LifeWise
Health Plan of Washington

December 5, 2024 – Provider News – LifeWise Washington

Medical Policy and Coding Updates
December 5, 2024

Special notices
Effective March 5, 2025

Surgical Treatments for Lymphedema and Lipedema, 7.01.567 Individual | Group

Medical necessity criteria added

- Evidence of cuff phenomenon (sparing of feet if lower extremities are affected, or sparing of hands if upper extremities are affected) is present, body mass index (BMI) less than or equal to 35 kg/m², the requested surgical intervention will be performed by a plastic surgeon
- Staged liposuction procedures may be considered medically necessary when there is a large total volume of aspirate (i.e. 5000 cc) during the initial procedure, and they are completed within a 12-month period

Investigational criteria added

- Liposuction or lipectomy for the treatment of lipedema in the trunk or back is considered investigational
- Retreatment of a previously treated area using the same procedure is considered investigational

Effective February 7, 2025

Gonadotropin Releasing Hormone (GnRH) Analogs, 5.01.625 Individual | Group

Drug added

- Synarel (nafarelin) to central precocious puberty, endometriosis and gender dysphoria criteria

Medical necessity criteria updated

- Initial gender dysphoria criteria updated to clarify that:
  - Puberty onset at Tanner stage 2 or higher is determined by serum testosterone level, serum estradiol level, serum estrone level, serum luteinizing hormone level, or serum follicle stimulating hormone for individuals assigned female at birth
  - Potential adverse effects have been discussed, including possible effects on fertility, bone mineralization and bone density
  - GnRH agonist is necessary to suppress characteristics of the gender assigned at birth that are not evident by observation or on physical examination in certain

individuals aged 23 and older, or after reaching Tanner stage 5, or after irreversible physical/anatomic secondary sexual characteristics are developed
    - Documentation is required demonstrating that cross-sex hormone/gender affirming hormone treatment is not effective when starting a GnRH agonist
- Updated initial gender dysphoria criteria notes to clarify confirmation of Tanner stages due to overlapping values
- Initial authorization duration updated from up to 6 months to up to 12 months
- Re-authorization gender dysphoria criteria updated to clarify that:
    - Documentation of suppression of secondary sex characteristics based on physical examination OR documentation of suppression of characteristics of the gender assigned at birth that are not evident by observation or on physical examination is required
    - Documentation of annual testing of bone age or bone density is required in certain individuals
    - For the first re-authorization request, if the previous coverage was under a non-Company plan, documentation that the initial authorization requirements have also been met is required
- Updated re-authorization gender dysphoria criteria notes to clarify acceptable documentation of suppression of characteristics of the gender assigned at birth

Investigational criteria added

- Use of GnRH analogs that does not meet the age or diagnosis requirements within the Medical Necessity section is considered investigational
- Use of GnRH analogs that meets the age and diagnosis requirements within the Medical Necessity section but does not meet other policy criteria within the Medical Necessity section is considered not medically necessary

Medical Necessity Criteria for Pharmacy Edits, 5.01.605 Individual | Group

Drug/medical necessity criteria added

- CytoGam (cytomegalovirus immune globulin) for the prophylactic treatment of cytomegalovirus (CMV) disease or CMV pneumonitis associated with transplantation in certain individuals

Miscellaneous Oncology Drugs, 5.01.540 Individual | Group

Drugs/medical necessity criteria added

- Brand bendamustine, Belrapzo (bendamustine), Bendeka (bendamustine), and Vivimusta (bendamustine) for the treatment of certain individuals with chronic lymphocytic leukemia or non-Hodgkin lymphoma
- Nipent (pentostatin) for the treatment of certain individuals with hairy cell leukemia
- Oncaspar (pegaspargase) for the treatment of certain individuals with acute lymphoblastic leukemia

- Vyxeos (cyatarabine-daunorubicin) coverage criteria for the treatment of certain individuals with acute myeloid leukemia

Effective January 3, 2025

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 (EP) testing +/- radiofrequency (RFA) or cryothermal ablation, cardiac
  - Mastectomy, prophylactic, total or simple
  - Osteotomy, proximal, first metatarsal (MT) (Bunionectomy)
  - Prostatectomy, radical
  - Salpingectomy
  - Tendon sheath incision or excision, hand, flexor
  - Video electroencephalographic (EEG) 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

Medical policies

New medical policies

No updates this month.

