LifeWise
Health Plan of Washington

January 4, 2024 – Provider News – LifeWise Washington

Medical Policy and Coding Updates
January 4, 2024

Special notices

Effective April 14, 2024

Updates to Carelon Medical Benefits Management Clinical Appropriateness Guidelines (formerly AIM Specialty Health).

Effective for dates of service on and after April 14, 2024, the following updates will apply to the Carelon Medical Benefits Management, Inc. Radiation Therapy Clinical Appropriateness Guidelines. As part of the Carelon guideline annual review process, these updates are focused on advancing efforts to drive clinically appropriate, safe, and affordable health care services.

Updates by section

Radiation Therapy

- Intensity-modulated radiation therapy (IMRT) for colon cancer
- New indication for adjuvant treatment of locally advanced adenocarcinoma of the cecum
- Stereotactic body radiotherapy for hepatocellular carcinoma
- Modify eligibility criteria to match clinical trial RTOG 1112
- External beam radiation therapy/IMRT for prostate cancer
- Adjust for 2 Gy [gray] fractions. The total allowed dosage is the same with each fraction is a little larger (now 2 Gy) and lower number of fractions.

Effective for dates of service on and after April 14, 2024, the following updates will apply to the Carelon Medical Benefits Management, Inc. Advanced Imaging Clinical Appropriateness Guidelines. As part of the Carelon guideline annual review process, these updates are focused on advancing efforts to drive clinically appropriate, safe, and affordable health care services.

Updates by section

Imaging of the Heart

- Cardiac computed tomography (CT)

        - Cardiomyopathy: Added specificity to establish the basis for the suspicion of arrhythmogenic right ventricular dysplasia to align with cardiac magnetic resonance imaging (MRI) guidelines
    - Resting transthoracic echocardiography
    - Evaluation of ventricular function
        - New indications for evaluation of patients on mavacamten for treatment of hypertrophic cardiomyopathy

Imaging of the Abdomen and Pelvis

- Biliary tract dilatation or obstruction
    - Added indication for annual surveillance in Caroli disease/syndrome based on a 2022 guideline recommendation
- Diffuse liver disease
    - Removed indication for LiverMultiScan in hemochromatosis as there is insufficient evidence that this provides an advantage over standard MRI for this condition
- Osteomyelitis
    - Added requirement for initial evaluation with radiographs in adult patients based on American College of Radiology (ACR) appropriateness criteria
- Septic arthritis
    - Added requirement for initial radiographs in adult patients based on ACR appropriateness criteria
- Pancreatic mass, indeterminate cystic
    - For enlarging lesions in individuals aged 80 or older, increased surveillance frequency to annually and removed endpoint of 4 years
- Pelvic floor disorders
    - Added indication for MRI (magnetic resonance [MR] defecography preferred) in suspected pelvic organ prolapse based on ACR appropriateness criteria
- Transplant-related imaging
    - Added indication for single CT abdomen or abdomen/pelvis prior to lung, kidney, or stem cell transplant to align with CT chest guidelines

Imaging of the Brain

- Movement disorders (Adult only)
    - Added indication for head CT for assessment of skull density prior to MR guided focused ultrasound for essential tremor
- Trauma
    - Added a 3-6 week follow-up study in individuals aged 6 or younger with stable or inconclusive exam due to difficulty in accurately assessing for changes in neurologic status
- Acoustic neuroma

- Added long-term follow-up intervals based on specialty society guidelines

Imaging of the Chest

- Perioperative or periprocedural evaluation, not otherwise specified
  - Added indication for chest CT to be used for planning of biopsy or placement of fiducial markers using navigational bronchoscopy

Imaging of the Head and Neck

- Acoustic neuroma
  - Added long-term follow-up intervals based on specialty society guidelines
- Localized facial pain (including trigeminal neuralgia)
  - Added MRI orbit/face/neck for this indication based on ACR criteria due to some facilities using MRI face rather than brain for this condition

