LifeWise
Health Plan of Washington

Medical Policy and Coding Updates
April 4, 2020

Special notices

Effective July 2, 2020

Services Reviewed Using InterQual® Criteria, 10.01.530

This policy outlines the specific services for which the Plan will use InterQual® criteria with those added for dates of service beginning July 2, 2020 and after. (* InterQual® criteria may vary from the medical policies listed below). Sign in to our website to view InterQual® criteria.

- Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses, 1.01.11
- Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias, 8.01.22
- Allogeneic Hematopoietic Cell Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms, 8.01.21
- Artificial Intervertebral Disc: Cervical Spine, 7.01.108
- Artificial Intervertebral Disc: Lumbar Spine, 7.01.87
- Artificial Pancreas Device Systems, 1.01.30
- Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions, 7.01.570
- Bariatric Surgery, 7.01.516
- Blepharoplasty, Blepharoptosis and Brow Ptosis Surgery, 7.01.508
- Cardioverter-Defibrillator Placement, 2.02.506
- Cervical Spine Surgeries: Discectomy, Laminectomy, and Fusion in Adults, 7.01.560
- Closure Devices for Patent Foramen Ovale and Atrial Septal Defects, 2.02.09
- Cochlear Implant, 7.01.05
- Continuous Passive Motion in the Home Setting, 1.01.10
- Coronary Angiography for Known or Suspected Coronary Artery Disease, 2.02.507
- Deep Brain Stimulation, 7.01.63
- Electrical Bone Growth Stimulation of the Appendicular Skeleton, 7.01.07
- Extracorporeal Photopheresis, 8.01.36
- Extracorporeal Shock Wave Treatment for Plantar Fasciitis and Other Musculoskeletal Conditions, 2.01.40
- Facet Joint Denervation, 7.01.555
- Gastric Electrical Stimulation, 7.01.522
- Heart Transplant, 7.03.09

- Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma, 8.01.15
- Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia, 8.01.30
- Hematopoietic Cell Transplantation for Hodgkin Lymphoma, 8.01.29
- Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma and POEMS Syndrome, 8.01.17
- Hip Arthroplasty in Adults, 7.01.573
- Hospital Beds and Accessories, 1.01.520
- Hyperbaric Oxygen Therapy, 2.01.505
- Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers), 7.01.107
- Interspinous Fixation (Fusion) Devices, 7.01.138
- Keratoprosthesis, 9.03.01
- Kidney Transplant, 7.03.01
- Knee Arthroplasty in Adults, 7.01.550*
- Knee Arthroscopy in Adults, 7.01.549
- Knee Orthoses (Braces), Ankle-Foot-Orthoses, and Knee-Ankle-Foot-Orthoses, 1.03.501
- Liver Transplant and Combined Liver-Kidney Transplant, 7.03.509*
- Lumbar Spinal Fusion, 7.01.542
- Lumbar Spine Decompression Surgery: Discectomy, Foraminotomy, Laminotomy, Laminectomy in Adults, 7.01.551
- Magnetic Resonance-Guided Focused Ultrasound, 7.01.109
- Mastectomy for Gynecomastia, 7.01.521*
- Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Conditions, 1.01.15
- Panniculectomy and Excision of Redundant Skin, 7.01.523
- Patient Lifts, Seat Lifts and Standing Devices, 1.01.519
- Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation, 2.02.26
- Percutaneous Vertebroplasty and Sacroplasty, 6.01.25
- Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers, 1.01.18
- Power Operated Vehicles (Scooters) (Excluding Motorized Wheelchairs), 1.01.527
- Radioembolization for Primary and Metastatic Tumors of the Liver, 8.01.521
- Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors, 7.01.95
- Reconstructive Breast Surgery/Management of Breast Implants, 7.01.533
- Reduction Mammaplasty for Breast-Related Symptoms, 7.01.503*
- Responsive Neurostimulation for the Treatment of Refractory Focal Epilepsy, 7.01.143
- Rhinoplasty, 7.01.558
- Semi-Implantable and Fully Implantable Middle Ear Hearing Aids, 7.01.84
- Spinal Cord and Dorsal Root Ganglion Stimulation, 7.01.546

- Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome, 7.01.554
- Total Artificial Hearts and Implantable Ventricular Assist Devices, 7.03.11
- Transcatheter Aortic Valve Implantation for Aortic Stenosis, 7.01.132
- Transcatheter Arterial Chemoembolization (TACE) as a Treatment for Primary or Metastatic Liver Malignancies, 8.01.11
- Transcatheter Mitral Valve Repair, 2.02.30
- Treatment of Varicose Veins/Venous Insufficiency, 7.01.519
- Upper Gastrointestinal (UGI) Endoscopy for Adults, 2.01.533
- Vagus Nerve Stimulation, 7.01.20
- Wearable Cardioverter-Defibrillators as a Bridge to Implantable Cardioverter-Defibrillator Placement, 2.02.506
- Wheelchairs (Manual or Motorized), 1.01.501

Effective July 2, 2020

Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions, 7.01.569

Removed from policy

- Site of service criteria and reference to policy, Site of Service: Select Surgery Procedures – 11.01.524, have been removed
- Site of service will be included in the medical necessity review for the primary procedure (knee arthroplasty, knee arthroscopy) using InterQual® criteria

Electrostimulation and Electromagnetic Therapy for Treating Wounds, 2.01.57

New policy

- This policy was archived in 2018 and is being reinstated
- Electrical stimulation and electromagnetic therapy for the treatment of wounds is considered investigational

Erythroid Maturation Agents, 5.01.614

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

- Reblozyl® (luspatercept-aamt)
  - Treatment of anemia in adults ages 18 and older with beta thalassemia

Meniscal Allografts and Other Meniscal Implants, 7.01.15

Removed from policy

- Site of service criteria and reference to policy, Site of Service: Select Surgery Procedures – 11.01.524, have been removed
- Site of service will be included within the medical necessity review for a knee arthroscopy procedure using InterQual® criteria

Miscellaneous Oncology Drugs, 5.01.540

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

- Padcev™ (enfortumab vedotin-ejfv)
  - Treatment of locally advanced or metastatic urothelial cancer (mUC) in patients ages 18 and older

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

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

Medical policies

New medical policies Effective April 1, 2020

Cognitive Rehabilitation, 8.03.10

- This policy replaces policy 8.03.504.
- Policy criteria remain the same; policy renumbered.

Postsurgical Home Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis, 1.01.28

- This policy replaces policy 1.01.525.
- Policy criteria remain the same; policy renumbered.

Treatment of Hyperhidrosis, 8.01.19

- This policy replaces policy 8.01.519.
- Policy criteria remain the same; policy renumbered.

Ultrasound Accelerated Fracture Healing Device, 1.01.05

- This policy replaces policy 1.01.531.
- Policy criteria remain the same; policy renumbered.

Revised medical policies Effective April 1, 2020

Transcatheter Aortic Valve Implantation for Aortic Stenosis, 7.01.132

- Medical necessity criteria have been updated. An exclusion of a unicuspid or bicuspid aortic valve has been added for patients with native valve aortic stenosis
- Patients at low risk for open surgery have been added to the intermediate risk section in the policy's "Definition of Terms"

Pharmacy policies

New pharmacy policies Effective April 1, 2020

Pharmacologic Treatment of Chronic Non-Infectious Liver Diseases, 5.01.615

Ocaliva® (obeticholic acid) may be considered medically necessary for the treatment of primary biliary cholangitis (PBC) in adults ages 18 and older when criteria are met

Revised pharmacy policies Effective April 1, 2020

Bruton's Kinase Inhibitors, 5.01.590

Brukinsa™ (zanubrutinib) has been added to the policy and may be considered medically necessary for the treatment of mantle cell lymphoma (MCL) in adults when criteria are met

CGRP Inhibitors for Migraine Prophylaxis, 5.01.584

- Vyepti™ (eptinezumab-jjmr), an intravenous CGRP, has been added to the policy and may be considered medically necessary for migraine prevention when criteria are met
- A new indication for Emgality™ (galcanezumab) for the treatment of episodic cluster headaches has been added to the policy and may be considered medically necessary when criteria are met

