LifeWise
Health Plan of Washington

October 3, 2024 – Provider News – LifeWise Washington

Medical Policy and Coding Updates
October 3, 2024

Special notices
Effective January 3, 2024

Advanced Therapies for Pharmacological Treatment of Pulmonary Arterial Hypertension, 5.01.522 Individual | Group

Medical necessity criteria updated

- Remodulin (treprostinil injection; for subcutaneous [SC] or intravenous [IV] infusion) updated to require trial and failure or intolerance to generic treprostinil injection (SC or IV infusion)

Alpha1-Proteinase Inhibitor, 5.01.624 Individual | Group

Medical necessity criteria updated

- Glassia (alpha1-proteinase inhibitor (PI) [human]) IV
  - Updated from first-line to second-line product
  - Requires trial and failure or intolerance to Aralast NP (alpha1-PI [human]), Prolastin C (alpha1-PI [human]), or Zemaira (alpha1-PI [human])

Dupixent (dupilumab), 5.01.575 Individual | Group

Medical necessity criteria updated

- Blood eosinophil count in asthma criteria increased from 150 cells/mcL within the last 12 months to 300 cells/mcL within the last 12 months
- Asthma diagnostic criteria updated to:
  - One or more asthma exacerbations requiring a hospitalization, an emergency department visit, or an urgent care visit in the previous 12 months, or
  - Forced expiratory volume in 1 second (FEV1) less than 80% predicted

Herceptin (trastuzumab) and Other HER2 Inhibitors, 5.01.514 Individual | Group

Medical necessity criteria updated

- Kanjinti (trastuzumab-anns) and Trazimera (trastuzumab-qyyp) updated to preferred trastuzumab products
- Herceptin (trastuzumab), Herceptin Hylecta (trastuzumab and hyaluronidase-oysk), and Ogivri (trastuzumab-dkst) updated to non-preferred trastuzumab products
- Herceptin, Herceptin Hylecta, Hercessi (trastuzumab-strf), Herzuma (trastuzumab-pkrb), Ogivri, and Ontruzant (trastuzumab-dttb) updated to require the individual to have had an adequate trial and failure with Kanjinti or Trazimera

IL-5 Inhibitors, 5.01.559 Individual | Group

Medical necessity criteria updated

- Nucala (mepolizumab), Fasenra (benralizumab), and Cinqair (reslizumab) asthma criterion on blood eosinophil count updated from greater than 150 cells/mcL to greater than 300 cells/mcL
- Nucala asthma and eosinophilic granulomatosis with polyangiitis criteria updated to include prescriber requirement
- Fasenra and Cinqair asthma criteria updated to include a prescriber requirement
- Nucala, Fasenra, and Cinqair asthma diagnostic criteria updated to:
    - Two or more asthma exacerbations in the previous 12 months requiring use of oral corticosteroids, or
    - One or more asthma exacerbations requiring a hospitalization, an emergency department visit, or an urgent care visit in the previous 12 months, or
    - FEV1 <80% predicted

Monoclonal Antibodies for the Treatment of Lymphoma, 2.03.502 Individual | Group

Medical necessity criteria updated

- Ruxience (rituximab-pvvr) updated to a preferred rituximab product
- Rituxan (rituximab) and Rituxan Hycela (rituximab and hyaluronidase human) updated to non-preferred rituximab products
- Riabni (rituximab-arrx), Rituxan, and Rituxan Hycela updated to require that the individual has had an adequate trial and failure with Ruxience or Truxima

Pharmacologic Treatment in Assisted Reproduction, 5.01.610 Individual | Group

Drugs/medical necessity criteria added

- Ganirelix SC for use in assisted reproduction when the individual has had an inadequate response or intolerance to Generic cetrorelix or Cetrotide (cetrorelix), and Generic ganirelix or Fyremadel (ganirelix)
- Generic ganirelix SC, and Fryremadel (ganirelix) SC for use in assisted reproduction when the individual has had tried and failed, or has intolerance to generic cetrorelix or brand Cetrotide (cetrorelix)

