the Mass General Brigham Health Plan Commercial policy.
041	Outpatient Drug Screening and Testing	Urine Drug Testing L39611 Urine Drug Testing L36029 Urine Drug Testing L36668 Urine Drug Testing L36707 Urine Drug Testing L35724 Urine Drug Testing L34645 LCD - Controlled Substance Monitoring	Urine Drug Testing L39611 Urine Drug Testing L36029 Urine Drug Testing L36668 Urine Drug Testing L36707 Urine Drug Testing L35724 Urine Drug Testing L34645 LCD - Controlled Substance Monitoring

		and Drugs of Abuse Testing (L36393) LCD - Controlled Substance Monitoring and Drugs of Abuse Testing (L35006)	and Drugs of Abuse Testing (L36393) LCD - Controlled Substance Monitoring and Drugs of Abuse Testing (L35006)
042	Phototherapeutic Keratectomy	NCD: Refractive Keratoplasty (80.7) The NCD is nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	NCD: Refractive Keratoplasty (80.7) The NCD is nonspecific and MassHealth considers the service nonpayable. Please follow the Mass General Brigham Health Plan Commercial policy.
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.	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 CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS criteria, and MassHealth does not consider the service payable. Please follow the Mass General Brigham Health Plan Commercial policy.
045	Prostatic Urethral Lift	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS or MassHealth criteria. Please follow the Mass General Brigham Health Plan Commercial policy.
046	Prostheses - Lower Limb	NCD - Prosthetic Shoe (280.10) LCD: Lower Limb Prostheses (L33787).	NCD - Prosthetic Shoe (280.10) LCD: Lower Limb Prostheses (L33787).
047	Prostheses - Upper Limb	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS or MassHealth criteria. Please follow the Mass General Brigham Health Plan Commercial policy.
048	Provenge	NCD: Autologous Cellular Immunotherapy Treatment (110.22). Medicare Benefit Policy Manual Chapter 15 -	NCD: Autologous Cellular Immunotherapy Treatment (110.22). Medicare Benefit Policy Manual Chapter 15 -

		Covered Medical and Other Health Services	Covered Medical and Other Health Services
049	Prostate-Specific Membrane Antigen Imaging for Patients for Prostate Cancer	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS or MassHealth criteria. Please follow the Mass General Brigham Health Plan Commercial policy.
050	Radiofrequency Ablation to Treat Uterine Fibroids	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS or MassHealth criteria. Please follow the Mass General Brigham Health Plan Commercial policy.
051	Reconstructive and Cosmetic Procedures	NCD - Treatment of Actinic Keratosis (250.4) NCD - Plastic Surgery to Correct "Moon Face" (140.4) CMS Medicare Benefit Policy Manual Chapter 16- General Exclusions from Coverage LCD - Varicose Veins of the Lower Extremity, Treatment of (L33575) LCD - Varicose Veins of the Lower Extremity, Treatment of (L34082) LCD - Treatment of Varicose Veins of the Lower Extremities (L34010) LCD - Treatment of Varicose Veins of the Lower Extremities (L34209) LCD - Treatment of Varicose Veins of the Lower Extremities (L39121) LCD - Treatment of Varicose Veins of the Lower Extremities (L34536) LCD - Blepharoplasty, Blepharoptosis and Brow Lift (L34528)	NCD - Treatment of Actinic Keratosis (250.4) NCD - Plastic Surgery to Correct "Moon Face" (140.4) CMS Medicare Benefit Policy Manual Chapter 16- General Exclusions from Coverage LCD - Varicose Veins of the Lower Extremity, Treatment of (L33575) LCD - Varicose Veins of the Lower Extremity, Treatment of (L34082) LCD - Treatment of Varicose Veins of the Lower Extremities (L34010) LCD - Treatment of Varicose Veins of the Lower Extremities (L34209) LCD - Treatment of Varicose Veins of the Lower Extremities (L39121) LCD - Treatment of Varicose Veins of the Lower Extremities (L34536) LCD - Blepharoplasty, Blepharoptosis and Brow Lift (L34528)

