Connection

News for our Participating Provider Partners

March 2024

Excellus BlueCross BlueShield

Everybody Benefits

An independent licensee of the Blue Cross Blue Shield Association

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Stay in the Know!

Visit the Provider News and Updates page on our website to review recent communications. Be sure to log into our provider portal with your username and password to view all news updates.

To view topic specific bulletins, select one of the available categories or enter a keyword in the Search area. While viewing an article, you can click "Email this article" to share it with a friend or co-worker! Save our Provider News and Updates page as an online "favorite" for easy access.

Thank you for your continued *Connection* readership.

Thank you for your continued Connection readership. We welcome your suggestions, questions and comments. Email Maria Valvo, editor, at maria.valvo@excellus.com.

2023 APEX® AWARDS FOR PUBLICATION EXCELLENCE

NEWS YOU CAN USE

New Local and National Coverage Determination Policies

The Health Plan is applying the following Local Coverage Determination policy to our Medicare and Dual lines of business.

- LCD L33398 Transcranial Magnetic Stimulation

The following National Coverage Determination policy is applied to our Medicare and Dual lines of business.

- NCD 100.5 Diagnostic Breath Analyses

Watch: Learn How ACQAs Help Increase Care Quality

An Accountable Cost & Quality Agreement (ACQA) is our localized approach to value-based payment agreements.

ACQAs promote a better, more holistic patient experience for members while working to reduce unnecessary medical costs for all. Watch our 3-minute video or visit our blog to learn more about ACQAs

Check Out Our 2024 Navigating the Blues Schedule

Our Navigating the Blues educational series is a great start for new members of your staff. It provides valuable information about Excellus BlueCross BlueShield products, BlueCard®, how to verify patient copay and eligibility, and much more!

There are several online training sessions available throughout 2024 from which to choose. Check out the full schedule here.

Public Health Emergency 'Unwind' Fact Sheet Available

The New York State Department of Health has released a new fact sheet: Unwinding the Public Health Emergency. This fact sheet includes important information regarding member renewal for Medicaid, Child Health Plus and Essential Plan coverage after the COVID-19 Public Health Emergency and how you can help patients at risk of losing coverage.

This fact sheet is available on the New York State of Health website.

Clarification of Provider Enrollment Contact Information

Please send all enrollment information and practitioner demographic change forms (if you are not filing electronically) via email to ProviderEnrollment@excellus.com.

Click here to ensure you are using the most up-to-date version of our enrollment and demographic changes forms.

If you have any questions, please contact your Provider Relations representative.

Web Self-Service Tools

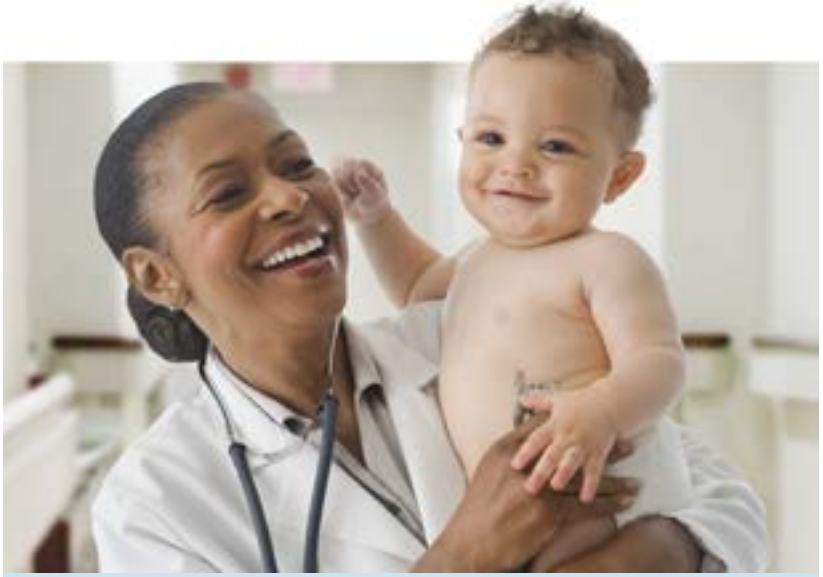
We know how busy your work day can be. That's why we remind you of the time-saving tools and information available on our website. They are quick, convenient and available 24/7!

We require the use of our web self-service tools to check member eligibility and benefits. Keep your web account active by logging in at least every 30 days.

