Blue Cross and Blue Shield of Nebraska (BCBSNE) is proud to work with our provider network to serve your patients, our members. We are updating several medical policies. Please review the changes and effective dates outlined here:

Medicare Advantage Medical Policy: Ablation of Peripheral Nerves to Treat Pain
Effective: 01/01/2024
Preauthorization Required: YES
Policy Statement:

I. Radiofrequency ablation or cryoneurolysis of peripheral nerves to treat pain associated with knee osteoarthritis, total knee arthroplasty, plantar fasciitis, occipital neuralgia, or cervicogenic headache is considered **investigational**.

II. Intercostal nerve cryoablation during pectus excavatum surgery, including Nuss procedure, for pain control is considered **investigational**.

III. Ablation of peripheral nerves to treat pain is considered **investigational** in all other conditions, with the exception of facet joint pain.

Medicare Advantage Medical Policy: Ambulatory Event Monitors and Mobile Cardiac Outpatient
Effective: 01/01/2024
Preauthorization Required: YES
Policy Statement:

I. External 48-hour ECG recording may be considered medically necessary for **ANY** of the following:

A. Arrhythmias **OR**
B. Chest pain **OR**
C. Syncope (lightheadedness) or near syncope **OR**
D. Vertigo (dizziness) **OR**
E. Palpitations **OR**
F. Transient ischemic episodes **OR**
G. Dyspnea (shortness of breath) **OR**
H. Evaluation of the response to antiarrhythmic drug therapy **OR**
I. Evaluation of myocardial infarction (MI) survivors with an ejection fraction of 40% or less **OR**
J. Assessment of patients with coronary artery disease with active symptoms, to correlate chest pain with ST-segment changes **OR**
K. Other acute and subacute forms of ischemic heart disease **OR**
L. To detect arrhythmias, post ablation procedures

II. External electrocardiographic recording **OR** event monitors may be considered medically necessary is the following criteria are met:

A. External electrocardiographic recording/external electrocardiographic event monitors for greater than 48 hours and up to 7 days or for greater than 7 days up to 15 days that are either patient-activated or auto-activated may be considered medically necessary as a diagnostic alternative to Holter monitoring in patients who experience infrequent symptoms (less frequently than every 48 hours) suggestive of cardiac arrhythmias (i.e., palpitations, dizziness, presyncope, or syncope).

III. Long term 30-day monitoring: Telephonic Transmission of ECG involves 24 hour attended monitoring per 30-day period of time; no other EKG monitoring codes can be billed simultaneously with these codes.

A. Indications for performing a Telephonic Transmission:

1. Arrhythmias
2. Chest pain
3. Syncope (lightheadedness) or near syncope
4. Vertigo (dizziness)
5. Palpitations
6. Transient ischemic episodes
7. Dyspnea (shortness of breath)
8. To initiate, revise or discontinue arrhythmia drug therapy.
9. Evaluation of myocardial infarction (MI) survivors.
10. Evaluation of acute and subacute forms of ischemic heart disease.
11. Assessment of patients with coronary artery disease with active symptoms, to correlate chest pain with ST-segment changes

IV. Implantable loop recorders in adults and children may be considered **medically necessary** for **ANY** of the following:

A. member has recurrent and unexplained symptoms suggestive of an arrhythmia such as palpitations, dizziness, near syncope or syncope that occur less frequently than once a month making it unlikely to be diagnosed by external cardiac event monitoring or when these studies are non-diagnostic **OR**

B**.** to assess the results after an ablation procedure performed for an arrhythmia OR

C. member with cryptogenic stroke with whom atrial fibrillation is suspected to be the cause and a 24-hour Holter monitor or hospital telemetry is non-diagnostic.

D. genetically based arrhythmia conditions (LongQT Syndrome, Short QT Syndrome, Brugada Syndrome, Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) in whom:

1. there is suspicion of symptoms only while sleeping **OR**
2. the family history is that of cardiac arrest while sleeping **OR**

E. patients with developmental delays precluding accurate symptom description but in whom there is sufficient reason (clinical signs/symptoms, family history) to believe the patient is at risk for an arrhythmia.