Pharmacological Treatment of Multiple Sclerosis, 5.01.565 Individual | Group

Policy reformatted

- Policy section 2 added to include criteria specific to Individual/Small Group/Student/International Student Metallic Formulary Plans (Rx Plan M1, M2, and M4) for the following drugs:
    - Lemtrada (alemtuzumab), Avonex (interferon-beta 1a), Rebif (interferon-beta 1a), Plegridy (interferon-beta 1a), Betaseron (interferon-beta 1b), Extavia (interferon-beta 1b), generic glatiramer, Glatopa (glatiramer), Copaxone (glatiramer),

Aubagio (teriflunomide), generic teriflunomide, Bafiertam (monomethyl fumarate), generic dimethyl fumarate, Tecfidera (dimethyl fumarate), Vumerity (diroximel fumarate), generic fingolimod, Gilenya (fingolimod), Tascenso ODT (fingolimod), Tyruko (natalizumab-sztn), Tysabri (natalizumab), Briumvi (ublituximab-xiiy), Kesimpta (ofatumumab), Ocrevus (ocrelizumab), Mavenclad (cladribine), Mayzent (siponimod), Ponvory (ponesimod), and Zeposia (ozanimod)

Drugs/medical necessity criteria updated

- Ocrevus (ocrelizumab) and Tysabri (natalizumab) added to site of service administration

Pharmacologic Treatment of Psoriasis, 5.01.629 Individual | Group

Medical necessity criteria updated

- Inflectra (infliximab-dyyb) updated to a first-line agent
- Avsola (infliximab-axxq) updated to a second-line agent
- Avsola and Renflexis updated to require the individual to have an adequate trial and failure with Inflectra, Infliximab (Janssen – unbranded), or Remicade
- Hyrimoz (Sandoz) (adalimumab-adaz) [NDCs starting with 61314] updated to a non-preferred product
- Humira (AbbVie) (adalimumab) [NDCs starting with 00074] updated to require that the individual has had an inadequate response or intolerance to a preferred product for new starts

Pharmacotherapy of Arthropathies, 5.01.550 Individual | Group

Medical necessity criteria updated

- Inflectra (infliximab-dyyb) updated to a first-line agent
- Avsola (infliximab-axxq) updated to a second-line agent
- Avsola and Renflexis updated to require the individual to have an adequate trial and failure with Inflectra, Infliximab (Janssen – unbranded), or Remicade
- Hyrimoz (Sandoz) (adalimumab-adaz) [NDCs starting with 61314] updated to a non-preferred product
- Humira (AbbVie) (adalimumab) [NDCs starting with 00074] updated to require that the individual has had an inadequate response or intolerance to a preferred product for new starts

Pharmacotherapy of Inflammatory Bowel Disorder, 5.01.563 Individual | Group

Medical necessity criteria added

- Inflectra (infliximab-dyyb) updated to a first-line agent
- Avsola (infliximab-axxq) updated to a second-line agent
- Avsola and Renflexis updated to require the individual to have an adequate trial and failure with Inflectra, Infliximab (Janssen – unbranded), or Remicade
- Hyrimoz (Sandoz) (adalimumab-adaz) [NDCs starting with 61314] updated to a non-preferred product

- Humira (AbbVie) (adalimumab) [NDCs starting with 00074] updated to require that the individual has had an inadequate response or intolerance to a preferred product for new starts

Pharmacotherapy of Miscellaneous Autoimmune Disorders, 5.01.564 Individual | Group
Medical necessity criteria updated

- Inflectra (infliximab-dyyb) updated to a first-line agent
- Avsola (infliximab-axxq) updated to a second-line agent
- Avsola and Renflexis criteria updated to require the individual to have an adequate trial and failure with Inflectra, Infliximab (Janssen – unbranded), or Remicade
- Rystiggo criteria updated to require for AChR antibody positive myasthenia gravis the individual has tried and failed Soliris, Ultomiris, Vyvgart, or Vyvgart Hytrulo
- Hyrimoz (Sandoz) (adalimumab-adaz) [NDCs starting with 61314] updated to a non-preferred product
- Humira (AbbVie) (adalimumab) [NDCs starting with 00074] updated to require that the individual has had an inadequate response or intolerance to a preferred product for new starts