Access and Availability Standards

We follow appointment availability standards established by the New York State Department of Health. These standards, which apply to all lines of business, are used to improve patient access to routine, urgent, preventive and specialty care.

We also follow 24-hour access standards to measure after-hours access. Learn more by viewing our access and availability tip sheet.



Nominate a Colleague for the 2024 Circle of Excellence Award

Attention value-based payment providers! You have until June 6, 2024 to submit a nomination for this year's Circle of Excellence Award.

The award is presented to nominees who have made significant impacts on the lives of our members' health care and/or social services interventions through superior examples of Excellus BlueCross BlueShield's mission to promote quality innovation and health equity among all patients.

The following is required criteria for nominees:

Circle of Excellence Health Equity Award

- Nominee has impacted the lives of underserved populations significantly through health care and/or social services interventions and through outstanding examples of the Health Plan's mission to promote health equity among all patients.
- Criteria:
  - Nominee must work in a role that addresses social determinants of health and/or health equity.
  - Nominee does not need to have a medical credential to qualify.
  - Nominee must have fulfilled one of the following criteria:
    - contributed to significant process improvement in addressing the care of underserved populations; or
    - dedicated 10+ years to exemplary work in this industry.
  - Nominee must be able to demonstrate positive outcomes.

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Answers to Questions about the Circle of Excellence Recognition Award

Q: Who is eligible for the award?

A: Any provider practice that is engaged in a value-based payment program with the Health Plan. Value-based payment programs include ACQA Total Cost of Care and ACQA Physician Incentive.

Q: Does the nominee have to be just one person?

A: No, the nominee can be one person, a group of people, or an entire practice. The nominee should reflect the individual or individuals involved in the process or initiative that is being recognized.

Q: How do I submit a nomination?

A: Nominations can be submitted by clicking on the survey link in the accompanying article or scanning the QR code and completing the brief electronic submission form.

Q: Can I nominate someone in my practice?

A: Yes!

Q: What if I don't know whether the person or people I would like to nominate meet the award criteria?

A: Go ahead and nominate them. We prefer to receive nominations for initiatives or processes that resonate with you as being innovative and impactful on clinical quality or health equity work than to not have this work be brought to our attention.

Q: Can I submit multiple nominations?

A: Yes!

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Circle of Excellence Innovation Award

- Nominee made meaningful impact to the quality of patients' lives through clinical leadership, vision, and outstanding examples of the Health Plan's mission to promote continuous improvement in the health care system.
- Criteria:
  - Nominee must work in the clinical field.
  - Nominee does not need to have a medical credential to qualify.
  - Nominee must have fulfilled one of the following criteria:
    - contributed to significant process improvement in the health care system; or
    - dedicated 10+ years to exemplary work in this industry.
  - Nominee must be able to demonstrate positive outcomes.

Category award winners will receive:

- Plaque for office
- Individual certificates for all office staff
- $500 voucher to a local food establishment toward a team luncheon
- Press release/announcements on social media
- Bragging rights

To Nominate a peer:

Click here or use this QR code to complete a simple and quick nomination form today!

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Q: Does the nomination have to apply only to initiatives or processes involving Excellus BlueCross BlueShield members?

A: No, we are looking for those initiatives or processes that either are, or can, improve quality and health equity at the population health level.

Q: If I nominate someone, they will have to create a slide deck for finalist selection, but I don't want to create more work for them. Is there anything that can be done to support this?

A: Yes! The Health Plan's value-based payment team is available to provide support in any way that we can. We are happy to work with the accepting nominees directly based on their need.

Q: I am uncomfortable nominating someone I know. Can nominations be anonymous?

A: Yes! The nomination form allows for anonymous nominations; the nominator demographic fields are optional.

Q: What is the deadline for submitting nominations?

A: To be eligible for the 2024 award, nominations must be received by June 1, 2024.

Keep Your Practice Information Current

Our online *Practitioner Demographic Changes* submission form makes it easier and faster to update the demographic information we have for your practice.

Visit the Update Practice Information section of our website. Log in with your username and password to use the new online form. You still have the option to download a PDF version of this form if you choose.

We recommend that you verify demographic information every 90 days using our Find a Doctor/Provider tool.

Please also verify and update your demographic information on the NPI Registry. Log into your NPI record at https://nppes.cms.hhs.gov/#/.