Oncologic Imaging

- Cancer screening
  - Breast cancer screening: Addition of high-risk genetic mutations (National Comprehensive Cancer Network [NCCN] alignment citing absolute risk of 20% or greater)
  - Lung cancer screening: Clarification of asbestos-related lung disease as risk factor independent of smoking, aligned with original intent
  - Pancreatic cancer screening: Alignment with NCCN recommended parameters; changes are overall expansive, except for an older start age (from 45 to 50 years) for certain genes (ATM, BRCA1, BRCA2, MLH1, MSH2, MSH6, EPCAM, PALB2, TP53); and family history alone (relative requirement)
- Breast Cancer
  - Chest CT, abdomen and pelvis CT: Added diagnostic workup allowance when metastatic disease is clinically suspected at presentation
  - MRI Breast: Addition/clarification of surveillance scenarios aligned with NCCN/ACR considerations
  - FDG-PET/CT: Added allowance for radiotherapy (RT) planning locoregional recurrence (e.g., confirmation of regional nodal involvement)
  - 18F-FES-PET/CT: Added that it is not indicated due to uncertain net benefit, low-level evidence, and insufficient data on outcomes
- Cervical Cancer
  - FDG-PET/CT: Update for follow-up of disease treated with either adjuvant RT or chemoradiation (NCCN alignment)
- Hepatocellular and Biliary Tract Cancers
  - FDG-PET/CT: Removed routine preop PET/CT for biliary tract cancers (NCCN alignment)

        - FDG-PET/CT: Added management allowance when standard imaging cannot be done or is nondiagnostic
    - Lung Cancer – Non-Small Cell
        - FDG-PET/CT: Added management allowance when recurrence demonstrated by surveillance imaging (NCCN alignment)
    - Lung Cancer – Small Cell
        - FDG-PET/CT: Clarification of initial staging allowance (NCCN alignment)
    - Lymphoma – Non-Hodgkin and Leukemia
        - FDG-PET/CT: NCCN alignment for interim restaging (allowed for diffuse large B-cell lymphoma stage I-IV with or without bulky disease)
    - Melanoma
        - Added surveillance option with MRI abdomen for liver metastases
    - Prostate Cancer
        - 18F Fluciclovine-PET/CT, 11C Choline-PET/CT, 68GaProstate-specific membrane antigen PET/CT, or 18F-DCFPyL PET/CT
        - Addition of diagnostic workup/initial staging indication
        - Specification of androgen-receptor pathway inhibitor treatment in alignment with Carelon Radiation Oncology guidelines
    - Sarcomas of Bone/Soft Tissue
        - FDG-PET/CT: Added allowance when standard imaging nondiagnostic or contraindicated (bone/soft tissue sarcoma)

For questions related to guidelines, please contact Carelon via email at MedicalBenefitsManagement.guidelines@Carelon.com. Additionally, you may access and download a copy of the current and upcoming guidelines here.

Effective April 4, 2024

Monoclonal Antibodies for the Treatment of Lymphoma, 2.03.502

Medical necessity criteria updated

- Rituxan Hycela (rituximab and hyaluronidase) to require documentation of CD20 antigen expression

Drug/Medical necessity criteria added

- Epkinly (epcoritamab-bysp) for the treatment of diffuse large B-cell lymphoma in certain adults

Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders, 2.01.526

Medical necessity added

- Maintenance transcranial magnetic stimulation (TMS) is considered not medically necessary (NMN) if the preceding course of intensive TMS was determined to be NMN

- A repeat full intensive course of TMS is considered NMN if the preceding full intensive course of TMS was determined to be NMN
- A short or brief intensive course of TMS is considered NMN if the preceding course of intensive TMS or maintenance TMS was determined to be NMN

Effective March 17, 2024

Updates to **Carelon Medical Benefits Management Clinical Appropriateness Guidelines** (formerly AIM Specialty Health).

