LifeWise
Health Plan of Washington

Medical Policy and Coding Updates
February 6, 2020

Special notices

Effective July 2, 2020

Services Reviewed Using InterQual® Criteria, 10.01.530

This policy outlines the specific services the Plan uses InterQual® criteria to review against. Effective for dates of service July 2, 2020, and after, InterQual® criteria will replace the following medical policies:

- Bariatric Surgery, 7.01.516
- Blepharoplasty, Blepharoptosis and Brow Ptosis Surgery, 7.01.508
- Coronary Angiography, 2.02.507
- Hip Arthroplasty in Adults, 7.01.573
- Knee Arthroplasty, 7.01.550
- Knee Arthroscopy in Adults, 7.01.549
- Mastectomy for Gynecomastia, 7.01.521
- Panniculectomy and Excision of Redundant Skin, 7.01.523
- Power Operated Vehicles, 1.01.527
- Reduction Mammaplasty for Breast-Related Symptoms, 7.01.503
- Rhinoplasty, 7.01.558

InterQual® criteria may vary from the medical policies listed above. The Plan will begin to review some pediatric services for medical necessity. Sign in to our provider website to view InterQual® criteria and these changes.

Effective June 5, 2020

Miscellaneous Oncology Drugs, 5.01.540

The following drug has been added and may be considered medically necessary when criteria are met:

- Darzalex® (daratumumab)
  - Treatment of multiple myeloma in adults when used as a combination treatment or monotherapy

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Effective May 17, 2020

Effective for dates of service on and after May 17, 2020, the following updates by will apply to the **AIM Specialty Health® Clinical Appropriateness Guidelines for Radiology: Vascular Imaging**

Updates by section

Aneurysm of the abdominal aorta or iliac arteries

- Added new indication for asymptomatic enlargement by imaging
- Clarified surveillance intervals for stable aneurysms as follows:
  - Treated with endografts, annually
  - Treated with open surgical repair, every 5 years

Stenosis or occlusion of the abdominal aorta or branch vessels, not otherwise specified

- Added surveillance indication and interval for surgical bypass grafts

Effective April 3, 2020

Herceptin® (trastuzumab) and Other HER2 Inhibitors, 5.01.514

- Trazimera™ (trastuzumab-qyyp), a biosimilar to Herceptin® (trastuzumab), has been changed to a first-line biosimilar for the treatment of HER2-postive breast cancer, HER2-postive metastatic gastric cancer, and HER2-postive gastroesophageal junction adenocarcinoma when criteria are met
- The biosimilars Herzuma® (trastuzumab-pkrb), Kanjinti™ (trastuzumab-anns), Ogivri™ (trastuzumab-dkst) and Ontruzant® (trastuzumab-dttb) are second-line biosimilars and require an inadequate response or intolerance to Herceptin® or Trazimera™ when criteria are met

IL-5 Inhibitors, 5.01.559

- Nucala® (mepolizumab) medical necessity criteria have been updated for the treatment of severe eosinophilic asthma. The age criterion has changed from age 12 to age 6 and older.
- Nucala® (mepolizumab) medical necessity criteria have also been updated for the treatment of eosinophilic granulomatosis with polyangiitis (EGPA) in adults to include blood eosinophil levels and documented evidence of polyangiitis, vasculitis, mononeuritis, or systemic symptoms

Monoclonal Antibodies for the Treatment of Lymphoma, 2.03.502

- Polivy™ (polatuzumab vedotin-piiq) has been added to the policy and may be considered medically necessary for the treatment of diffuse large B-cell lymphoma (DLBCL) in adults when criteria are met

- Ruxience™ (rituximab-pvvr), a biosimilar to Rituxan® (rituximab), has been added to the policy as a first-line biosimilar and may be considered medically necessary for non-Hodgkin's lymphoma and chronic lymphocytic leukemia
- Truxima® (rituximab-abbs) is a second-line biosimilar and requires an inadequate response or intolerance to Rituxan® or Ruxience™ when criteria are met

Pharmacotherapy of Arthropathies, 5.01.550

Ruxience™ (rituximab-pvvr) has been added to the policy and may be considered medically necessary as a second-line anti-CD20 agent when criteria are met

Pharmacotherapy of Miscellaneous Autoimmune Diseases, 5.01.564

Ruxience™ (rituximab-pvvr) has been added to the policy and may be considered medically necessary as a first-line treatment for systemic lupus erythematosus when criteria are met