If you need help using the new online form, please contact your Provider Relations representative. Thank you for helping us ensure we have the most up-to-date information available.

Wellness Visit Program Aims to Improve Patient Health

We partner with Emcara Health (formerly PopHealthCare, LLC), an independent company, to offer a wellness-visit program to our Medicare Advantage members. The voluntary program is offered free of charge to our members. Wellness visits can be conducted in-person or via telehealth.

This clinically driven program focuses on the evaluation of members who have comorbid risk factors for undiagnosed chronic conditions. Through this program, we target a small segment of our membership based on claims and clinical data, who are identified as at-risk, but may be unlikely to visit their physician for treatment in a timely fashion.

If your patient is selected to participate, here's what you can expect:

- They will receive a letter providing details about the program and advising that Emcara Health will reach out to schedule an in-home or telehealth wellness visit.
- Within two weeks of receiving the letter, they will be called by Emcara Health to schedule the visit.
- If your patient schedules a visit, they will receive a reminder via phone or text 24-48 hours prior.
- During the visit, which typically takes an hour or less, a nurse practitioner or physician assistant will conduct a short physical, review medications, discuss any health concerns and assess living conditions.
- After the wellness visit, your patient will be given items for discussion with you at their next appointment.
- A written summary of the visit will be sent to you, which gives you the results of the wellness visit, including any diagnoses made.

Our wellness-visit program was established to help ensure members who may have potential health risks turn to their primary care physician for any necessary action or treatment. Additionally, the diagnostic information obtained through the wellness visit is necessary to provide adequate funding of care. This funding is secured through the risk adjustment process required by the Centers for Medicare & Medicaid Services.

Our goal is to support our members and your practice by supplying you with comprehensive information about your patients who choose to participate in our program. We hope this program will help us narrow gaps in care relating to the use of evidence-based practices.

If you have questions about our wellness visit program, please call your Provider Relations representative.

We appreciate your support and look forward to working with you toward improving the health of your patients who are our members.

Wellness Visits are conducted by nurse practitioners or physician assistants employed by Midtown East Medical Services, P.C., an affiliate of Emcara Health.

A Dangerous Trend: Skipping Cervical Cancer Screening

A growing number of individuals who are eligible to be screened for cervical cancer are skipping this important test, and that decision could cost them their lives. Each year in the U.S., 11,500 individuals are diagnosed with cervical cancer, according to the Centers for Disease Control and Prevention (CDC), and 4,000 die from the disease.

"When diagnosed early, cervical cancer is treatable and often curable," says Angel L. Kerney, M.D., a board-certified obstetrician-gynecologist and medical director at Excellus BlueCross BlueShield.

In 2005, 14% of eligible individuals were overdue for cervical cancer screening, and by 2019, that number grew to 23%, according to the National Cancer Institute. National Institutes of Health researchers reviewed survey data from more than 20,000 individuals who were eligible to be screened and found that 10% reported a lack of access to screening, 12% said screening was never recommended by their health care provider, and 55% expressed a lack of knowledge about the importance of getting screened.

The US Preventive Services Taskforce (USPSTF) recommends screening for cervical cancer every 3 years with a Pap test for individuals ages 21 to 29. For ages 30 to 65, the USPSTF recommends screening every 3 years with a Pap test, every 5 years with human papillomavirus (hrHPV) testing for high-risk individuals, or every 5 years with both types of tests. Each type of screening can be done during a routine pelvic examination.

"Many people mistakenly believe that any examination of their pelvis includes a Pap smear," cautions Dr. Kerney. "Only a pelvic exam that includes a Pap smear will screen for cervical cancer."

The USPSTF recommends against screening for cervical cancer in individuals who are younger than 21 years, those who have had a hysterectomy that included removal of the cervix and haven't had a high-grade precancerous lesion or cervical cancer, or those who are older than 65 years, have had adequate screening, and aren't at high risk for cervical cancer.

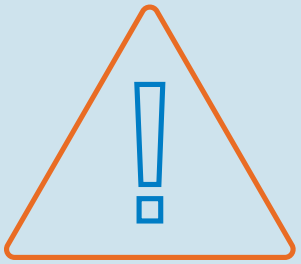
In addition to screening, the USPSTF recommends eligible individuals receive the HPV vaccine to help prevent cancer-causing infections and precancers that can lead to some types of cervical cancer.