V.. Implantable loop recorders are considered **investigational** for all other indications not listed above because their effectiveness for other indications has not been established.

Medicare Advantage Medical Policy: Bioengineered Skin and Soft Tissue Substitutes
Effective: 01/01/2024
Preauthorization Required: YES
Policy Statement:

I. The use of bioengineered skin and soft tissue substitutes is considered **scientifically validated** for the following indications:

A. Breast reconstruction **OR**
B. Diabetic lower extremity ulcers **OR**
C. Venous insufficiency lower extremity ulcers **OR**
D. Dystrophic epidermolysis bullosa **OR**
E. Second- or third-degree burns.

II. The use of bioengineered skin and soft tissue substitutes is considered **investigational** for all other indications.

Autologous Cell Harvesting Device
I. Autologous cell harvesting device (e.g., RECELL system) is considered **scientifically validated** for the treatment of 2nd and 3rd degree burns when the following criteria is met:

A. **ONE** of the following:
1. acute partial thickness (2nd and 3rd degree burns in patients 18 years of age and older **OR**
2. in combination with meshed autografting for acute full thickness thermal burn wounds in pediatric or adult patients with 3rd degree burns.

AND

B. The member has **NONE** of the following contraindications.
1. wounds clinically diagnosed as infected or with necrotic tissue present in the wound bed **AND**
2. patients with a known hypersensitivity to trypsin or compound sodium lactate solution (e.g., Hartmann's Solution **AND**
3. patients with a known hypersensitivity to anesthetics, adrenaline/epinephrine, povidone-iodine or chlorhexidine solutions **AND**

II. All other uses of autologous cell harvesting device (RECELL system) is considered **investigational.**

Medicare Advantage Medical Policy: Computer Assisted Musculoskeletal Surgical Navigation
Effective: 01/01/2024
Preauthorization Required: YES
Policy Statement:

I. Computer-assisted musculoskeletal surgical navigation for orthopedic procedures of the pelvis, appendicular skeleton, and lumbar spine is **investigational.**

II. Radiology studies performed solely to support preoperative surgical navigation for orthopedic procedures of the pelvis, appendicular skeleton, and lumbar spine is **investigational.**

III. Computer-assisted surgical navigation, including the preoperative CT or MRI (e.g., MAKOplasty/MAKO Tactile Guidance System) for hip and knee replacement is considered **investigational**.

Benefits are still payable for the main musculoskeletal surgery. The surgical navigation should be the only procedure that is denied as investigative.

Medicare Advantage Medical Policy: Cosmetic and Reconstructive Surgery
Effective: 01/01/2024
Preauthorization Required: YES
Policy Statement:

I. Breast reconstruction to the affected and contralateral breast may be medically necessary following a medically necessary mastectomy.
II. Removal or revision of a breast implant whether placed for reconstructive or cosmetic reasons may be medically necessary when it is removed for one of the following reasons:
    A. Mechanical complication of breast prosthesis; including rupture or failed implant, and/or implant extrusion.
    B. Infection or inflammatory reaction due to a breast prosthesis; including infected breast implant, or rejection of breast implants.
    C. Other complication of internal breast implant; including siliconoma, granuloma, interference with diagnosis of breast cancer, and/or painful capsular contracture with disfigurement.

III. Breast Reduction to reduce or lift enlarged or sagging breasts to reshape the breasts to improve appearance is considered cosmetic and not a Medicare benefit.
IV. A breast reduction may be medically necessary when:
    A. There are signs and/or symptoms resulting from the enlarged breasts (macromastia) that have not responded adequately to non-surgical interventions (See Guidelines Below) and meet one of the following:
        1. Back, neck or shoulder pain from macromastia and unrelieved by 6 months of:
           - Conservative analgesia,
           - Supportive measures (garment, etc.),
           - Physical Therapy, OR
        2. Significant arthritic changes in the cervical or upper thoracic spine, optimally managed with persistent symptoms and/or significant restriction of activity, OR
        3. Intertriginous maceration or infection of the inframammary skin refractory related to dermatologic measures OR
        4. Permanent shoulder grooving with skin irritation by supporting garment (bra strap).