Effective for dates of service on and after March 17, 2024, the following updates will apply to the **Carelon Medical Benefits Management, Inc. Genetic Testing Clinical Appropriateness Guidelines**.

Updates by section

Cell-free DNA Testing (Liquid Biopsy) for the Management of Cancer

- Replaced "contraindicated" with "unsafe or infeasible" for clarification of tissue biopsy

Prenatal Testing using Cell Free DNA

- Clarified required components of genetic counseling
- For viable singleton or twin pregnancy, clarified sex prediction for pregnancies at risk for an X-linked disorder

Somatic Tumor Testing

- Clarification for Food and Drug Administration approved test moved to umbrella criteria
- Expanded BRAF V600E criteria to include RAS variant in localized colorectal cancer
- Removed Afirma standalone assay for testing indeterminate thyroid nodules
- Restricted testing to 50 genes or less for bladder, colorectal, ovarian, acute lymphoblastic leukemia (ALL), acute myelogenous leukemia (AML), chronic myelogenous leukemia, myeloproliferative neoplasms, and myelodyplastic syndromes (MDS)
- Expanded specimen type in tissue-based testing for ALL, AML, and MDS. For ALL, specimen-type, measurable residual disease and BCR-ABL1 monitoring

For questions related to guidelines, please contact Carelon via email at **MedicalBenefitsManagement.guidelines@Carelon.com**. Additionally, you may access and download a copy of the current and upcoming guidelines **here**.

Effective March 7, 2024

Carelon Medical Benefits Management Clinical Appropriateness Guidelines (formerly AIM Specialty Health) added services for review.

Effective for dates of service on and after March 7, 2024, the Plan will utilize **Carelon Medical Benefits Management to apply clinical appropriateness guidelines and cancer treatment pathways**.

Additions by section

Therapeutic Radiopharmaceuticals

- Updated Azedra (iobenguane I 131)
  - For the treatment of iobenguane scan-positive, unresectable, locally advanced or metastatic pheochromocytoma or paraganglioma in individuals who require systemic anticancer therapy
  - Removed from policy Therapeutic Radiopharmaceuticals in Oncology, 6.01.525
- Updated Xofigo (radium Ra 223 dichloride)
  - For the treatment of castration-resistant prostate cancer with symptomatic bone metastases
  - Removed from Therapeutic Radiopharmaceuticals in Oncology, 6.01.525
- Added Zevalin (Ibritumomab tiuxetan)
  - For the treatment of certain types of B-cell non-Hodgkin lymphoma

For questions related to guidelines, please contact Carelon via email at **MedicalBenefitsManagement.guidelines@Carelon.com**. Additionally, you may access and download a copy of the current and upcoming guidelines **here**.

Gene Therapies for Thalassemia, 5.01.42

Medical necessity criteria updated

- Updated Zynteglo (betibeglogene autotemcel) criteria including:
  - Requirement that the individual does not have an uncorrected bleeding disorder or history of advanced liver disease
  - Individual must be 50 years of age or younger
  - Individuals 5 years of age or younger must weigh a minimum of 6 kilograms
  - Individual must be clinically stable and eligible to undergo a hematopoietic stem cell transplant

Gonadotropin Releasing Hormone (GnRH) Analogs, 5.01.625

Medical necessity criteria updated

- Eligard's (leuprolide acetate) removed from coverage for the palliative treatment of advanced prostate cancer and added coverage for the treatment of advanced prostate cancer