The CDC credits the 2006 introduction of the HPV vaccine in the U.S. with the drastic reduction seen in HPV infections and cervical precancers. According to CDC disease tracking, among teen girls, the HPV infections that cause most HPV cancers and genital warts have dropped 88% and by 81% among young adult women. Among vaccinated women, the CDC found a 40% drop in cervical precancers caused by the types of HPV that are most often linked to cervical cancer.

Dr. Angel Kerney, M.D.
Medical Director

Help Stop Fraud, Waste and Abuse

To report potential fraud, waste or abuse, please call our **Fraud Hotline** at **1-800-378-8024** or visit our website to complete and submit our Fraud Reporting form. For federal employees, call 1-800-337-8440. All fraud, waste and abuse referrals are confidential and can be made anonymously. Those who report wrongdoing are protected from retaliation.



Chronic Kidney Disease Complex Care Program Available to Members

According to the Centers for Medicare & Medicaid Services (CMS), $114 billion (20%) of Medicare annual spending goes toward kidney disease care.[1]

Excellus BlueCross BlueShield is now offering members who have a diagnosis of chronic kidney disease (CKD) access to a complex care program through a partnership with REACH Kidney Care, LLC, an independent company, and the member's nephrologist.

REACH is a mission-driven, non-profit health management program designed to benefit patients along the continuum of kidney disease. The REACH program aims to slow the progression of CKD and increase pre-emptive transplant rates while optimizing the clinical and logistical choices associated with dialysis initiation through member education and support.

Our Case Management team will engage members with CKD stages I-III and diabetes, while REACH will engage members with CKD stages IV-V who have not begun renal replacement therapy.

The REACH multi-disciplinary care team will work closely with eligible members and network nephrologists to optimize outcomes while focusing on evidence-based, patient-centered nephrology care. Efforts focus on comorbidities management, coordination of care, patient education, self-management, behavior change counseling and patient navigation. The program is intended to support and enhance specialist care through provider collaboration and increased patient engagement. It will never alter or replace nephrologist treatment plans.

Eligible members will have the ability to opt in or out of participation in the REACH program. REACH will communicate with eligible members who have opted into the program via telehealth at a minimum of every one to three months.

Interested nephrology offices can participate in an annual pay-for-performance incentive program based on engaged membership and associated clinical outcomes. REACH will provide actionable data reports to participating nephrology practices to synergize their outreach activity with office workflows.

For more information, contact our Case Management team at 1-877-222-1240.

[1] https://www.cms.gov/newsroom/press-releases/cms-announces-transformative-new-model-care-medicare-beneficiaries-chronic-kidney-disease

Re-Engage Your Medicare Patients in Medication Adherence Discussions

Part 1: Cost Interventions

Why?

- Studies have shown that your patient may not take their medication as prescribed as much as 50% of the time.
- Most patients who decide not to fill a prescription or take their medications do not tell their medical provider.
  - Example: In our study of 320 members, providers stated the member was receiving a statin, but 18% of those members hadn't refilled it in a year or more.
- Ask your patient about medication adherence at every appointment. It is recommended to never assume that any patient is fully adherent.
  - Consider medication nonadherence first as a reason a patient's condition is not under control.
  - Initiate shame and blame-free adherence discussions. Sharing that other patients experience the same barriers can help open the conversation.
- To alleviate cost barriers:
  - Check your patient's 2024 Medicare formulary for alternative medications with a lower tier copay:
    - Check our drug formulary here.
    - Choose generic medications when possible.
  - Recommend that your patients get a 3-month supply of maintenance medication. Many Medicare members will only pay 2 copayments for a 3-month supply.
  - Ask your patient to investigate NYS EPIC insurance eligibility by calling:
    - 1-800-332-3742
    - Website: Elderly Pharmaceutical Insurance Coverage (EPIC) Program (ny.gov)
  - If a brand product is unaffordable and your patient meets income eligibility guidelines, they may qualify for pharmaceutical company sponsored Patient Assistance Programs. Use this website to check: Find a Pharmaceutical Assistance Program for the drugs you take (medicare.gov)

1. Brown M, Sinsky CA. Steps Forward: Medication Adherence: Improve Patient Outcomes and Reduce Cost. American Medical Association. [Internet] Accessed January 25, 2024. Available at: https://edhub.ama-assn.org/steps-forward/module/2702595

Levemir® to be Discontinued

Levemir (insulin detemir) long-acting insulin will be discontinued by the manufacturer in 2024.