        AND

        5. The amount of breast tissue to be removed must be proportional to the body surface area (BSA) per the Schnur18 scale (See below)

            Note: If the individual's body surface area and weight of breast tissue removed fall above the 22nd percentile, then the surgery is considered medically reasonable and necessary with the appropriate criteria. If only one breast meets the Schnur scale criteria; breast tissue may be removed from the other breast in order to achieve symmetry.

    OR

    B. To improve or correct asymmetry following cancer surgery on one breast.

        Note: either the involved breast or contralateral breast may be treated to achieve symmetry.
        Note: For coverage indications for contralateral reconstruction of an unaffected breast following a medically necessary mastectomy, refer to the CMS Internet-Only Manual, Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §140.2.

Guidelines:

Non-surgical interventions preceding breast reduction should include as appropriate, but are not limited to, the following:

C. Determining the macromastia is not due to an active endocrine or metabolic process.
D. Determining the symptoms are refractory to appropriately fitted supporting garments, or following unilateral mastectomy, persistent with an appropriately fitted prosthesis or reconstruction therapy at the site of the absent breast.
E. Determining that dermatologic signs and/or symptoms are refractory to, or recurrent following, a completed course of medical management.

Schnur Scale:

Body Surface Area (m2)	Average grams of tissue per breast to be removed
1.40-1.50	218-260
1.51–1.60	261-310
1.61-1.70	311-370
1.71-1.80	371-441
1.81-1.90	442-527
1.91-2.00	528-628
2.01-2.10	629-750
2.11-2.20	751-895
2.21-2.30	896-1068
2.31-2.40	1069-1275
2.41-2.50	1276-1522
2.51-2.60	1523-1806
2.61-2.70	1807-2154
2.71-2.80	2155-2568
2.81-2.90	2569-3061
2.91-3.00	3062-3650

V.Mastectomy for gynecomastia with nipple preservation or reduction mammoplasty may be medically necessary for males with gynecomastia Grade III and IV or abnormal breast development with redundancy when following criteria are met:

F. Persists more than 3 to 4 months after the pathological causes are ruled out (e.g. not limited to testosterone deficiency, testicular tumor, liver disease, or drug induced).[34] AND
G. Persists after 3 to 4 months of unsuccessful medical treatment for pathological gynecomastia.[16] AND
H. Pain or tenderness directly related to the breast tissue which has a clinically significant impact upon activities of daily living. AND
I. Clinical symptoms refractory to a trial of analgesics or anti-inflammatory agents AND
J. For significant clinical manifestations when the excessive breast weight adversely affects the supporting structures of the shoulders, neck and trunk.

American Society of Plastic Surgeons' gynecomastia scale:[16]

K. Grade I: Small breast enlargement with localized button of tissue that is concentrated around the areola.
L. Grade II: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.
M. Grade III: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest with skin redundancy present.
N. Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast

VI. Subtotal mastectomy or reduction mammoplasty for the unusual condition of Gigantomastia of Pregnancy may be medically necessary when accompanied by any of the following complications (and delivery is not imminent) medically reasonable and necessary when signs or symptoms are refractory to medical treatment or physical interventions have not adequately alleviated symptoms such as:

O. Massive infection
P. Significant hemorrhage
Q. Tissue necrosis with slough
R. Ulceration of breast tissue
S. Intertriginous maceration or infection of the inframammary skin refractory to dermatologic measures.

VII. Tattooing To correct color defects of the skin may be considered reconstructive when performed in connection with a payable post-mastectomy reconstruction, or for reconstruction following trauma or removal of cancer from an eyelid, eyebrow or lip(s).