		LCD - Blepharoplasty, Eyelid Surgery, and Brow Lift (L34194) LCD - Blepharoplasty, Eyelid Surgery, and Brow Lift (L36286) LCD - Blepharoplasty, Eyelid Surgery, and Brow Lift (L34411) LCD - Blepharoplasty (L33944) LCD - Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow (L34028) LCD - Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow (L35004) LCD - Cosmetic and Reconstructive Surgery (L39506) LCD - Cosmetic and Reconstructive Surgery (L38914) LCD - Cosmetic and Reconstructive Surgery (L35090) LCD - Cosmetic and Reconstructive Surgery (L33428) LCD - Cosmetic and Reconstructive Surgery (L39051) LCD - Plastic Surgery (L35163) LCD - Plastic Surgery (L37020) LCD - Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L33979) LCD - Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L34233)	LCD - Blepharoplasty, Eyelid Surgery, and Brow Lift (L34194) LCD - Blepharoplasty, Eyelid Surgery, and Brow Lift (L36286) LCD - Blepharoplasty, Eyelid Surgery, and Brow Lift (L34411) LCD - Blepharoplasty (L33944) LCD - Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow (L34028) LCD - Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow (L35004) LCD - Cosmetic and Reconstructive Surgery (L39506) LCD - Cosmetic and Reconstructive Surgery (L38914) LCD - Cosmetic and Reconstructive Surgery (L35090) LCD - Cosmetic and Reconstructive Surgery (L33428) LCD - Cosmetic and Reconstructive Surgery (L39051) LCD - Plastic Surgery (L35163) LCD - Plastic Surgery (L37020) LCD - Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L33979) LCD - Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L34233)

		LCD - Removal of Benign and Malignant Skin Lesions (L33445) LCD - Removal of Benign Skin Lesions (L34200) LCD - Removal of Benign Skin Lesions (L34938) LCD - Removal of Benign Skin Lesions (L35498) LCD - Mohs Micrographic Surgery (L34195) LCD - Mohs Micrographic Surgery (L35702) LCD - Mohs Micrographic Surgery (L35704) LCD - Mohs Micrographic Surgery (L35494) LCD - Mohs Micrographic Surgery (MMS) (L33689) LCD - Mohs Micrographic Surgery (MMS) (L34961)	LCD - Removal of Benign and Malignant Skin Lesions (L33445) LCD - Removal of Benign Skin Lesions (L34200) LCD - Removal of Benign Skin Lesions (L34938) LCD - Removal of Benign Skin Lesions (L35498) LCD - Mohs Micrographic Surgery (L34195) LCD - Mohs Micrographic Surgery (L35702) LCD - Mohs Micrographic Surgery (L35704) LCD - Mohs Micrographic Surgery (L35494) LCD - Mohs Micrographic Surgery (MMS) (L33689) LCD - Mohs Micrographic Surgery (MMS) (L34961)
053	Speech Generating Devices	NCD - Speech Generating Devices (50.1) LCD: Speech Generating Devices (SGD) (L33739). Local Coverage Article: Speech Generating Devices (SGD) – Policy Article (A52469).	NCD - Speech Generating Devices (50.1) 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) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services The NCD lacks sufficient specificity to ensure consistent medical review and coverage decisions. Please follow the Mass General Brigham Health Plan commercial policy.	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services When the member does not meet CMS criteria, use MassHealth criteria.
055	Therapeutic Lens	NCD: Hydrophilic Contact Lens for Corneal Bandage 80.1	NCD: Hydrophilic Contact Lens for Corneal Bandage 80.1