The following alternatives will be covered under Medicare plans:

- Lantus Solostar 100 units/ml 3 ml Pens
- Lantus Insulin Vials 100 units/ml 10 ml

Neulasta®, Udenyca® Preauthorization Requirement Lifted

Neulasta and Udenyca no longer require prior authorization under members' pharmacy or medical benefit.

As a reminder, Neulasta and Udenyca are the preferred formulations of pegfilgrastim for Commercial, Exchange, Medicaid, Child Health Plus, Essential Plan, and Medicare lines of business.

Full drug policy criteria can be found here.

IVIG and SCIG Therapy Policy Updates

We would like you to be aware of the following updates to Intravenous Immune Globulin (IVIG) and Subcutaneous Immune Globulin (SCIG) Therapy policies:

- The step therapy requirement for Cutaquig®, Cuvitru®, Hizentra®, HyQvia®, and Xembify® now requires documentation of drug failure or serious side effects to TWO of the following: Gamunex-C, Gammaked, or Gammagard Liquid administered subcutaneously.
  - This applies to all lines of business except Medicare Part B.
  - This step does not apply for a diagnosis of ITP (idiopathic (immune) thrombocytopenic purpura), as there is risk of hematoma formation.
- The following update for Asceniv™ has been made:
  - The Health Plan has determined that Asceniv is not medically necessary due to the availability of lower costing options that are likely to produce equal therapeutic results.
  - This applies to all lines of business except Medicare Part B.
- Criteria for a diagnosis of myasthenia gravis has been updated to align with clinical guidelines regarding myasthenia crisis/acute exacerbation, refractory myasthenia gravis, immune globulin use in the pre-operative management setting and as "bridge" therapy to slower acting immunosuppressive therapy.
  - These updates apply to all lines of business.

This policy was reviewed and approved by our Pharmacy & Therapeutics (P&T) committee. The P&T committee is comprised of local physicians and pharmacists who provide their expert opinion related to drug therapy and appropriate policy criteria. The voting members of the committee are not employed by the Health Plan.

Full drug policy criteria can be found here.

Documentation Specificity for Malnutrition

Malnutrition refers to deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients, and can occur in people who are either under nourished or over nourished. Malnutrition, in all forms, includes undernutrition (wasting, stunting, underweight), inadequate vitamins or minerals, and diet-controlled noncommunicable diseases.

To properly document malnutrition, medical record documentation should specify:

- A confirmed diagnosis and that the condition is current and/or actively being treated
  - Clinical indicators such as American Society for Parental and Enteral Nutrition (ASPEN) or Global Leadership Initiative on Malnutrition (GLIM) criteria
  - Treatment
    - Vitamin supplements alone do not support active treatment
  - Documentation of a current referral, testing, medication, and/or nutritional support
- Severity
  - Mild
  - Moderate (stage 1)
  - Severe (stage 2)

To assign ICD-10 codes for malnutrition, it is important to understand the following:

- There should be a confirmed diagnosis of malnutrition
- Body Mass Index (BMI) alone does not support the diagnosis of malnutrition
- Clinical indicators as outlined below:
  - ASPEN criteria:
    - Insufficient energy intake
    - Weight loss
    - Loss of muscle mass
    - Localized or generalized fluid accumulation
    - Diminished functional status
  - GLIM criteria:
    - Phenotypic criteria: (symptom)
      - ✓ Non-volitional weight loss
      - ✓ Low BMI (less than 20)
      - ✓ Reduced muscle mass
  - Etiologic criteria: (cause)
    - Reduced food intake or assimilation.
    - Inflammation or disease burden

ICD-10 Code	Description
E43	Unspecified severe protein-calorie malnutrition
E44.-	Protein-calorie malnutrition of moderate and mild degree
E46	Unspecified protein-calorie malnutrition

Please refer to the Official ICD-10-CM code book for a complete list of codes.