VIII.Punch graft hair transplant may be considered medically necessary when its performed for eyebrow(s) or symmetric hairline replacement following a burn injury, trauma or tumor removal.

IX.Rhinoplasty may be considered medically necessary when the procedure is performed for correction and repair for one of the following:

A. Secondary to trauma, disease, congenital defect with nasal airway obstruction that has not resolved after previous septoplasty/turbinectomy or would not be expected to resolve with septoplasty/turbinectomy alone.[19]
B. chronic, non-septal, nasal obstruction due to vestibular stenosis (i.e., collapsed internal valves).
C. nasal deformity secondary to a cleft lip/palate or other congenital craniofacial deformity causing a functional impairment. (e.g., cleft lip nasal deformities, choanal atresia, oronasal or oromaxillary fistula)[13]

X. Septoplasty may be considered medically necessary when performed for one of the following:

A. septal deviation/deformity causing nasal airway obstruction that has proved unresponsive to a trial of conservative medical management lasting at least 6 weeks (e.g. topical nasal corticosteroids, decongestants, antibiotic, allergy evaluation and therapy, etc.).[22, 23]
B. recurrent sinusitis (4 or more episodes in a year) secondary to a deviated septum that does not resolve after appropriate medical and antibiotic therapy., [20, 23]
C. recurrent epistaxis (4 or more significant episodes) related to a septal deformity.[20]
D. asymptomatic septal deformity that prevents access to other trans nasal areas when such access is required to perform medically necessary procedures (e.g., ethmoidectomy).
E. performed in association with cleft lip or cleft palate repair.[21]
F. obstructed nasal breathing due to septal deformity or deviation that has proved unresponsive to medical management and is interfering with the effective use of medically necessary Continuous Positive Airway Pressure (CPAP) for the treatment of an obstructive sleep disorder.[14]

XI. Chemical peel may be considered medically necessary for the treatment of Actinic Keratosis

XII. Dermabrasion

A. Dermabrasion may be considered medically necessary when correcting defects from one of the following:
    a. Traumatic injury OR

b. Surgery, OR
c. Disease OR
d. Segmental, face dermabrasion may be medically necessary for the diagnosis of Rhinophyma when used in conjunction with antimicrobial therapy.

B. Dermabrasion is considered cosmetic for the following indications:
a. Post acne scarring
b. Rosacea other than rhinophyma
c. All other indications not identified a

Note: Rhinophyma is characterized by skin thickening, which can cause an enlargement of the nose due to excess tissue and overgrowth of sebaceous glands.[7] Rhinophyma in its most severe cases can affect breathing and even vision.[3,7]

XIII. Dermal injections may be medically necessary for the diagnosis of Lipodystrophy syndrome (LDS) and only in Human Immunodeficiency virus (HIV)-infected Medicare beneficiaries who manifest depression secondary to their physical stigma of HIV treatment.

XIV. Abdominal Lipectomy/Panniculectomy may be medically necessary when the following criteria are met:

A. The pannus or panniculus hangs below the level of the pubis, and the medical records document that the panniculus causes chronic intertrigo [dermatitis occurring on opposed surfaces of the skin, skin irritation, infection or chafing that consistently recurs or remains refractory to appropriate medical therapy (e.g., topical antifungals, corticosteroids, antibiotics)] over a period of 3 months.[12] AND
B. When surgery is performed to alleviate such complicating factors as inability to walk normally due to pannus size, chronic pain, ulceration created by the abdominal skin fold, or intertrigal dermatitis, such surgery is considered reconstructive. Preoperative photographs may be required to support justification and should be supplied upon request.[12] AND (If applicable)
C. This procedure may also be medically necessary for the patient that has had a significant weight-loss following the treatment of morbid obesity, in addition to meeting the criteria noted above, there should be evidence that the individual has maintained a stable weight for at least 6 months. If the weight loss is the result of bariatric surgery, abdominoplasty/panniculectomy should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for at least the most recent 6 months and infection and inflammation has continued for the most recent 3 months.[12]