Revised medical policies Effective December 1, 2024

Electrical Stimulation Devices, 1.01.507 Individual | Group
Investigational criteria added

- Transcutaneous tibial nerve stimulation is considered investigational for the treatment of overactive bladder

Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis, 1.01.525 Individual | Group
Policy reformatted; policy intent unchanged

- Policy statements emphasize the type of surgery performed and if there is or is not a contraindication with use of standard anticoagulant medications
- Risk of bleeding and moderate to high-risk of venous thromboembolism reformatted to a guideline directed note

Pharmacy policies

(H2) New pharmacy policies

No updates this month.

(H2) Revised pharmacy policies
(H2) Effective December 1, 2024

Multiple Receptor Tyrosine Kinase Inhibitors, 5.01.534 Individual | Group

Medical necessity criteria updated

- Augtyro (repotrectinib) criteria updated to include treatment of certain individuals with solid tumors
- Clarified that Lenvima (lenvatinib) can be used as first-line treatment for individuals with unresectable hepatocellular carcinoma

Prostate Cancer Targeted therapy, 5.01.544 Individual | Group

Medical necessity criteria updated

- Yonsa (abiraterone) criteria updated to include a trial and failure of generic abiraterone

Tadalafil Products for Benign Prostatic Hyperplasia, 5.01.545 Individual | Group

Title Changed

- Title changed from “Tadalafil Products for Benign Prostatic Hyperplasia” to “Pharmacologic Treatment of Benign Prostatic Hyperplasia”

Drugs/medical necessity criteria added

- Avodart (dutasteride), Chewtadzy (tadalafil), Flomax (tamsulosin), and Tezruly (terazosin) may be considered medically necessary for the treatment of benign prostatic hyperplasia when criteria are met

Medical necessity criteria updated

- Quantity limits clarified for Cialis (tadalafil) and generic tadalafil (5 mg once daily)
- Cialis (tadalafil) step therapy requirements updated from tried and had an inadequate response or intolerance to a generic alpha blocker and generic finasteride, dutasteride or silodosin to tried and had an inadequate response or intolerance to a generic alpha blocker and generic tadalafil
- Generic tadalafil step therapy requirements updated from tried and had an inadequate response or intolerance to a generic alpha blocker and generic finasteride, dutasteride or

silodosin to tried and had an inadequate response or intolerance to a generic alpha blocker

Use of Granulocyte Colony-Stimulating Factors (G-CSF), 5.01.551 Individual | Group
Drugs added

- Added Nypozi (filgrastrim-txid) as a non-preferred treatment for all labeled indications
- Ziextenzo (pegfilgrastim-bmez) added for treatment acute exposure to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome)

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

- Ocrevus Zunovo (ocrelizumab-hyaluronidase-ocsq) may be considered medically necessary for the treatment of:
  - Relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, when criteria are met
  - Primary progressive multiple sclerosis when criteria are met

BRAF and MEK Inhibitors, 5.01.589 Individual | Group
Drug/medical necessity criteria updated

- Clarified definition of pediatric individuals for Tafinlar (dabrafenib) and Koselugo (selumetinib) from '1 year of age and older' to 'at least 1 year of age and under 18 years of age'

Drug/medical necessity criteria added

- Added coverage for Ojemda (tovorafenib) for the treatment of relapsed or refractory pediatric low-grade glioma harboring a BRAF fusion or rearrangement, or BRAF V600 mutation in pediatric individuals

Epidermal Growth Factor Receptor (EGFR) Inhibitors, 5.01.603 Individual | Group
Drug/medical necessity criteria added