Important Reminders

- All diagnoses submitted on a claim should be supported by the **M**onitoring, **E**valuation, **A**ssessment and/or **T**reatment of the condition in the medical record documentation
- "Unspecified" codes should only be reported when a more specific diagnosis cannot be determined

For more information on how to receive coding and documentation tips specific to your office please contact Risk.Adjustment.Provider.Contact@excellus.com

Helpful HEDIS® Information

Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents

- **Measure description:** The percentage of children 3-17 years of age who had an outpatient visit with a PCP or OB/GYN during the measurement year; and who had evidence of:
  - BMI percentile documentation
  - Counseling for nutrition
  - Counseling for physical activity
- **Medical record documentation needed:**
  - The date and evidence of weight assessment (BMI Percentile), nutrition, and physical activity
- **Documentation that we are looking for:**
  - **Weight Assessment**
    - Member-reported biometric measures (height, weight and BMI percentile) will meet numerator criteria if the information is documented in the medical record by the member's primary care physician or a specialist when taking the member's history
    - BMI percentile written as a value
    - Plotted on an age-growth chart
  - **Nutrition**
    - Discussion of current nutrition behaviors
    - A checklist (completed) of showing nutrition was discussed
    - Referral for nutritional education
    - Obesity or weight counseling
    - Eating disorder counseling and/or other services
    - Documentation indicating patient received nutrition education documents at in office visit
    - Anticipatory guidance for nutrition
  - **Physical Activity**
    - Discussion of current physical activity behaviors
    - A checklist (completed) of showing physical activity was discussed (sports physicals count)
    - Referral for physical activity
    - Obesity or weight counseling
    - Documentation indicating patient received physical activity education documents at in office visit
    - Eating disorder counseling and/or other services
    - Anticipatory guidance for physical activity
- For more information regarding HEDIS measures, please contact HEDIS.Clinical.Team@excellus.com

Medical Policy

Excellus BlueCross BlueShield works to ensure that the development of corporate medical policies occurs through an open, collaborative process. We encourage participating providers to become actively involved in medical policy development. Each month, draft policies are available on our website for review and comment. To access the draft policies, click here. Providers may now attach supporting documentation related to their comments.

The following new and updated medical policies have been reviewed and were approved in **January 2024** by the Corporate Medical Policy Committee, including practitioner representatives from all our regions. A complete library of our medical policies can be found on our website.

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Current Policies – Significant Updates

(#6.01.30) The Brachytherapy after Breast-Conserving Surgery (as Boost with Whole Breast Irradiation or Alone as Accelerated Partial Breast Irradiation (APBI) policy allows for APBI using interstitial or balloon brachytherapy of the breast when existing criteria in the policy are met. The criteria mirror National Comprehensive Cancer Network guidelines for breast cancer treatment. APBI as a boost treatment in women who are treated with breast-conserving surgery and whole-breast external beam radiation therapy is considered not medically necessary. Both intra-operative breast radiotherapy and electronic brachytherapy are considered investigational based on the American Brachytherapy Society Guidelines on APBI. *This annual update corrects an error pertaining to required negative margin widths for consideration of APBI. This update will require a 90-day provider notification, with a planned effective date of May 15, 2024.*

(#2.01.28) The **Sleep Studies** policy defines various diagnostic methods used in the diagnosis of patients with disorders of sleep and daytime alertness and provides indications and coverage criteria for polysomnography (PSG), home/portable sleep studies, split-night studies, CPAP titration, multiple sleep latency test/maintenance of wakefulness test, nocturnal oximetry, and actigraphy. The following tests are considered investigational for screening, diagnosis, or treatment planning in persons with suspected or known obstructive sleep apnea (OSA) and for all other indications: EEG Topography, PAP-Nap, acoustic pharyngometry (e.g., Eccovision Acoustic Pharyngometer), versions of the SNaP Testing System using fewer than three (3) channels, rhinomanometry, acoustic rhinometry, and optical rhinometry. *This off-cycle update includes changes to the covered benefit language.*