- Updated initial gender dysphoria criteria to require documentation that the individual has no comorbid psychiatric disorders and that potential adverse effects have been discussed including specifically possible effects on fertility
- Updated initial gender dysphoria criteria to clarify that an individual must be ≥ 14 years of age, Tanner stage 2 or higher puberty onset based on physical examination, or Tanner stage 2 or higher puberty onset based on serum testosterone level in addition to being less than 23 years of age
- Updated initial gender dysphoria criteria to clarify that the individual has not undergone a gonadectomy
- Added a note that for individuals assigned female at birth, total testosterone of at least 11 ng/dL or 0.36 nmol/L is required to confirm Tanner stage 2
- Added a note that use of these products is also investigational for the treatment of gender dysphoria for individuals who have completed puberty
- Updated gender dysphoria re-authorization criteria to require documented specific rationale for why the individual has not undergone a gonadectomy if the individual ≥ 22 years of age, that suppression of secondary sex characteristics is based on physical examination, and documentation of annual testing of bone age or bone density

Growth Hormone Therapy, 5.01.500

Drug added

- Ngenla (somatrogon-ghla) added as a second-line agent for the treatment of growth hormone deficiency

Pharmacologic Treatment of Hemophilia, 5.01.581

Medical necessity criteria updated

- Hemgenix to require:
  - Factor IX prophylaxis to be discontinued following administration of Hemgenix
  - Assessment by hepatologist if the individual has radiological liver abnormalities or sustained liver enzyme elevations
- Roctavian to require:
  - Factor VIII prophylaxis to be discontinued following administration of Roctavian
  - Documentation demonstrating that the individual received education relating to alcohol abstinence and the use of concomitant medications

Effective February 7, 2024

Botulinum Toxins, 5.01.512

Medical necessity criteria updated

- Botox, Dysport, Myobloc, and Xeomin for the treatment of cervical dystonia requiring individual does not have acute cervical dystonia caused by exposure to dopamine receptor-blocking drugs

Medical policies

New medical policies
Effective January 1, 2024

High-Risk Conditions (Oral Health) Dental Benefit, 10.01.535

New policy

- Outlines oral health preventive services covered for high-risk conditions that the Center for Disease Control and Prevention note impact oral health

Revised medical policies
Effective January 1, 2024

Applied Behavior Analysis (ABA), 3.01.510

Medical necessity criteria updated/removed

- Updated criteria for medical necessity or coverage determinations (diagnosis, types of services, treatment settings, and covered provider types)
- Removed criteria that are no longer utilized medical necessity or coverage determinations
- Added recommendations to refer to the most recent editions of Behavior Analyst Certification Board documents for guidance regarding details and intensity of treatment service and frequency of supervision

Orthognathic Surgery, 9.02.501

Investigational criteria added

- Endoscopically assisted nasomaxillary expansion as a treatment for obstructive sleep apnea is considered investigational

Pharmacy policies

New pharmacy policies

No updates this month.

Revised pharmacy policies
Effective January 1, 2024

CGRP Inhibitors for Migraine Prophylaxis, 5.01.584

Medical necessity criteria removed

- Removed requirement for trial with a triptan for preventive treatment of migraines criteria for Aimovig, Ajovy, Emgality, Nurtec, Qulipta, and Vyepti

Drugs for Rare Diseases, 5.01.576

Drug/medical necessity criteria added

- Pombiliti (cipaglucosidase alfa-atga) and Opfolda (miglustat) for the treatment of late-onset Pompe disease in adults
- Rivfloza (nedosiran) for the treatment of primary hyperoxaluria type 1 in adults

Immune Checkpoint Inhibitors, 5.01.591

Medical necessity criteria updated

- Jemperli (dostarlimab-gxly) criteria updated to include treatment of primary advanced or recurrent endometrial cancer in certain adult individuals
- Keytruda (pembrolizumab) criteria updated to include treatment of resectable non-small cell lung cancer and locally advanced unresectable or metastatic biliary tract cancer in certain individuals
- Opdivo (nivolumab) criteria updated to include treatment of completely resected Stage IIB, Stage IIC, Stage III, or Stage IV melanoma in certain individuals

Medical necessity criteria removed

- Opdivo (nivolumab) removed coverage for BRAF V600 wild type and BRAF V600 mutation-positive unresectable or metastatic melanoma to align with removal from Food and Drug Administration approved indications