Pharmacotherapy of Thrombocytopenia, 5.01.566

Ruxience™ (rituximab-pvvr) and Truxima® (rituximab-abbs) have been added to the policy and may be considered medically necessary as anti-CD20 agents for the treatment of chronic immune thrombocytopenia when criteria are met

Rituximab: Non-oncologic and Miscellaneous Uses, 5.01.556

- Ruxience™ (rituximab-pvvr), a biosimilar to Rituxan® (rituximab), has been added to the policy as a first-line biosimilar and may be considered medically necessary when criteria are met
- Truxima® (rituximab-abbs) is a second-line biosimilar and requires an inadequate response or intolerance to Rituxan® or Ruxience™ when criteria are met

Use of Vascular Endothelial Growth Factor Receptor (VEGF) Inhibitors and Other Angiogenesis Inhibitors in Oncology Treatment, 5.01.517

- Zirabev™ (bevacizumab-bvzr), a biosimilar to Avastin® (bevacizumab), has been changed to a first-line biosimilar and may be considered medically necessary when criteria are met
- Mvasi™ (bevacizumab-awwb) is a second-line biosimilar and requires an inadequate response or intolerance to Avastin® (bevacizumab) or Zirabev™ (bevacizumab-bvzr) when criteria are met

Effective March 5, 2020

Knee Arthroplasty in Adults, 7.01.550

- A description of Kellgren-Lawrence grade 3 is added to the medical necessity statement of radiographic evidence

- The conservative management section is modified to now include a requirement of both medical measures and physical measures

Pharmacotherapy for Multiple Sclerosis, 5.01.565

Medical necessity of Ocrevus® (ocrelizumab) intravenous will now include site of service review. See policy for more details.

Site of Service: Infusion Drugs and Biologic Agents, 11.01.523

Medical necessity of Ocrevus® (ocrelizumab) intravenous will now include site of service review. See policy for more details.

Effective March 4, 2020

Updates to **AIM Specialty Health® Clinical Appropriateness Guidelines**

Effective for dates of service on and after March 4, 2020, the following updates by section will apply to the **AIM Specialty Health® Clinical Appropriateness Guidelines for Genetic Testing**

Updates by section

Genetic Testing for Hereditary Cancer Susceptibility

Multi-Gene Panel Testing

- Restricted the genes on allowable panels to those with peer-reviewed clinical validity data for the cancers present in the individual's personal and/or family history

CHEK2 and PALB2

- Restricted to exclude coverage for those with a family history of prostate cancer only and no history of other relevant cancers

Prostate Cancer

- Removed RAD51D from the allowable gene list

Effective February 21, 2020

Massage Therapy, 8.03.506

Massage therapy may be considered medically necessary when criteria in the policy are met and it is not intended for prolonged treatment

Services Reviewed Using InterQual® Criteria, 10.01.530

This policy is updated to add physical therapy and occupational therapy services to the list of services that will be reviewed using InterQual® criteria

Effective February 9, 2020

Updates to **AIM Specialty Health® Clinical Appropriateness Guidelines**

Effective for dates of service on and after February 9, 2020, the following updates by section will apply to the **AIM Specialty Health® Clinical Appropriateness Guidelines for Radiology**

Updates by section

Abdomen and Pelvis

Foreign body (pediatric only)

- Gastrointestinal bleeding
- Henoch-Schoenlein purpura
- Hematoma or hemorrhage – intracranial or extracranial
- Perianal fistula/abscess (fistula in ano)
- Ascites
- Biliary tract dilatation or obstruction
- Cholecystitis
- Choledocholithiasis
- Cocal liver lesion
- Hepatomegaly
- Jaundice
- Azotemia
- Adrenal mass
- Indeterminate hematuria
- Renal mass
- Urinary tract calculi
- Adrenal hemorrhage
- Adrenal mass
- Lymphadenopathy
- Splenic hematoma
- Undescended testicle (cryptorchidism)

Abdominal and/or pelvic pain

- Combined pelvic pain with abdominal pain criteria into a new "abdominal and/or pelvic pain" indication

- Required ultrasound or colonoscopy for select adult patients based on clinical scenario
- Added ultrasound-first approach for pediatric abdominal and pelvic pain