Rituxan (rituximab): Non-oncologic and Miscellaneous, 5.01.556 Individual | Group
Medical necessity criteria updated

- Ruxience (rituximab-pvvr) updated to a preferred product
- Rituxan (rituximab) and Rituxan Hycela (rituximab and hyaluronidase human) updated to non-preferred products
- Riabni (rituximab-arrx), Rituxan, and Rituxan Hycela updated to require the individual has had an adequate trial and failure with Ruxience or Truxima
- Hyrimoz (Sandoz) (adalimumab-adaz) [NDCs starting with 61314] updated to a non-preferred product

Shoulder Arthroplasty, 7.01.590 Individual | Group
New policy

- Total shoulder arthroplasty, reverse total shoulder arthroplasty, and shoulder hemiarthroplasty may be considered medically necessary in certain individuals

Thymic Stromal Lymphopoietin (TSLP) Inhibitors, 5.01.627 Individual | Group
Medical necessity criteria updated

- Tezspire (tezepelumab-ekko) updated to include a prescriber requirement
- Diagnostic criteria updated to include the following alternatives:
    - One or more asthma exacerbations requiring a hospitalization, an emergency department visit, or an urgent care visit in the previous 12 months, or
    - FEV1 less than 80% predicted

Use of Vascular Endothelial Growth Factor Receptor (VEGF) Inhibitors and

Other Angiogenesis Inhibitors in Oncology Treatment, 5.01.517 Individual | Group
Medical necessity criteria updated

- Mvasi (bevacizumab-awwb) updated to a preferred product
- Avastin (bevacizumab) updated to a non-preferred product
- Alymsys (bevacizumab-maly), Avastin, Avzivi (bevacizumab-tnjn) and Vegzelma (bevacizumab-adcd) updated to require the individual has had an adequate trial and failure with Mvasi or Zirabev

Xolair (omalizumab), 5.01.513 Individual | Group
Medical necessity criteria updated

- Removed requirement for asthma to be a current non-smoker or be enrolled in a smoking cessation program
- Asthma diagnostic criteria updated to:
  - Two or more asthma exacerbations in the previous 12 months requiring use of oral corticosteroids, or
  - One or more asthma exacerbations requiring a hospitalization, an emergency department visit, or an urgent care visit in the previous 12 months, or
  - FEV1 less than 80% predicted, or
  - Dependence on oral corticosteroids of at least 5 mg per day of prednisone or equivalent

Effective December 5, 2024

Pharmacotherapy of Arthropathies, 5.01.550 Individual | Group
Medical necessity criteria updated

- Cosentyx (secukinumab) IV and Tofidence (tocilizumab-bavi) IV will be reviewed for site of service

Pharmacotherapy of Inflammatory Bowel Disorder, 5.01.563 Individual | Group
Medical necessity criteria updated

- Tyruko (natalizumab-sztn) will be reviewed for site of service

Pharmacotherapy of Miscellaneous Autoimmune Diseases, 5.01.564 Individual | Group
Medical necessity criteria updated

- Tofidence (tocilizumab-bavi) IV will be reviewed for site of service

Pharmacotherapy of of Multiple Sclerosis, 5.01.565 Individual | Group
Medical necessity criteria updated

- Tyruko (natalizumab-sztn) will be reviewed for site of service

Services Reviewed Using InterQual Criteria, 10.01.530 Individual | Group
Services added

Durable Medical Equipment

- The following modules were added and will be used to review for medical necessity:
  - Continuous glucose monitors, insulin pumps, and automated insulin delivery technology
  - Home mechanical ventilation devices: Invasive, noninvasive, and multifunction

Procedures

- The following modules were added and will be used to review for medical necessity:
  - Arthrotomy, shoulder arthroscopy or arthroscopically assisted surgery, shoulder
  - Arthrotomy, shoulder
  - Electrophysiology testing +/- radiofrequency or cryothermal ablation, cardiac
  - Mastectomy, prophylactic, total or simple
  - Osteotomy, proximal, first metatarsal (Bunionectomy)
  - Prostatectomy, radical
  - Salpingectomy
  - Tendon sheath incision or excision, hand, flexor
  - Video electroencephalographic monitoring

