Medical Policy Title	Policy Number	Description of Change	Effective Date	Line of Business Affected	Policy Type
Infertility Treatment	UM185POL	• Definition: Changed definition of infertility and removed below bullets • Policy A.: Added the underlined: "HNE Infertility benefits include coverage for non-experimental services that are medically necessary to diagnose and treat medical infertility <u>for members with uteri/eggs</u> when such treatment is likely to result in viable offspring. Covered services …" • II., General Eligibility Criteria B. o Added the underlined: "For a member <u>with uteri/eggs</u> to be considered for cycle initiation of a covered ART service:" o Added 2.: "Treatment is likely (i.e., with greater than 5% probability) to result in viable offspring." C.: Added section C., Evaluation Requirements D.: o Added section D., Testing of the Female o Added "Diminished ovarian reserve …" with bullets o Added "Alternate testing options only for those members not able to do CCCT" with bullets o Removed (former) B., 3., a., b., and d. E., Evaluation of the Male: o 1.: "Results of a semen analysis performed within the past year demonstrating normal fertility must be submitted." o 3.: "Medical and reproductive history (including any substance use) must be submitted." o 4.: Added language to section 4. o Removed Body Mass Index (BMI) section o Removed rubella immunity, TSH level which followed BMI section	9/1/2021	Commercial Medicare	Medical

		SERVICE-SPECIFIC CRITERIA: • Advanced Maternal Age, Women >42 yrs. and up to member's 44th birthday o Removed last sentence in section B. • Intrauterine Insemination (IUI) o Removed the underlined: "Unexplained <u>infertility</u>" Added "failure to successfully conceive with regular sperm exposure using unprotected vaginal intercourse" o At bottom, added: "A uterine cavity evaluation is required after a pregnancy or pregnancy loss." • Assisted Hatching (AH) *From:* D., "Thick Zonae in prior IVF for a woman over age 35." *To:* D., "Thick Zonae in prior or current IVF." • Cryopreservation of Eggs and/or Embryos For women who are **not in active** infertility treatment: A., added to the end of the sentence: "or other treatment that is expected to render them permanently infertile (excluding voluntary sterilization). Removed "that is likely to result in infertility." • Cryopreservation and Sperm Collection B., added the underlined to the end of the sentence: "<u>for members in active infertility treatment</u>; or" C., added to the end of the sentence: "or other treatment that is expected to render them infertile. Removed "that is likely to result in infertility." • Cryopreservation of Eggs or Sperm (including retrieval and up to one year of storage) for members undergoing Gender Reassignment Treatment Added: Cryopreservation is limited to one cycle only • Donor Eggs (Donor Oocyte) o Removed "➔ now listed in what is not covered section" o Added: "Donor egg is covered for medical illness which causes a natural loss of egg quantity and/or quality." o B., Changed to "≥"			

		• Donor Sperm: Added "One vial per IVF/IUI cycle." Changed lettering on right side. • Intra-Cytoplasmic Sperm Injection (ICSI) C.: "OR" added at end. D.: Added D.: "With use of frozen eggs" • In-Vitro Fertilization (IVF) o On left side: For members <35 years of age with favorable prognosis Added description of favorable prognosis (1st IVF cycle, previous IVF success, good quality embryos/excess embryos available for freezing). Changed symbol to Others "≤" For members age 35-37 Changed "2" to "1" Changed Others to symbol ≤ For members age 38-40: Changed symbols to ≤ For members age 41 and greater: Removed statement "There is insufficient data …" and added "With favorable prognosis ≤ 3, all others ≤3 o On right side: C.: Removed statement "There must be documentation confirming that the condition cannot be improved by standard conservative treatment(s), and cannot be addressed via IUI." • IV., What is Not Covered? A.: Added statements 25. and 26. • Source/Citation Section: Updated dates. Removed references related to obesity and others not applicable. • Codes: Under HCPC Code, added S4028 - Sperm aspiration from epididymis by means of microsurgery			