A. **Limitations**
1. Cosmetic surgery performed to treat psychiatric or emotional problems is not covered.

2. If a non-covered cosmetic surgery is performed in the same operative period as a covered surgical procedure, benefits will be provided for the covered surgical procedure only.
3. Dermabrasion
    - Post-acne scarring
    - Rosacea other than rhinophyma
    - All other indications not identified as covered in the section above
4. Abdominal Lipectomy/Panniculectomy
    - Repairing abdominal wall laxity, or diastasis recti
    - Redundancies resulting from weight loss or weight loss surgery when that tissue is without evidence of chronic infection or inflammation that is refractory to conservative treatment as outlines in the indications listed above.
    - Solely to improve appearance
    - All other indications unless covered in the section above

    Note: Abdominal Lipectomy/Panniculectomy is considered experimental and investigational for minimizing the risk of hernia formation or recurrence. There is no evidence that pannus contributes to hernia formation. The primary cause of hernia formation is an abdominal wall defect or weakness, not a pulling effect from a large or redundant pannus.

5. Liposuction used for body contouring, weight reduction or the harvest of fat tissue for transfer to another body region for alteration of appearance or self-image or physical appearance is considered cosmetic and not covered as medically necessary.
6. Reconstructive Breast Surgery: Removal of Breast Implants for re-implantation of an implant inserted for cosmetic purposes only and not for history of mastectomy for treatment of breast cancer, lumpectomy, or treatment of contralateral breast to bring it into symmetry with a reconstructed breast following cancer surgery is not a covered Medicare benefit.
7. Reduction Mammaplasty
    - Surgery performed primarily to reshape the breasts to improve appearance or self-image.
    - Mammapexy unrelated to breast reconstruction following a medically necessary mastectomy.
8. Mastectomy for gynecomastia
    - Breast reduction or surgical mastectomy for gynecomastia, either unilateral or bilateral, as the first line treatment.
    - When performed solely to improve appearance of the male breast or to alter contours of the chest wall.
9. Gigantomastia of Pregnancy
    - Surgery to reshape the breasts to improve appearance or self-image.
    - All other indications not identified as covered in the section above.

10. Corrective facial surgery will be considered cosmetic rather than reconstructive when there is no functional impairment present. However, some congenital, acquired, traumatic or developmental anomalies may not result in functional impairment, but are so severely disfiguring as to merit consideration for corrective surgery. These situations will be handled through the appeal process.
11. Thyroid chrondoplasty to alter the appearance of the thyroid cartilage which is without functional defect is considered cosmetic.
12. Rhinoplasty is not covered when performed for **either** of the following indications because it is considered cosmetic in nature or not medically necessary:
    - Solely for the purpose of changing appearance or improving self-image in the absence of any signs or symptoms of functional abnormalities.
    - As a primary treatment for an obstructive sleep disorder when the above criteria for approval have not been met.
13. Rhytidectomy is generally considered a cosmetic procedure. It may be considered medically necessary upon review to correct a functional impairment as a result of a disease state ie; facial paralysis. Often this procedure is performed in conjunction with other procedures to correct the impairment.

Medicare Advantage Medical Policy: Drug Eluting Sinus Stents
Effective: 01/01/2024
Preauthorization Required: YES
Policy Statement:

I. The use of drug-eluting sinus stents for postoperative treatment following endoscopic sinus surgery and for treatment of recurrent sinonasal polyposis is considered **investigational**.

II. The use of drug-eluting sinus stents is considered **investigational** in all other conditions.

Medicare Advantage Medical Policy: Dynamic Posturography
Effective: 01/01/2024
Preauthorization Required: YES

Policy Statement

I. Dynamic posturography is considered experimental/investigational. The evidence is insufficient to determine whether dynamic posturography improves health outcomes in patients with balance disorders.