Site of Service: Infusion Drugs and Biologic Agents, 11.01.523 Individual | Group
Drugs added

- Alyglo (immune globulin intravenous, human-stwk), Cosentyx IV (secukinumab), Spevigo IV (spesolimab-sbzo), Tofidence IV (tocilizumab-bavi), and Tyruko (natalizumab-sztn) will be reviewed for site of service

Effective November 1, 2024

Alpha-1 Proteinase Inhibitors, 5.01.624 Individual | Group
Medical necessity criteria updated

- Aralast NP, Glassia, Prolastin-C, and Zemaira will be reviewed for site of service

Site of Service: Infusion Drugs and Biologic Agents, 11.01.523 Individual | Group
Drugs added

- Aralast NP, Glassia, Prolastin-C, and Zemaira will be reviewed for site of service

Effective October 20, 2024

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

Effective for dates of service on and after October 20, 2024, the following updates will apply to the Carelon Medical Benefits Management, Inc. Radiology 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

Brain Imaging

- Added indications for Magnetic Resonance Imaging and amyloid beta positron emission tomography imaging in Alzheimer disease to address patients considering or receiving lecanemab

Spine Imaging

- Changed “Perioperative and Periprocedural Imaging” to “Postoperative and Postprocedural Imaging;” pre-procedure requests should be reviewed based on more specific indication

Extremity Imaging

- Separated criteria for osteomyelitis and septic arthritis into separate indications
- Ultrasound or arthrocentesis as preliminary tests were placed only in the “septic arthritis” indication

Vascular Imaging

- Computed tomography angiography (CTA) and magnetic resonance angiography (MRA) Head addition for chronic posterior circulation Stroke/ transient ischemic attack presentations (CTA/MRA neck already allowed, intracranial eval needed for full extent of anatomy)
- Lower Extremity peripheral artery disease: Updated physiologic testing parameters and added allowance for ischemic signs/symptoms at presentation, in alignment with American College of Radiology Appropriateness Criteria
- Suboptimal imaging option downgrades/removals in Brain, Head and Neck and Abdomen/Pelvis

Effective for dates of service on and after October 20, 2024, the following updates will apply to the **Carelon Medical Benefits Management, Inc. Cardiology 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

- Resting Transthoracic Echocardiography
    - Expanded frequency of echocardiographic evaluation in patients on mavacamten for treatment of hypertrophic obstructive cardiomyopathy

- Expanded criteria for echocardiographic evaluation to allow a single screening for cardiac disease in patients undergoing evaluation for solid organ or hematopoietic cell transplant

Effective for dates of service on and after October 20, 2024, the following updates will apply to the **Carelon Medical Benefits Management, Inc. Genetic Testing 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

Chromosomal Microarray Analysis

- Clarified recommendations for Genetic Counseling
- Clarified requirements for postnatal evaluation of individuals with:
  - Congenital or early onset epilepsy (before age 3 years) without suspected environmental causes
  - Autism spectrum disorder, developmental delay, or intellectual disability with no identifiable cause (idiopathic)
- Clarified prenatal evaluation of a fetus with a structural fetal anomaly noted on ultrasound

Pharmacogenomic Testing

- Added Apolipoprotein E testing

Polygenic Risk Scores renamed Predictive and Prognostic Polygenic Testing

- Broadened guideline scope to include polygenic expression prognostic testing and multivariable prognostic genetic testing (essentially clarifications)
  - Moved these tests to exclusions as they are considered not medically necessary
- Retitled guideline to Predictive and Prognostic Polygenic Testing to address the change in scope

Somatic Testing of Solid Tumors

- Clarified gene expression profiling is to guide adjuvant therapy for localized Breast Cancer

Whole Exome and Whole Genome Sequencing

- Expanded whole exome sequencing (WES) criteria to include congenital or early onset epilepsy (before age 3) without suspected environmental etiology and added other clarifications
- Clarified well-delineated genetic syndrome in criterion for multiple anomalies