Miscellaneous Oncology Drugs, 5.01.540

Drug added/medical necessity criteria added

- Purixan (mercaptopurine) for the treatment of acute lymphoblastic leukemia as part of a combination chemotherapy maintenance regimen

Multiple Receptor Tyrosine Kinase Inhibitors, 5.01.534

Drug added/medical necessity criteria added

- Vanflyta (quizartinib) for the treatment of adults with newly diagnosed acute myeloid leukemia that is FLT3 internal tandem duplication-positive

Pharmacotherapy of Arthropathies, 5.01.550

Medical necessity criteria updated

- Amjevita [National Drug Codes (NDCs) starting with 55513] updated from a preferred to a non-preferred product
- Hyrimoz LCF (Sandoz) updated from a non-preferred to a preferred product

Drugs added/medical necessity criteria added

- Tofidence (tocilizumab-bavi) for the treatment of rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, and systemic juvenile idiopathic arthritis
- Hyrimoz (Cordavis) [NDCs starting with 83457] added as a non-preferred product

- Adalimumab-adbm (Cyltezo unbranded) added as a preferred product
- Cosentyx IV (secukinumab) added as a non-preferred product

Pharmacotherapy of Inflammatory Bowel Disorder, 5.01.563

Medical necessity criteria updated

- Amjevita [NDCs starting with 55513] updated from a preferred to a non-preferred product
- Hyrimoz LCF (Sandoz) updated from a non-preferred to a preferred product

Medical necessity criteria added

- Hyrimoz (Cordavis) [NDCs starting with 83457] added as a non-preferred product
- Adalimumab-adbm (Cyltezo unbranded) added as a preferred product
- Velsipity (etrasimod) criteria added for the treatment of ulcerative colitis

Pharmacotherapy of Miscellaneous Autoimmune Diseases, 5.01.564

Medical necessity criteria updated

- Amjevita [NDCs starting with 55513] updated from a preferred to a non-preferred product
- Hyrimoz LCF (Sandoz) updated from a non-preferred to a preferred product

Medical necessity criteria added

- Hyrimoz (Cordavis) [NDCs starting with 83457] added as a non-preferred product
- Adalimumab-adbm (Cyltezo unbranded) added as a preferred product

Pharmacotherapy of Spinal Muscular Atrophy (SMA), 5.01.574

Medical necessity criteria updated

- Zolgensma (onasemnogene abeparvovec-xioi) criteria to include coverage of individuals with 4 copies of the SMN2 gene

Pharmacologic Treatment of Psoriasis, 5.01.629

Medical necessity criteria updated

- Amjevita [NDCs starting with 55513] updated from a preferred to a non-preferred product
- Hyrimoz LCF (Sandoz) updated from a non-preferred to a preferred product

Medical necessity criteria added

- Hyrimoz (Cordavis) [NDCs starting with 83457] added as a non-preferred product
- Adalimumab-adbm (Cyltezo unbranded) added as a preferred product

Services Reviewed Using InterQual Criteria, 10.01.530

Procedures added/investigational criteria updated

- Added salpingo-oophorectomy, bilateral and unilateral; and salpingo, unilateral and bilateral to procedures
- This policy replaces Prophylactic Bilateral Salpingo-Oophorectomy, 7.01.580 which is now deleted

Site of Service: Infusion Drugs and Biologic Agents, 11.01.523

Medical necessity criteria added

- Site of service review for Panzyga (immune globulin)

Archived policies

No updates this month.

Deleted policies

(H2) Effective January 1, 2024

Prophylactic Bilateral Salpingo-Oophorectomy, 7.01.580

- This policy is replaced with Services Reviewed Using InterQual Criteria, 10.01.530

Coding updates

Added codes Effective January 1, 2024

Amniotic Membrane and Amniotic Fluid, 7.01.583

Now requires review for investigational.