Upper Airway Stimulation Device (UAS) / Hypoglossal Nerve Stimulation (HGNS) (Inspire)	UM692POL	• VI., Criteria for Medicare Approval Medicare link was updated for criteria. • VII. Section title was clarified to indicate not covered by MassHealth. • All sources and citations were reviewed, updated with sites confirmed.	9/1/2021	Commercial Medicare	Medical
Knee Braces	UM684POL	• I., Criteria for Approval D.: Section D. was added - "Fracture Knee Brace/Rehabilitative Knee Brace."	9/1/2021	Commercial Medicare Medicaid	Medical
Proton Beam Therapy	UM408POL	• I., Criteria for Approval: Added "for Commercial and Medicaid" • II. o Added II., Criteria for Medicare, follow below link o Under the above addition, Medicare link added	9/1/2021	Commercial Medicare Medicaid	Medical
Speech Therapy	UM339POL	• Definitions: Added Dysfluency and related definition • I., Criteria for Approval: Added to the title, "for Medicare, MassHealth and Commercial" • IV., Required Documentation for Subsequent or Ongoing Treatment Determination D.: Added statement 2. & bullets • Codes section: Labeled codes with PA needed or No PA needed • V., What is Not Covered Added TT. – Speech therapy services rendered by a SLP assistant or aide; and Added UU. – Melodic intonation therapy (MIT) • Source/Citation Section: Updated, with one new one added	9/1/2021	Commercial Medicare Medicaid	Medical

Sacroiliac Joint Fusion for the Treatment of Adult Low Back Pain	UM403POL	• I., Sacroiliac joint fusion Added the underlined: "Sacroiliac joint fusion **(OPEN)** (Fuses iliac bone (pelvis) to the spine (sacrum) procedures are considered **medically necessary** for **any** of the following indications:" • II., Criteria for Approval - **Commercial and Medicaid Plans A.: o Added 1.: "Adults 18 years old or greater with SI joint pain for greater than 6 months (or greater than 18 months for pregnancy-induced pelvic girdle pain); AND" (Subsequent numbering was updated.) o 3.: Removed "There is an" and added a capital A. to Absence. o 5.: Added the underlined: "Pain is caudal to the lumbar spine (L5 vertebra), localized over the posterior sacroiliac joint, posterior superior iliac spine (Fortin's point), non-radiating lumbar/pelvic pain without radiation to hip, groin or radiating to legs and consistent with sacroiliac joint pain; **AND**" o 10.: Added the word **AND** to the end of the statement o 11.: Added #11. • III., Criteria for Approval - **Medicare Plans Medicare link was confirmed that it is still active. • V., What is Not Covered: Added sections B., C., and D. with corresponding 1. through 10. below letter D. • Covered Codes: Confirmed that 27280 is not covered under Medicaid • Source/Citation Section: Updated with 3 new citations added	9/1/2021	Commercial Medicare Medicaid	Medical

Total Ankle Replacement	UM405POL	• CPT Codes: Removed codes 27700, 27703, 27704	9/1/2021	Commercial Medicare Medicaid	Medical
Transplants and Ventricular Assist Devices	UM680POL	• Definitions VAD: Added #3. and #4. to the definition • I., Criteria for Approval: B. was added, and re-lettering was done. C.: The following new sentence was added at the end: "Medicare uses Liver Transplant National Coverage Determination 260.1 and Cardiac National coverage Determination 260.9 for review of these transplants." • IV., Ventricular Assist Devices (VAD): A. Removed the underlined test: "HNE covers the implantation of <u>both bridge to transplant and destination</u> VADs that are FDA approved and performed in a Center of Excellence. These devices must be used in accordance with the FDA labeling instructions. B. Added new B., and re-lettering was done. • V., What is Not Covered: Added letter N. • VI., CPT Codes: o Removed code 33997 and corresponding description o Added the following codes with descriptions: 33975, 33977, 33979, 33981, 33982, 33983, 33990, 33991, 33995 • Source/Citation Section: o References and citations checked and updated o Removed Approved Transplant Centers citation	9/1/2021	Commercial Medicare Medicaid	Medical

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<td>Water Vapor Thermal Therapy (Rezum)</td>
<td>UM760POL</td>
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I., Criteria for Approval
A.

Added MassHealth
Superseded LCD was updated to a non-superseded LCD for state of Massachusetts

B.: Removed B., “Not covered by MassHealth.”
Sources/Citation Section:
All were reviewed and updated, deleted one and added one.

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<td>9/1/2021</td>
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Medicare
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<td>UM580POL</td>
<td>

Config request sent for PA added to the following codes (already on policy)
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Source/Citation Section: All sources/citations were confirmed.

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<td>Laser-Assisted Uvulopalatoplasty or Uvulopalatopharyngoplasty</td>
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