		NCD: Hydrophilic Contact Lenses 80.4 NCD: Scleral Shell 80.5 LCD - Refractive Lenses (L33793) Article - Refractive Lenses - Policy Article (A52499)	NCD: Hydrophilic Contact Lenses 80.4 NCD: Scleral Shell 80.5 LCD - Refractive Lenses (L33793) Article - Refractive Lenses - Policy Article (A52499) When the member does not meet CMS criteria, follow MassHealth criteria.
057	UVB Home Phototherapy for Skin Disease	NCD - Durable Medical Equipment Reference List (280.1) The NCD is nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	NCD - Durable Medical Equipment Reference List (280.1) The NCD is nonspecific, and MassHealth does not consider the service payable. Please follow the Mass General Brigham Health Plan Commercial policy.
058	Vitamin D Screening and Testing in Adults	LCD - Vitamin D Assay Testing (L33996) LCD - Vitamin D Assay Testing (L37535) LCD - Vitamin D Assay Testing (L36692) LCD - Vitamin D Assay Testing (L39391) LCD - Vitamin D Assay Testing (L34658) LCD - Vitamin D; 25 hydroxy, includes fraction(s), if performed (L33771)	LCD - Vitamin D Assay Testing (L33996) LCD - Vitamin D Assay Testing (L37535) LCD - Vitamin D Assay Testing (L36692) LCD - Vitamin D Assay Testing (L39391) LCD - Vitamin D Assay Testing (L34658) LCD - Vitamin D; 25 hydroxy, includes fraction(s), if performed (L33771)
059	Yescarta	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services The NCD lacks sufficient specificity to ensure consistent medical review and coverage decisions. Please follow the Mass General	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services When the member does not meet CMS criteria, follow MassHealth criteria.

		Brigham Health Plan commercial policy.	
060	Zolgensma	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services Criteria nonspecific. Please follow MassHealth criteria.
061	Carvytki	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services The NCD lacks sufficient specificity to ensure consistent medical review and coverage decisions. Please follow the Mass General Brigham Health Plan commercial policy.	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services When the member does not meet CMS criteria, follow MassHealth criteria.
062	Pluvicto	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services When the member does not meet CMS criteria, follow MassHealth criteria.
064	Vertebral Body Tethering	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS or MassHealth criteria. Please follow the Mass General Brigham Health Plan Commercial policy.
065	Skysona	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services When the member does not meet CMS criteria, follow MassHealth criteria.

066	Transurethral Waterjet Ablation of the Prostate	LCD: Fluid Jet System Treatment for LUTS/BPH (38367). LCD: Transurethral Waterjet Ablation of the Prostate (L38726) LCD: Transurethral Waterjet Ablation of the Prostate (L38705) LCD: Transurethral Waterjet Ablation of the Prostate (L38712) LCD: Transurethral Waterjet Ablation of the Prostate (38707) LCD: Transurethral Waterjet Ablation of the Prostate (L38549) LCD: Transurethral Waterjet Ablation of the Prostate (L38682) LCD: Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (BPH) (L38378)	LCD: Fluid Jet System Treatment for LUTS/BPH (38367). LCD: Transurethral Waterjet Ablation of the Prostate (L38726) LCD: Transurethral Waterjet Ablation of the Prostate (L38705) LCD: Transurethral Waterjet Ablation of the Prostate (L38712) LCD: Transurethral Waterjet Ablation of the Prostate (38707) LCD: Transurethral Waterjet Ablation of the Prostate (L38549) LCD: Transurethral Waterjet Ablation of the Prostate (L38682) LCD: Fluid Jet System in the Treatment of Benign Prostatic Hyperplasia (BPH) (L38378)
067	Hemgenix	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.
068	Adstiladrin	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.
070	Roctavian	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.

		General Brigham Health Plan Commercial policy.	
071	Balloon Dilation of the Eustachian Tube	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS or MassHealth criteria. Please follow the Mass General Brigham Health Plan Commercial policy.
072	Elevidys	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.
073	Vyjuvek	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.
074	Omisirge	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.
075	Casgevy	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.
077	Amtagvi	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.

078	Lyfgenia	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.
079	Zynteglo	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.
080	Lenmeldy	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.
081	Liposuction for the Treatment of Lipedema and Lymphedema	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy.	No CMS or MassHealth criteria. Please follow the Mass General Brigham Health Plan Commercial policy.
085	Breast Imaging	NCD: Percutaneous Image-Guided Breast Biopsy 220.13 LCD: Breast Imaging Mammography/Breast Echography (Sonography)/Breast MRI/Ductography (L33950) LCD: Breast Imaging: Breast Echography (Sonography)/Breast MRI/Ductography (L33585)	NCD: Percutaneous Image-Guided Breast Biopsy 220.13 LCD: Breast Imaging Mammography/Breast Echography (Sonography)/Breast MRI/Ductography (L33950) LCD: Breast Imaging: Breast Echography (Sonography)/Breast MRI/Ductography (L33585) When member does not meet CMS criteria for breast MRI, follow MassHealth criteria. When member does not