Lower extremity edema
Added requirement to exclude DVT prior to abdominopelvic imaging

Splenic mass, benign; splenic mass, indeterminate; splenomegaly
Added new indications for diagnosis, management, and surveillance of splenic incidentalomas following the American College of Radiology White Paper (previously reviewed against "tumor, not otherwise specified")

Pancreatic mass
Criteria for solid and cystic pancreatic masses now appear separately and follow up intervals for cystic pancreatic masses are now defined

Diffuse liver disease
Added criteria to address MR elastography

Inflammatory bowel disease
Limited requirement for upper endoscopy to patients with relevant symptoms and include new requirement for fecal calprotectin or CRP to differentiate IBS from IBD

Enteritis or colitis not otherwise specified
Incorporated intussusception (pediatric only), and ischemic bowel

Prostate cancer
This indication is now found in the Oncologic Imaging Guideline

Effective for dates of service on and after February 9, 2020, the following updates by section will apply to the **AIM Specialty Health® Clinical Appropriateness Guidelines for Radiation Oncology**

Updates by section

Special treatment procedure and special physics consult
Oral cone endocavitary indication is removed

Intensity modulated radiation therapy (IMRT), stereotactic Radiosurgery (SRS) or stereotactic body radiotherapy (SBRT) for bone metastases
Broadened description of adjacent normal tissues

Single fraction treatment
Removed poor performance status criteria

Central nervous system cancers
Now includes evidence review

Spine lesions; primary or metastatic lesions of the spine, metastatic lesions in the lung
Incorporated note calling out separate criteria for curative intent treatment of extracranial oligometastatic disease

SBRT in the treatment of extracranial oligometastatic disease
Added new section with discussion and indications

Prostate cancer – hypofractionation
Added fractionation guideline with EBRT/IMRT

Prostate cancer – postoperative radiotherapy and SBRT
Added indication based on ASTRO/ASCO/AUA recommendation

Prostate cancer – use of hydrogel spacer
Added discussion and medical necessity statement about hydrogel spacers for prostate irradiation

Effective for dates of service on and after February 9, 2020, the following updates by section will apply to the **AIM Specialty Health® Clinical Appropriateness Guidelines for Sleep Disorder Management**

Updates by section

Polysomnography and Home Sleep Testing: Established sleep disorder (OSA or other) – follow-up laboratory studies
Expanded contraindications including the addition of chronic narcotic use based on the American Academy of Sleep Medicine Clinical Practice Guideline recommendation

Management of OSA using APAP and CPAP Devices
- Expanded treatment of mild OSA with APAP and CPAP to patients with any hypertension based on the American Academy of Sleep Medicine Clinical Practice Guideline recommendation
- Expanded contraindications including the addition of chronic narcotic use based on the American Academy of Sleep Medicine Clinical Practice Guideline recommendation

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Medical policies

Revised medical policies Effective February 1, 2020

Cosmetic and Reconstructive Services, 10.01.514

Medical necessity criteria have been added to the policy for the following reconstructive services:

- Genioplasty
- Labiaplasty
- Otoplasty/pinnaplasty
- Rhytidectomy
- Scar revision
- Skin tag removal
- Tattoo as part of breast reconstructive surgery

The following services have been added to the list of cosmetic procedures:

- Canthopexy/canthoplasty
- Facial bone reduction or enhancement
- Laser skin resurfacing, lip augmentation
- Liposuction for body contouring for alteration of appearance
- Vaginal rejuvenation

Pharmacy policies

Revised pharmacy policies Effective February 1, 2020

Drugs for Rare Diseases, 5.01.576

Generic miglustat and Zavesca® (miglustat) have been added to the policy and may be considered medically necessary for patients age 18 and older for the treatment of Type 1 Gaucher's disease when criteria are met

Medical Necessity Criteria for Pharmacy Edits, 5.01.605

The following drugs have been added to the policy and may be considered medically necessary when criteria are met:

- Aklief® (trifarotene) for the treatment of acne
- Xcopri® (cenobamate) for adult patients for the treatment of partial-onset seizures
- Dayvigo® (lemborexant) for adult patients for the treatment of insomnia
- Ibsrela® (tenapanor) for the treatment of irritable bowel syndrome with constipation (IBS-C)

- Scenesse® (afamelanotide) for patients age 18 and older for the treatment of erythropoietic protoporphyria (EPP)

Criteria for Pulmozyme® (dornase alfa) have been updated for the treatment of cystic fibrosis. In patients under age 5, a documented forced expiratory volume (FEV1) value is no longer required.