- Clarified Genetic Counseling details for WES

Effective for dates of service on and after October 20, 2024, the following updates will apply to the **Carelon Medical Benefits Management, Inc. Radiation Oncology 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 (excludes Proton)

- Removed criteria for hyperthermia
- Clarified inclusion criteria of the RTOG 1112 protocol

Effective for dates of service on and after October 20, 2024, the following updates will apply to the **Carelon Medical Benefits Management, Inc., Sleep 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

Sleep Disorder Management

- Expanded definitions and terminology
- Expanded documentation of hypoventilation
- Expanded criteria for home and in-lab sleep studies
- Added contraindication to automatic positive airway pressure titration for use of supplemental oxygen
- Removed home sleep apnea testing as an option in medical necessity of multiple sleep latency test/maintenance of wakefulness test for suspected narcolepsy
- Management of obstructive sleep apnea (OSA) using Implanted Hypoglossal Nerve Stimulators (HNS):
    - Narrowed age range (raised lower limit to 13) for HNS in individuals with Down syndrome and OSA to align with age range suggested by Food and Drug Administration
- Miscellaneous Devices section added:
    - Electronic positional therapy and neuromuscular electrical training of the tongue musculature are considered not medically necessary due to lack of high-quality evidence

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.**

Effective October 8, 2024

Surgical Treatment of Femoral Acetabular Impingement, 7.01.592
New policy

- Surgical treatment of femoral acetabular impingement is considered medically necessary when criteria are met

Medical policies

New medical policies Effective October 1, 2024

Surgical Treatment of Sleep Apnea, 7.01.554 Individual | Group
Policy renumbered from 7.01.101 (see Deleted policies)
Medical necessary criteria updated
Hypoglossal nerve stimulation to treat OSA in adults

- Updated age band from individuals aged 22 years of age and older to those aged 18 years and older
- Updated AHI span to include a cap of no more than 100
- Updated body mass index from at least 40 kg/m^2 to at least 35 kg/m^2

Medical necessary criteria updated
Hypoglossal nerve stimulation to treat OSA in individuals with Down syndrome

- Updated age band from individuals aged 10 to 21 years of age to those aged 13 to 18 years

Revised medical policies Effective October 1, 2024

Prescription Drug Therapeutics, 13.01.500 Individual | Group
Investigational criteria updated

- Added RevitalVision to the list of devices considered investigational

Transcatheter Mitral Valve Repair or Replacement, 2.02.30 Individual | Group
Title expanded to include "or Replacement"
Medical necessity criteria updated

- Added the Pascal device to the list of devices included for coverage when performing transcatheter mitral valve repair

Medical necessity criteria added

- Added coverage criteria for transcatheter mitral valve replacement in individuals with failure of a surgical bioprosthetic mitral value:

- Must have New York Hearth Association heart failure class II, II, or IV symptoms

AND

- Must not an operable candidate for open surgery, as documented by at least 2 cardiovascular specialists

OR

- Must be an operable candidate but is considered at increased surgical risk for open surgery due to a history of congenital vascular anomalies, as documented by at least 2 cardiovascular specialists

OR

- Must be considered at increased surgical risk for open surgery due to a history of congenital vascular anomalies

AND/OR

- Must have a complex intrathoracic surgical history, as documented by at least 2 cardiovascular specialists

Pharmacy policies

New pharmacy policies Effective October 1, 2024

No updates this month.

Revised pharmacy policies Effective October 1, 2024

Medical Necessity Criteria for Pharmacy Edits, 5.01.605 Individual | Group

Drug added

Medical necessity criteria added

- Added Restasis (cyclosporine ophthalmic emulsion) and coverage criteria for treatment of the sign sand symptoms of dry eye disease in individuals aged 18 years and older:
  - Must have had inadequate response or intolerance to generic cyclosporine ophthalmic emulsion 0.05%
  - Must not be used concurrently with another ophthalmic cyclosporine product

Monoclonal Antibodies for the Treatment of Lymphoma, 2.03.502 Individual | Group

Medical necessity criteria added

- Added coverage criteria for Epkinly (epcoritamab-bysp) for the treatment of relapsed and refractory follicular lymphoma in individuals aged 18 years and older when two or more lines of systemic therapy have been tried and failed

Archived policies
Effective October 1, 2024

Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias, 8.01.538

Deleted policies
Effective October 1, 2024

Surgical Treatment of Sleep Apnea, 7.01.101
Policy renumbered. See Surgical Treatment of Sleep Apnea, 7.01.554 Individual | Group

Coding updates

Added codes
Effective October 1, 2024

Amniotic Membrane and Amniotic Fluid, 7.01.583 Individual | Group
Now requires review for investigational.