			meet CMS criteria for other services, follow the Mass General Brigham Health Plan Commercial Policy.
086	Medically Necessary Services	No CMS criteria. Please follow the Mass General Brigham Health Plan Commercial policy. Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for medical necessity determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and documentation included in the Medicare manuals are the basis for medical necessity determinations. Mass General Brigham Health Plan does not cover services listed in section 1862 of the Social Security Act (42 U.S.C. 1395y), "Exclusions from coverage and Medicare as a secondary payer". When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan medical policies are used for medical necessity determinations, including InterQual criteria (Change Healthcare) and other vendor polices for services such as sleep	No CMS or MassHealth criteria. Please follow the Mass General Brigham Health Plan Commercial policy. Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for medical necessity determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and documentation included in the Medicare manuals are the basis for medical necessity determinations. Mass General Brigham Health Plan does not cover services listed in section 1862 of the Social Security Act (42 U.S.C. 1395y), "Exclusions from coverage and Medicare as a secondary payer". When there is no guidance from CMS for the requested service, MassHealth criteria are used for medical necessity determinations. When there is no guidance from CMS or MassHealth, Mass General Brigham Health Plan medical policies are used for

		apnea supplies and genetic testing. If a service is requested that requires medical necessity determination but no medical necessity criteria are available from CMS, InterQual or Mass General Brigham Health Plan medical policies, a medical director will review the request. The Medical director may also utilize external specialists to review requests.	medical necessity determinations, including InterQual criteria (Change Healthcare) and other vendor polices for services such as sleep apnea supplies and genetic testing. If a service is requested that requires medical necessity determination but no medical necessity criteria are available from CMS, InterQual or Mass General Brigham Health Plan medical policies, a medical director will review the request. The Medical director may also utilize external specialists to review requests.
087	Tecelra	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services Criteria nonspecific. Please follow the Mass General Brigham Health Plan Commercial policy.	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.
088	Aucatzyl	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services The NCD lacks sufficient specificity to ensure consistent medical review and coverage decisions. Please follow the Mass General Brigham Health Plan commercial policy.	NCD: Chimeric Antigen Receptor (CAR) T-cell Therapy (110.24) Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services When the member does not meet CMS criteria, follow MassHealth criteria.
089	Fertility Services/Assisted Reproductive Services	No CMS criteria. Please follow the Mass General	No CMS criteria. Noncovered by MassHealth. Please

		Brigham Health Plan Commercial policy.	follow the Mass General Brigham Health Plan Commercial policy.
097	Interventional Pain Management of the Spine	LCD: Epidural Steroid Injections for Pain Management (L39015) LCD: Epidural Steroid Injections for Pain Management (L33906) LCD: Epidural Steroid Injections for Pain Management (L39240) LCD: Epidural Steroid Injections for Pain Management (L39242) LCD: Epidural Steroid Injections for Pain Management (L36920) LCD: Epidural Steroid Injections for Pain Management (L38994) LCD: Epidural Steroid Injections for Pain Management (L39054) LCD - Facet Joint Interventions for Pain Management (L38773) LCD - Facet Joint Interventions for Pain Management (L33930) LCD - Facet Joint Interventions for Pain Management (L35936) LCD - Facet Joint Interventions for Pain Management (L38801) LCD - Facet Joint Interventions for Pain Management (L38803) LCD - Facet Joint Interventions for Pain Management (L34892) LCD - Facet Joint Interventions for Pain Management (L38765) LCD - Facet Joint Interventions for Pain Management (L38841)	LCD: Epidural Steroid Injections for Pain Management (L39015) LCD: Epidural Steroid Injections for Pain Management (L33906) LCD: Epidural Steroid Injections for Pain Management (L39240) LCD: Epidural Steroid Injections for Pain Management (L39242) LCD: Epidural Steroid Injections for Pain Management (L36920) LCD: Epidural Steroid Injections for Pain Management (L38994) LCD: Epidural Steroid Injections for Pain Management (L39054) LCD - Facet Joint Interventions for Pain Management (L38773) LCD - Facet Joint Interventions for Pain Management (L33930) LCD - Facet Joint Interventions for Pain Management (L35936) LCD - Facet Joint Interventions for Pain Management (L38801) LCD - Facet Joint Interventions for Pain Management (L38803) LCD - Facet Joint Interventions for Pain Management (L34892) LCD - Facet Joint Interventions for Pain Management (L38765) LCD - Facet Joint Interventions for Pain Management (L38841)