- Lazcluze (lazertinib) may be considered medically necessary for the treatment of non-small cell lung cancer (NSCLC) when criteria are met

Drug/medical necessity criteria updated

- Rybrevant (amivantamab-vmjw) criteria updated to include first-line treatment of NSCLC in combination with Lazcluze (lazertinib) in certain individuals

Continuity of Coverage for Maintenance Medications, 5.01.607 Individual | Group
Medical necessity criteria added

- Continuation of a maintenance medication criteria added for new to plan members for a drug that does not have a preferred generic or biosimilar alternative

- Continuation of a maintenance medication criteria added for current plan members for a drug that does have a preferred generic or biosimilar alternative

Drugs for Weight Management, 5.01.621 Individual | Group
Medical necessity criteria added/updated

- Wegovy (semaglutide) criteria updated to include use in certain individuals with established cardiovascular disease

Pharmacologic Treatment of Atopic Dermatitis, 5.01.628 Individual | Group
Drug/medical necessity criteria added

- Ebglyss (lebrikizumab-lbkz) for the treatment of moderate to severe atopic dermatitis when criteria are met

Pharmacologic Treatment of Psoriasis, 5.01.629 Individual | Group
Medical necessity criteria updated

- Bimzelx (bimekizumab-bkzx) brand step therapy requirement updated from trial and inadequate response or intolerance to two agents to trial and inadequate response or intolerance to one agent

Pharmacologic Treatment of Alopecia, 5.01.637 Individual | Group
Drug/medical necessity criteria added

- Leqselvi (deuruxolitinib) for the treatment of severe alopecia areata

Immune Globulin Therapy, 8.01.503 Individual | Group
Medical necessity criteria updated

- Humoral immunodeficiency states updated to include acute lymphocytic leukemia

Medical necessity criteria removed

- Requirement to have recurrent or persistent infections from the humoral immunodeficiency states removed from criteria

Archived policies

No updates this month.

Deleted policies

No updates this month.

Coding updates

Added codes

LifeWise
Health Plan of Washington

Effective December 5, 2024

Cervical Spine Surgeries: Discectomy, Laminectomy, and Fusion in Adults, 7.01.560 Individual | Group
Now requires review for medical necessity, including site of service and prior authorization.

63001, 63015, 63040, 63050, 63051, 63075, 63081, 63265

Pharmacotherapy of Multiple Sclerosis, 5.01.565 Individual | Group
Now requires review for medical necessity and prior authorization.

J1826, J1830, Q3027, Q3028

Effective December 1, 2024

Hyperbaric Oxygen Therapy, 2.01.505 Individual | Group
Now requires review for investigational.

E0446

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

M0224, M0249, M0250, Q0224, Q0249

Revised codes
Effective December 5, 2024

Site of Service: Infusion Drugs and Biologic Agents, 11.01.523 Individual | Group
No longer requires review for site of service. Review for medical necessity and prior authorization still required.

J1599, J1747, J3247, Q5133, Q5134

Effective December 1, 2024

Hyperbaric Oxygen Therapy, 2.01.505 Individual | Group
No longer requires review for medical necessity and prior authorization. Now requires review for investigational.

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A4575

Removed codes
Effective December 1, 2024

Surgical Treatment of Femoroacetabular Impingement, 7.01.592 Individual | Group
No longer requires review.

29916

Therapeutic Radiopharmaceuticals in Oncology, 6.01.525 Individual | Group
No longer requires review.

A9590

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

LifeWise
Health Plan of Washington

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:
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  - 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
Effective March 5, 2025

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

92972

Effective December 1, 2024

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

23430, 25447, 26055, 27427, 28297, 29806, 29807, 29822, 29827, 29828, 29916, 30140, 30520, 33249, 38525, 45378, 45380, 45381, 45385, 45388, 45390, 45398, 49650, 55866, 57425, 58558, 58661, 58662, 64718, 93653, 95716, E0465, E0784

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