Travoprost has been added to the list of generics which must be tried and failed for a patient to qualify for coverage for brand ophthalmic prostaglandin analogs for the treatment of intraocular pressure with glaucoma

Miscellaneous Oncology Drugs, 5.01.540

Inrebic® (fedratinib) has been added to the policy and may be considered medically necessary for adults for the treatment of intermediate-2 or high-risk primary or secondary (polycythemia vera myelofibrosis or post-essential thrombocythemia) myelofibrosis when criteria are met

Pharmacologic Treatment of Cystic Fibrosis with Ivacaftor Products, 5.01.539

- Policy title has been changed from "Kalydeco® (ivacaftor), Orkambi® (lumacaftor ivacaftor), and Symdeko™ (tezacaftor ivacaftor)" to "Pharmacologic Treatment of Cystic Fibrosis with Ivacaftor Products"
- Trikafta™ (elexacaftor/tezacaftor/ivacaftor) has been added to the policy and may be considered medically necessary for patients age 12 and older for the treatment of cystic fibrosis when criteria are met

Pharmacologic Treatment of Idiopathic Pulmonary Fibrosis, 5.01.555

Ofev® (nintedanib) has been added to the policy and may be considered medically necessary for the treatment of idiopathic pulmonary fibrosis and for patients age 18 and older for the treatment of systemic sclerosis-associated interstitial lung disease (SSc-ILD) when criteria are met

Pharmacotherapy of Multiple Sclerosis, 5.01.565

- Vumerity™ (diroximel fumarate) has been added to the policy and may be considered medically necessary for adults for the treatment of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapse-remitting disease, and active secondary progressive disease when criteria are met
- Tecfidera® (dimethyl fumarate) medical necessity criteria have been updated to include the following relapsing forms of multiple sclerosis: clinically isolated syndrome, relapse-remitting disease, and active secondary progressive disease

Archived policies

No updates this month

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Deleted policies

No updates this month

Coding updates

Added codes
Effective March 5, 2020

Pharmacotherapy of Multiple Sclerosis, 5.01.565
Now requires prior authorization, currently reviewed for medical necessity.

J2350

Site of Service: Infusion Drugs and Biologic Agents, 11.01.523
Now requires review for site of service as part of medical necessity and prior authorization.

J2350

Effective February 21, 2020

Massage Therapy, 8.03.506
Now requires review for medical necessity after initial 6 visits in an episode of care.

97010, 97112, 97124, 97140

Services Reviewed Using InterQual® Criteria, 10.01.530

97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97129, 97130, 97139, 97140, 97150, 97164, 97168, 97530, 97533, 97535, 97542, 97750, 97755, 97760, 97761, 97763, 97799, G0283

Effective February 9, 2020

Effective for dates of service on and after February 9, 2020, the following updates by section will apply to the AIM Specialty Health® Clinical Appropriateness Guidelines for Radiation Oncology

Now requires review for medical necessity and prior authorization.

55874

Effective February 1, 2020

Cognitive (Neurologic) Rehabilitation in the Outpatient Setting, 8.03.504

Now requires review for outpatient rehabilitation through eviCore.

97129, 97130

Cosmetic and Reconstructive Services, 10.01.514

Now requires review for cosmetic and reconstructive.

67950

Miscellaneous Oncology Drugs, 5.01.540

Now requires review for medical necessity and prior authorization.

J9214

Myoelectric Prosthetic and Orthotic Components for the Upper Limb, 1.04.502

Now requires review for investigative.

L2006

Wheelchairs (Manual or Motorized), 1.01.501

Now considered noncovered.

E2372

Revised codes
Effective February 1, 2020

Allergy Testing, 2.01.500

Now reviewed for medical necessity (previously reviewed for investigative).

95060

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Multimarker Serum Testing Related to Ovarian Cancer, 2.04.62

Currently reviewed for investigative. No longer requires prior authorization.

0003U

Wheelchairs (Manual or Motorized), 1.01.501

Currently reviewed for medical necessity. Now requires prior authorization.

E0988

Removed codes
Effective February 1, 2020

Miscellaneous Oncology Drugs, 5.01.540

No longer requires review for medical necessity and prior authorization.

J9213