Medicare Advantage Medical Policy: Implantable Bone Conduction and Bone Anchored Hearin Aid
Effective: 01/01/2024
Preauthorization Required: YES
Policy Statement

I. **Unilateral** fully or partially implantable bone-conduction, percutaneous or transcutaneous (bone-anchored) hearing aid(s) **may be considered medically necessary** as an alternative to an air-conduction hearing aid in patients 5 years of age and older with conductive or mixed sensorineural/conductive hearing loss, when the following criteria is met:

A. Must meet **ONE** of the following medical criteria:

1. Congenital or surgically induced malformations (eg, atresia) of the external ear canal or middle ear; **OR**

2. Chronic external otitis or otitis media; **OR**

3. Tumors of the external canal and/or tympanic cavity; **OR**

4. Dermatitis of the external canal.

AND

B. A pure-tone average bone-conduction threshold measured at 0.5, 1, 2, and 3 kHz of better than or equal to 45 dB (OBC and BP100 devices), 55 dB (Intenso device), or 65 dB (Cordele II device).

II. For **Bilateral** implantable bone-conduction, percutaneous or transcutanous bone anchored hearing aids for symmetrically conductive or mixed hearing loss **may be considered medically necessary** in patients 5 years of age and older patients meeting the above audiologic criteria (A and B) with loss as defined by a difference between left- and right-side bone-conduction threshold of < 10 dB on average measured at 0.5, 1, 2, and 3 kHz (4 kHz for OBC and Ponto Pro), or < 15 dB at individual frequencies.

III. For **Unilateral Sensorineural deafness** with normal hearing in the other ear an implantable bone-conduction, percutaneous or transcutaneous (bone-anchored) hearing aid **may be considered medically necessary** in patients 5 years of age and older patients when the pure-tone average air-conduction threshold of the normal ear is >20 dB measured at 0.5, 1, 2, and 3 kHz.

V. Other uses of implantable bone-conduction (bone-anchored) hearing aids, including use in patients with **bilateral sensorineural deafness**, are considered **investigational.**

Medicare Advantage Medical Policy: Myoelectric Upper-Limb Prosthetic
Effective: 01/01/2024
Preauthorization Required: YES

Policy Statement

I. Myoelectric upper-limb prosthetic components may be considered **medically necessary** when the **ALL** the following conditions are met:

A. The prosthetic device is ordered or provided by a physician or under the direction of a physician, **AND**

B. Amputee is evaluated by an independent qualified professional (prosthetist/orthoptist) to determine the most appropriate prosthetic components and control mechanism (e.g., body-powered, myoelectric, or combination of body-powered and myoelectric), **AND**

C. The patient has an amputation or missing limb at the wrist or above (e.g., forearm, elbow) due to trauma or congenital absence, **AND**

D. Standard body-powered prosthetic devices cannot be used or are insufficient to meet the functional needs of the individual in performing activities of daily living AND use of the limb for employment/school environment or extracurricular activities is not sufficient evidence for prescription of this device over standard prosthetic application, **AND**

E. The remaining musculature of the arm(s) contains the minimum microvolt threshold to allow operation of a myoelectric prosthetic device, **AND**

F. The patient has demonstrated sufficient neurologic and cognitive function to operate the prosthesis effectively, **AND**

G. The patient is free of comorbidities that could interfere with function of the prosthesis (e.g., neuromuscular disease), **AND**

H. Functional evaluation indicates that with training, use of a myoelectric prosthesis is likely to meet the functional needs of the individual (e.g., gripping, releasing, holding, coordinating movement of the prosthesis) when performing activities of daily living. This evaluation should consider the patient's needs for control, durability (maintenance), function (speed, work capability), and usability.

II. Myoelectric prostheses are contraindicated, and therefore considered **not medically necessary** for:

A. ADLs that require frequent lifting of heavy objects (16lbs or greater), **OR**

B. Environments involve frequent contact with dirt, dust, grease, water, and solvent, **OR**

C. When neuromas and/or phantom limb pain are exacerbated with the use of the prosthesis.

III. High-definition silicone used to make a prosthesis resemble a patient's skin is considered **not medically necessary** and cosmetic.