Q4334, Q4335, Q4336, Q4337, Q4338, Q4339, Q4340, Q4341, Q4342, Q4343, Q4344, Q4345

Bioengineered Skin and Soft Tissue Substitutes, 7.01.113 Individual | Group
Now requires review for investigational.

A2027, A2028, A2029

Carelon Medical Benefits Management Clinical Appropriateness Guidelines for Genetic Testing
Now reviewed by Carelon Medical Benefits Management for medical necessity and prior authorization.

0476U, 0477U, 0478U, 0481U, 0485U, 0486U, 0487U, 0488U, 0489U, 0493U, 0494U, 0496U, 0497U, 0498U, 0499U, 0500U, 0506U, 0507U, 0508U, 0509U, 0516U

Cranial Electrotherapy Stimulation and Auricular Electrostimulation, 8.01.540 Individual | Group
Now requires review for investigational.

A4543, E0721

Evaluation of Biomarkers for Alzheimer Disease, 2.04.521 Individual | Group

Now requires review for investigational.

0479U, 0503U

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

J9329

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

0490U, 0491U, 0492U, 0495U, 0501U, 0505U, 0510U, 0511U, 0512U, 0513U

Maternal Serum Biomarkers for Prediction of Adverse Obstetric Outcomes, 2.04.152
Individual | Group
Now requires review for investigational.

0482U

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

C9170

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

A4544, A4545, A7021, E0469, E0683, E0715, E0716, E0736, E0737, E0743, E0767, E3200, L8720, L8721, P9027

Non-covered Services and Procedures, 10.01.517 Individual | Group
No longer covered.

0517U, 0518U, 0519U, 0520U, Q0516, Q0517, Q0518, Q0519, Q0520

Pharmacologic Treatment of Bladder Cancer, 5.01.632 Individual | Group
Now requires review for medical necessity and prior authorization.

C9169

Pharmacologic Treatment of Hemophilia, 5.01.581 Individual | Group

Now requires review for medical necessity and prior authorization.

C9172

Pharmacologic Treatment of Interstitial Lung Disease, 5.01.555 Individual | Group
Now requires review for medical necessity and prior authorization.

Q5135

Preventive Care Services, 10.01.523 Individual | Group
Now covered as part of the standard benefit.

0502U

Transcatheter Mitral Valve Repair and Replacement, 2.02.30 Individual | Group
Now requires review for medical necessity and prior authorization.

0483T, 0484T

Added codes
Effective October 8, 2024

Surgical Treatment of Femoroacetabular Impingement, 7.01.592 Individual | Group
Now requires review for medical necessity and prior authorization.

29914, 29915, 29916

Revised codes
Effective October 1, 2024

Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia, 8.01.531 Individual | Group
No longer requires review for medical necessity and prior authorization. Now requires review for investigational.

38230, 38240

Removed codes
Effective October 1, 2024

Prescription Digital Therapeutics, 13.01.500

No longer requires review.

T1505

Synthetic Cartilage Implants for Joint Pain, 7.01.160
No longer requires review.

L8641, L8642, 28291

Updates for group plans only

Special notices

No updates this month.

Revised medical policies

No updates this month.

Deleted medical policies

No updates this month.

Archived medical policies

No updates this month.

Coding updates

No updates this month.