		LCD: Intraosseous Basivertebral Nerve Ablation (L39642) LCD: Intraosseous Basivertebral Nerve Ablation (L39644) LCD: Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain (L39420) For members outside of the MAC jurisdictions, please follow the Mass General Brigham Health Plan Commercial policy.	LCD: Intraosseous Basivertebral Nerve Ablation (L39642) LCD: Intraosseous Basivertebral Nerve Ablation (L39644) LCD: Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain (L39420) For members outside of the MAC jurisdictions, please follow the Mass General Brigham Health Plan Commercial policy.
099	DefenCath	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services	Medicare Benefit Policy Manual Chapter 15: Covered Medical and Other Health Services When member does not meet CMS criteria, follow MassHealth criteria.

Effective Date

January 2026: Off-cycle Update. Made the following edits to Table 1:

- Updated policy for OneCare and SCO members
- Removed (retired)
  - 04: Acute Inpatient
  - 76: Basivertebral Nerve Ablation
  - 84: Epidural Steroid Injection
- Added
  - 89: Fertility Services/Assisted Reproductive Services
  - 97: Interventional Pain Management of the Spine
  - 99: DefenCath
- Updated NCD/LCD information for:
  - Abecma
  - Acupuncture
  - Adstiladrin
  - Amtagvi
  - Aucatzyl
  - Bariatric Surgery
  - Breast Surgeries
  - Carvykti
  - Casgevy
  - Chiropractic Services
  - Durable Medical Equipment
  - Elevidys

- Hemgenix
- Home Health Care
- Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea
- Intravenous Ketamine for Treatment-Resistant Depression
- Kymriah
- Lenmeldy
- Lutathera
- Luxturna
- Lyfgenia
- Omisirge
- Outpatient Chest Physical Therapy
- Outpatient Drug Screening and Testing
- Pluvicto
- Prostheses – Lower Limb
- Provenge
- Reconstructive and Cosmetic Procedures
- Roctavian
- Skysona
- Speech Generating Devices
- Tecartus
- Tecelra
- Therapeutic Lens
- UVB Home Phototherapy for Skin Disease
- Vitamin D Testing and Screening in Adults
- Vyjuvek
- Yescarta
- Zolgensma
- Zynteglo

May 2025: Annual Update. Made the following edits to Table 1:

- Renumbered Zynteglo
- Updated name of and NCD and LCD information for policy 049
- Updated NCD and LCD information for:
  - Abecma
  - Acute Inpatient
  - Bariatric Surgery
  - Breast Surgeries
  - Breyanzi
  - Continuous Glucose Monitors
  - Home Health Care
  - Kymriah
  - Luxturna
  - Neuromodulation for Overactive Bladder and Fecal Incontinence
  - Outpatient Drug Screening and Testing
  - Tecartus
  - Therapeutic Lens
  - Vitamin D Screening and Testing in Adults
  - Yescarta
  - Carvytki

    - Skysona
    - Transurethral Waterjet Ablation of the Prostate
- Added the following to Table 1:
    - 064: Vertebral Body Tethering
    - 072: Elevidys
    - 073: Vyjuvek
    - 074: Omisirge
    - 075: Casgevy
    - 076: Basivertebral Nerve Ablation
    - 077: Amtagvi
    - 078: Lyfgenia
    - 080: Lenmeldy
    - 081: Liposuction for Lipedema and Lymphedema
    - 084: Epidural Steroid Injections
    - 085: Breast Imaging
    - 086: Medically Necessary Services
    - 087: Tecelra
    - 088: Aucatzyl
- Removed the following from Table 1:
    - 02: Absorbent Products for Incontinence as not a covered service for Medicare Advantage members.
    - 05: Arthrodesis of Sacroiliac Joint Pain: policy retired
    - 06: Artificial Pancreas Device System: policy retired
    - 012: Bronchial Thermoplasty: policy retired
    - 035: Mobile Cardiac Outpatient Telemetry: policy retired
    - 056: Tumor Treating Fields: policy retired

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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