IV. Upper-limb prosthetic components **investigational** under all other conditions because their effectiveness has not been established, including but not limited to:

A. Advanced upper-limb prosthetic components with both sensor and myoelectric control (e.g., LUKE Arm).

B.A prosthesis with individually powered digits, including but not limited to a partial hand prosthesis (e.g., ProDigits).

C. Myoelectric controlled upper-limb orthoses.

D. Implantable myoelectric sensors for upper limb prostheses and hand prostheses.

E. Transcranial direct current stimulation for enhancing performance of myoelectric prostheses.

F. Adjustable click systems (e.g., Revo and Boa click systems).

G. Targeted muscle re-innervation for improved control of myoelectric upper limb prostheses and treatment of painful post-amputation **neuroma**.

H. Myo-electric hand prostheses.

V. The following supplies or accessories **may be medically necessary** for effective functioning of allowed equipment:

A. Prosthetic sheaths/socks, including a gel cushion layer (prosthetic gel stockings; 12 in 12 months).

B. No more than 2 socket inserts per individual prosthesis in 12 months. Any additional would be reviewed for medical necessity.

C. No more than two replacement liners per prosthesis in 12 months.

VI. One myoelectric prosthesis per limb per 5 (five) years is covered when medically indicated. Coverage will not be provided if the prosthesis is functioning properly and in good general condition.

VII. Evaluation of the member, measurement and/or casting, and fitting/adjustments of the prosthesis are included in the allowance for the prosthesis. There is no separate payment for these services. There is no separate payment if CAD-CAM technology is used to fabricate a prosthesis. Reimbursement is included in the allowance of the codes for a prosthesis.

VIII. Additional warranties and guarantees beyond the included base warranty or manufacturer warranty, are considered convenience items and are not medically necessary.

IX. Items billed for replacement that are still under manufacturer warranty are considered not medically necessary.

X. Custom fabricated socket inserts L6696 and L6697 are for atypical congenital or atypical traumatic amputations. These codes are for use only with the initial issue of a custom fabricated socket insert. Additional inserts (either custom fabricated or prefabricated) provided at the time of initial issue or replacement socket inserts are coded L6694, or L6695 whichever is applicable. There must be adequate documentation by the prosthetist of functional and/or physiological need for custom socket inserts. The simple entry of atypical amputation in those records is not sufficient.

XI. There is no separate payment for batteries (L7360, L7364, L7367, and L8505) and/or battery chargers (L7362, l7366, L7368) billed concurrently with a powered base item or associated add-ons.

Medicare Advantage Medical Policy: Percutaneous Disc Procedures
Effective: 01/01/2024
Preauthorization Required: YES

Policy Statement

I. Intradiscal electrothermal therapy (IDET) is considered **investigational.**

II. Endoscopic discectomy is considered **investigational** as a technique of intervertebral disc decompression in patients with back pain and/or radiculopathy related to disc herniation in the lumbar, thoracic, or cervical spine.

III. Percutaneous intradiscal radiofrequency thermocoagulation, percutaneous laser disc decompression, and percutaneous spinal discectomy are **investigational** for all indications

Medicare Advantage Medical Policy: Multimarker Algorithmic Testing for Ovarian Cancer
Effective: 01/01/2024
Preauthorization Required: YES

Policy Statement

Ovarian Cancer Diagnostic Algorithmic Tests

I. Ovarian cancer diagnostic algorithmic tests (i.e., OVA1, Overa, ROMA, and OvaWatch) (0003U, 81500, 81503, 0375U) may be considered **investigational** for all indications, including but not limited to:

   A. Preoperative evaluation of adnexal masses to triage for malignancy.
   B. Screening for ovarian cancer

C. Selecting patients for surgery for an adnexal mass
D. Evaluation of patients with clinical or radiologic evidence of malignancy
E. Evaluation of patients with nonspecific signs or symptoms suggesting possible malignancy
F. Postoperative testing and monitoring to assess surgical outcome and/or to detect recurrent malignant disease following treatment.