Updates for individual plans only

Special notices

Effective December 5, 2024

Services Reviewed Using InterQual Criteria, 10.01.530 Individual
Services added
Durable Medical Equipment

- The following modules were added and will be used to review for medical necessity:

- Continuous glucose monitors, insulin pumps, and automated insulin delivery technology
- Home mechanical ventilation devices: Invasive, noninvasive, and multifunction

Procedures

- The following modules were added and will be used to review for medical necessity:
  - Arthrotomy, shoulder arthroscopy or arthroscopically assisted surgery, shoulder
  - Arthrotomy, shoulder
  - Electrophysiology testing +/- radiofrequency or cryothermal ablation, cardiac
  - Mastectomy, prophylactic, total or simple
  - Osteotomy, proximal, first metatarsal (Bunionectomy)
  - Prostatectomy, radical
  - Salpingectomy
  - Tendon sheath incision or excision, hand, flexor
  - Video electroencephalographic monitoring

Revised medical policies

No updates this month.

Deleted medical policies

No updates this month.

Archived medical policies

No updates this month.

Coding updates

Added codes

No updates this month.

Revised codes
Effective January 3, 2025

Biofeedback for Incontinence, 2.01.540 Individual
Now requires review for medical necessity and prior authorization.

90901, 90912, 90913

Continuous Home Pulse Oximetry, 1.01.533 Individual
Now requires review for medical necessity and prior authorization.

A4606, E0445

Endometrial Ablation, 7.01.578 **Individual**
Now requires review for medical necessity and prior authorization.

58353, 58356, 58563

External Counterpulsation Therapy, 2.02.514 **Individual**
Now requires review for medical necessity and prior authorization.

G0166

Eye-Anterior Segment Optical Coherence Tomography, 9.03.509 **Individual**
Now requires review for medical necessity and prior authorization.

92132

Fundus Photography, 9.03.507 **Individual**
Now requires review for medical necessity and prior authorization.

92250

Glaucoma, Invasive Procedures, 9.03.510 **Individual**
Now requires review for medical necessity and prior authorization.

66174, 66175, 66183

High-Resolution Anoscopy, 2.01.539 **Individual**
Now requires review for medical necessity and prior authorization.

46601, 46607

Home Apnea Monitoring, 1.01.534 **Individual**
Now requires review for medical necessity and prior authorization.

94774, 94775, 94776, 94777

Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring, 1.01.536 **Individual**
Now requires review for medical necessity and prior authorization.

93792, 93793, G0248, G0249, G0250

Laryngeal Injection for Vocal Cord Augmentation, 2.01.541 **Individual**
Now requires review for medical necessity and prior authorization.

31513, 31570, 31571, 31573, 31574

Noninvasive Tests for Hepatic Fibrosis, 2.01.536 **Individual**
Now requires review for medical necessity and prior authorization.

76981, 76982, 76983

Posterior Tibial Nerve Stimulators, 7.01.579 **Individual**
Now requires review for medical necessity and prior authorization.

64566

Presbyopia Correcting Intraocular Lenses (PIOLs) and Astigmatism Correcting Intraocular Lenses (ACIOLs), 9.03.511 **Individual**
Now requires review for medical necessity and prior authorization.

66982, 66983, 66984, V2630, V2631, V2632

Rabies Vaccine, Home Setting, 9.01.508 **Individual**
Now requires review for medical necessity and prior authorization.

90375, 90376, 90377, 90675, 90676

Services Reviewed Using InterQual Criteria, 10.01.530 **Individual**
Now requires review for medical necessity and prior authorization.

34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708, 34709, 34710, 34711, 34712, 34713, 34714, 34715, 34716, 34808, 34812, 34813, 34820, 34833, 34834, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 58720, 58940, A4633, E0424, E0431, E0433, E0434, E0439, E0441, E0442, E0443, E0444, E1390, E1391, E1392, E1405, E1406, K0378

Supervised Exercise Therapy for Peripheral Artery Disease, 8.01.537 **Individual**
Now requires review for medical necessity and prior authorization.

93668

Ultraviolet B Light Therapy in the Home to Treat Skin Conditions, 2.01.542 **Individual**

Now requires review for medical necessity and prior authorization.

E0691, E0692, E0693, E0694

Visual Evoked Response Test, 9.03.512 **Individual**
Now requires review for medical necessity and prior authorization.

95930