(#2.02.56) Circulating Tumor DNA for Management of Cancer (Liquid Biopsy) The standard for treatment selection in some cancers is biomarker analysis of tissue samples during biopsy or surgery. When tissue is not available, an alternative to tissue-based molecular testing is cell-free DNA from plasma in blood of patients with cancer. Cell-free DNA in blood is derived from nonmalignant and malignant cells of DNA. The small DNA fragments released into the blood by tumor cells are referred to as circulating tumor DNA (ctDNA). The ctDNA can be used for genomic characterization of the tumor and identification of the biomarkers of interest. Genetic testing of ctDNA can be targeted to specific genes or at commonly found, acquired, somatic variants ("hotspots") that occur in specific cancers, which can impact therapy decisions. Cell-free/circulating tumor DNA analysis for specific gene mutations that are listed in the criteria, are considered medically appropriate for individuals with colorectal cancer, non-small-cell lung cancer (NSCLC) including adenocarcinoma, large cell, squamous cell, and NSCLC not otherwise specified, pancreatic cancer, metastatic prostate, and HR+/HER2- breast cancer. Liquid biopsy and tumor tissue testing should not be done simultaneously. Liquid biopsy for any other indication is considered experimental and investigational. *This annual update includes the addition of criteria from CMP 2.02.51 (Molecular Testing of Tumor Tissue to Identify Targeted Therapies for Cancers) for melanoma and ovarian cancer as NCCN is now recommending liquid biopsy if tissue is not available.*

(#3.01.09) Transcranial Magnetic Stimulation is a noninvasive office procedure that employs magnetic fields to stimulate nerve cells in the brain to improve symptoms of treatment resistant depression. The Health Plan considers TMS a medically appropriate treatment for major depressive disorder when specific criteria are met, as outlined in the medical policy. Retreatment with TMS is also medically appropriate for patients who meet the guidelines/criteria for initial treatment and have subsequently developed relapse of depressive symptoms. Continued treatment with TMS as maintenance therapy (defined as less than 3 months between treatment courses) remains investigational. *This year's annual review includes the relocation of age requirements to the policy statements, clarifications for both absolute and relative contraindications, and reformatting for more prominent placement of criteria. The changes are neutral in nature and will not require review or approval from the NYS Office of Mental Health.*

(#6.01.03) Magnetic Resonance Spectroscopy (MRS) is used to measure different low molecular weight chemicals to provide a functional image related to underlying dynamic physiology. Based upon our criteria and assessment of peer-reviewed literature, MRS is medically appropriate to differentiate cerebral tumors from abscess or an inflammatory/infectious process and to also differentiate

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cerebral tumor from radiation necrosis. MRS has not been medically proven to be effective and therefore is considered investigational for all other indications. *With this annual update, positive coverage criteria have been added for MRS for the diagnosis of certain rare inborn errors of metabolism affecting the central nervous system, and when evidence or suspicion exists for primary or secondary neoplasm. The updates are in alignment with eviCore V.1.2024 Head Imaging Guidelines.*

(#6.01.29) Positron Emission Tomography (PET) Oncologic Applications is an imaging technology that can reveal both metabolic and anatomical information in various tissue sites. PET is considered medically appropriate as an imaging tool for various cancers as outlined in the policy. *This off-cycle update includes the addition of the newly U.S. Food and Drug Administration (FDA) approved radiotracer 18F Flotufolastat, as well as new criteria for Follicular and Marginal Cell lymphomas requiring that systemic therapy is planned. The updates are in alignment with eviCore V.1.2024 Oncology Imaging Guidelines which follow current NCCN guidelines.*

(#6.01.37) CT (Computed Tomography) Perfusion Imaging of the Brain provides a detailed study of cerebral blood flow that may assist in identification of ischemic regions of the brain, especially within the first few hours of an acute stroke. T*his year's annual update includes the addition of positive coverage criteria for cerebral perfusion analysis using CT for many indications, which include but are not limited to, the evaluation of acute stroke (<24 hours) for follow up for acute cerebral ischemic or infarction and/or reperfusion in the subacute or chronic phase of recovery, assisting in planning and evaluating effectiveness of therapy for cervical or intracranial arterial occlusive disease, to identify cerebral hypoperfusion syndrome following revascularization, to evaluate the vascular status of solid tumors or tumor response to therapy, for transient ischemic attacks, hemorrhagic stroke, or subdural hemorrhage. CT perfusion imaging is considered investigational for all other indications.*