Q4279, Q4287, Q4288, Q4289, Q4290, Q4291, Q4292, Q4293, Q4294, Q4295, Q4296, Q4297, Q4298, Q4299, Q4300, Q4301, Q4302, Q4303, Q4304

Amyotrophic Lateral Sclerosis (ALS) Medications, 5.01.578

Now requires review for medical necessity and prior authorization.

J1304

Bariatric Surgery, 7.01.516

Now requires review for investigational.

0813T

Botulinum Toxin, 5.01.512

Now requires review for medical necessity and prior authorization.

C9160

C3 and C5 Complement Inhibitors, 5.01.571

Now requires review for medical necessity and prior authorization.

C9162

Carelon Genetic Testing
Now requires review for medical necessity and prior authorization.

0420U, 0422U, 0423U, 0424U, 0425U, 0426U, 0428U, 0433U, 0434U, 0437U, 0438U, 75580, 81457, 81458, 81459, 81462, 81463, 81464, A9608

Coronary Angiography for Known or Suspected Coronary Artery Disease in Adults, 2.02.507
Now requires review for medical necessity.

C7557, C7558

Cranial Electrotherapy Stimulation and Auricular Electrostimulation, 8.01.58
Now requires review for investigational.

E0732

Cryoablation for Chronic Rhinitis, 7.01.168
Now requires review for investigational.

31242, 31243

Diagnosis and Treatment of Sacroiliac Joint Pain, 6.01.527
Now requires review for investigational.

27278

Drugs for Rare Diseases, 5.01.576
Now requires review for medical necessity and prior authorization.

J0217, J2508

Electrical Stimulation Devices, 1.01.507
Now requires review for investigational.

A4541, A4542, E0733, E0734

Folate Antimetabolites, 5.01.617
Now requires review for medical necessity and prior authorization.

J9255, J9324

Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for Select Intra-Abdominal and Pelvic Malignancies, 2.03.07
Now requires review for medical necessity and prior authorization.

96547

Immune Checkpoint Inhibitors, 5.01.591
Now requires review for medical necessity and prior authorization.

J9258

Implantable Peripheral Nerve Stimulation for the Treatment of Chronic Pain and Other Conditions, 7.01.574
Now requires review for investigational.

0816T, 0817T, 0818T, 0819T, 64596, 64597

Intravenous Anesthetics for the Treatment of Chronic Pain and Psychiatric or Substance Use Disorders, 5.01.586
Now requires review for investigational.

0820T, 0821T, 0822T

Laboratory Testing Investigational Services, 2.04.520
Now requires review for investigational.

0371U, 0372U, 0373U, 0374U, 0377U, 0384U, 0385U, 0421U

Leadless Cardiac Pacemakers, 2.02.515
Now requires review for medical necessity and prior authorization.

0823T, 0824T, 0825T, 0826T

Microprocessor-Controlled and Powered Prostheses and Orthoses for the Lower Limb, 1.04.503
Now requires review for medical necessity and prior authorization.

L5615

Miscellaneous Oncology Drugs, 5.01.540
Now requires review for medical necessity and prior authorization.

C9163, C9165, J9321

Monoclonal Antibodies for the Treatment of Lymphoma, 2.03.502
Now requires review for medical necessity and prior authorization.

J9286

Non-covered Experimental/Investigational Services, 10.01.533
Now requires review for investigational.

0408T, 0435U, 0436U, 0811T, 0812T, 0814T, 0858T, 0859T, 0860T, 0864T, 0865T, 0866T, 88305, 88312, 27278, A4468, A7023, C9793, C9794, C9795, 8E0492, E0493, E0530, E0678, E0679, E0680, E0681, E0682, E3000

Non-covered Services and Procedures, 10.01.517
No longer covered.

0827T, 0828T, 0829T, 0830T, 0831T, 0832T, 0833T, 0834T, 0835T, 0836T, 0837T, 0838T, 0839T, 0840T, 0841T, 0842T, 0843T, 0844T, 0845T, 0846T, 0847T, 0848T, 0849T, 0850T, 0851T, 0852T, 0853T, 0854T, 0855T, 0856T, 97037, 0753T, 0756T, A4287, A4457, E1301, E2001, G0019, G0022, G0023, G0024, G0136, G0140, G0146

Peripheral Subcutaneous Field Stimulation, 7.01.139
Now requires review for medical necessity.

L8680

Pharmacotherapy of Arthropathies, 5.01.550
Now requires review for investigational.

Q5132

Pharmacotherapy of Miscellaneous Autoimmune Diseases, 5.01.564
Now requires review for medical necessity and prior authorization.

J9333, J9334

Pharmacologic Prevention and Treatment of HIV/AIDS, 5.01.588
Now requires review for investigational and prior authorization.

J0750, J0751, J0799

Pharmacologic Treatment of Duchenne Muscular Dystrophy, 5.01.570
Now requires review for medical necessity and prior authorization.

J1413

Pharmacologic Treatment of Epidermolysis Bullosa, 5.01.635
Now requires review for medical necessity and prior authorization.

J3401

Pharmacy Treatment of Hemophilia, 5.01.581
Now requires review for medical necessity and prior authorization.

J1412

Prescription Digital Therapeutics, 13.01.500
Now requires review for investigational.

0687T, 0688T

Preventive Care, 10.01.523
Now covered as part of the standard benefit.

90623, 90683, G0011, G0012, G0013

Remote Electrical Neuromodulation for Migraines, 7.01.171
Now requires review for investigational.

A4540

Responsive Neurostimulation for the Treatment of Refractory Focal Epilepsy, 7.01.143
Now requires review for medical necessity and prior authorization.

61889, 61891

Sacral Nerve Neuromodulation/Stimulation, 7.01.69
Now requires review for medical necessity and prior authorization.

0786T

Sacral Nerve Neuromodulation/Stimulation, 7.01.69
Now requires review for medical necessity.

0787T

Spinal Cord and Dorsal Root Ganglion Stimulation, 7.01.546
Now requires review for medical necessity, including site of service and prior authorization.

0784T, 0785T

Vagus Nerve Stimulation, 7.01.20
Now requires review for investigational.

E0735

Vascular Endothelial Growth Factor (VEGF) Receptor Inhibitors for Ocular Disorders, 5.01.620
Now requires review for medical necessity and prior authorization.

C9161

Revised codes

No updates this month.

Removed codes
Effective January 1, 2024

Amyotrophic Lateral Sclerosis (ALS) Medications, 5.01.578
Code terminated

C9157

Cranial Electrotherapy Stimulation and Auricular Electrostimulation, 8.01.58
Code terminated

K1002

Cryoablation for Chronic Rhinitis, 7.01.168
Code terminated

C9771

Diagnosis and Treatment of Sacroiliac Joint Pain, 6.01.527
Code terminated

0775T, 0809T

Electrical Stimulation Devices, 7.01.507
Code terminated

K1018, K1019

Microprocessor-Controlled and Powered Prostheses and Orthoses for the Lower Limb, 1.04.503
Code terminated

K1014

Monoclonal Antibodies for the Treatment of Lymphoma, 2.03.502
Code terminated

C9155

Non-covered Experimental/Investigational Services, 10.01.533
Code terminated

0715T, 0768T, 0769T, K1009, K1016, K1017, K1021, K1024, K1025, K1026, K1027, K1028, K1029, K1031, K1032, K1033

Non-covered Services and Procedures, 10.01.517
Code terminated

K1003

Remote Electrical Neuromodulation for Migraines, 7.01.171
Code terminated

K1023

Vagus Nerve Stimulation, 7.01.20
Code terminated

K1020