(#6.01.46) Magnetic Resonance Imaging - Prostate/ Multiparametric MRI is an imaging exam that can be used for staging, treatment selection, surgical or radiation therapy planning of prostate cancer. MRI of the prostate is usually performed after a biopsy-proven diagnosis of prostate cancer to provide patients with more detailed information about their disease so they can make the most informed treatment decision and/or understand whether the treatment they have received thus far has been effective. MRI or MRI/TRUS (transrectal ultrasound) fusion biopsy of the prostate is considered medically appropriate for men with suspected prostate cancer who meet specific age, PSA, digital rectal exam result, lesion classification and prior diagnostic testing requirements. MRI is also considered medically appropriate for the initial workup, staging, restaging, or recurrence of prostate cancer when certain criteria within the policy are met. *This off-cycle update includes the addition of new medically appropriate criteria for MRI for restaging or recurrence and for follow-up on active surveillance for non-metastatic prostate cancer. The updates are in alignment with eviCore Oncology Imaging Guidelines V1.2024.*

(#7.01.105) The Gender Reassignment/Gender Affirming Surgery and Treatments for Medicaid Managed Care Plan (MMCP) and Health and Recovery Plan (HARP) Members policy outlines those surgeries considered medically appropriate. This policy is based upon New York State codes, rules and regulations including Title 18 NYCRR 505.2(l [lowercase L]) and the Physician-Procedure Codes, Section 5 available through eMedNY. The policy includes criteria for hormone therapy, gender affirming surgery, surgeries and treatments related to secondary sex characteristics, voice modification surgery, surgical revision and continuation of care. Cases requiring a clinical peer review must be made by a Health Plan medical director who specializes in behavioral health. *This annual update includes the addition of two procedures (neck tightening and jaw shortening) to our current non-inclusive list of medically appropriate treatments related to secondary sex characteristics when criteria in the policy are met, mirroring NYS criteria. Additionally, formatting was conducted for clarity, and continuing care language was updated in alignment with the NYS law and No Surprise Act Circular Letter No. 11 for pregnancy through post-partum when a participating provider leaves our network. The policy requires review and submission to the NYS Department of Health and therefore, has a future anticipated effective date.*

(#11.01.13) Out of Network refers to out of area and out of network services for the Health Plan. The policy is based on the Health Plan Certificate of Coverage: EXEC-100 (Rev. 2) and EXEC-101 (Rev. 1), the NYS DFS website for New York Insurance Law

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for Out of Network and Surprise Bills, the Affordable Care Act (ACA) for Emergency Services requirements, and input from legal counsel. The policy applies to all lines of business. *The off-cycle policy update expands continuing care for pregnancy through postpartum when a participating provider leaves the network and becomes a non-participating provider to align with the New York state Law and the No Surprise Act/Circular Letter No. 11 Regarding Continuity of Care Requirements.*

Current Policies - minor updates

The following policies have been updated to reflect minor changes, such as applicable references, criteria, or system pend, and are available on our website.

(#2.01.24) Growth Factors for Wound Healing

(#2.01.42) Immunizations

(#2.02.50) Neuropsychological Testing

(#2.02.51) Molecular Testing of Tumor Tissue to Identify Targeted Therapies for Cancers

(#3.01.13) Ketamine Therapy for the Treatment of Psychiatric Disorders

(#7.01.64) Gastric Electrical Stimulation

Archived Medical Policies

Policies are archived either because the criteria for evaluating the procedure/technology have not changed or because there has been little utilization or few requests. Archived policies are available on our website.

Newly Archived:

(#2.01.24) Growth Factors for Wound Healing

(#6.01.40) Electromagnetic Navigation Bronchoscopy

Previously Archived:

(#1.01.06) Positive Airway Pressure Devices- CPAP, BiPap, AutoPap

(#6.01.19) Low-Dose Computed Tomography (LDCT) for Lung Cancer Screening

Deleted Medical Policies

The following policy is scheduled to be deleted as it has been determined that this policy is no longer being medically managed:

(#2.02.06) Genetic Testing for Hereditary BRCA Mutations

(#2.02.07) Genetic Testing for Germline Mutations of the RET Proto Oncogene in Medullary Carcinoma of the Thyroid

(#2.02.11) Genetic Testing for Inherited Susceptibility to Colorectal Cancer

(#2.02.44) Genetic Testing for Susceptibility to Hereditary Cancers

(#7.01.78) Peptide Receptor Radionuclide Therapy (PRRT)

(#10.01.05) Prostate Cancer Screening

Note: When policy criteria change, Excellus BCBS' requirements related to medical records may also change. Medical record requirements are available here. Failure to submit required records with the claim submission could delay claim processing and payment.

Although medical policies are effective, services may not be reviewed until our systems are updated.

Questions regarding medical policies should be directed to your Provider Relations representative.