Drugs for Rare Diseases, 5.01.576

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

- Adakveo® (crizanlizumab-tmca) for the treatment of sickle cell disease in patients ages 16 and older
- Oxbryta™ (voxelotor) for the treatment of sickle cell disease in patients ages 12 and older Givlaari™ (givosiran) for the treatment of acute hepatic porphyria (AHP) in patients ages 18 and older

- Gattex® (teduglutide) for the treatment of short bowel syndrome in patients ages 1 year and older

Excessively High Cost Drug Products with Lower Cost Alternatives, 5.01.560

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

- Northera® (droxidopa) for the treatment of symptomatic neurogenic orthostatic hypotension in adults ages 18 and older
- Riomet ER™ (metformin extended-release oral suspension) to control high blood sugar in patients with type 2 diabetes

Medical Necessity Criteria and Dispensing Quantity Limits for Exchange Formulary Benefits, 5.01.547

- A new indication has been added for the drug Jakafi® (ruxolitinib). Jakafi® may be considered medically necessary for the treatment of steroid-refractory acute graft-versus-host disease in adult and pediatric patients ages 12 and older when criteria are met.
- Age criteria for other Jakafi® indications have been updated to adults ages 18 and older for the treatment of myelofibrosis and polycythemia vera
- Drugs subject to Step Therapy Protocol now have two requirements for first-step therapy agents unless otherwise specified
- Generic solifenacin has been added as a first-step therapy agent for overactive bladder
- The following drugs have been removed from the formulary and policy:
  - Epiduo® Forte and Tazorac® for the treatment of acne
  - Ranexa® for the treatment of angina
  - Welchol® for the treatment of high cholesterol
  - Toviaz® and Vesicare® for the treatment of overactive bladder

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:

- The calcium channel blocker Conjupri® (levamlodipine) for the treatment of hypertension in patients ages 6 and older
- The anticonvulsants Sabril® (vigabatrin) and generic vigabatrin for the treatment of refractory complex partial seizures in pediatric and adult patients
- The human nerve growth factor Oxervate™ (cenegermin-bkbj) ophthalmic solution for the treatment of neurotrophic keratitis in patients ages 2 and older
- The topical products Adapalene/Benzoyl Peroxide/Clindamycin and Adapalene/Benzoyl Peroxide/Niacinamide for the treatment of acne or rosacea

The following drugs in this policy have been moved to other policies:

- Emflaza® (deflazacort) to **Pharmacologic Treatment of Duchenne Muscular Dystrophy, 5.01.570**

- Ezallor™ Sprinkle (rosuvastatin), Flolipid (simvastatin liquid), Livalo® (pitavastatin), Nikita™ (pitavastatin), and Zypitamag™ (pitavastatin) to **Pharmacological Treatment of High Cholesterol, 5.01.558**

Miscellaneous Oncology Drugs, 5.01.540

Tazverik™ (tazemetostat) has been added to policy and may be considered medically necessary for the treatment of inoperable epithelioid sarcoma in patients ages 16 and older when criteria are met

Multiple Receptor Tyrosine Kinase Inhibitors, 5.01.534

Ayvakit™ (avapritinib) has been added to the policy and may be considered medically necessary for the treatment of gastrointestinal stromal tumor (GIST) that is metastatic or inoperable in adult patients when criteria are met

Pharmacologic Treatment of Duchenne Muscular Dystrophy, 5.01.570

- This policy has been retitled from "Exondys 51® (eteplirsen)" to "Pharmacologic Treatment of Duchenne Muscular Dystrophy"
- The following drugs have been added to the policy and may be considered medically necessary when criteria are met:
  - Vyondys 53™ (golodirsen) for the treatment of Duchenne muscular dystrophy (DMD) in male patients up to age 15 who have a gene mutation that is amenable to exon 53 skipping
  - Emflaza® (deflazacort) for the treatment of Duchenne muscular dystrophy (DMD) in patients ages 2 and older

Pharmacologic Treatment of High Cholesterol, 5.01.558

- This policy has been retitled from "Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors" to "Pharmacologic Treatment of High Cholesterol"
- The following drugs have been added to the policy and may be considered medically necessary when criteria are met:
  - Vascepa® (icosapent ethyl) for the treatment of established cardiovascular disease and severe hypertriglyceridemia
  - Nexletol™ (bempedoic acid), and Nexlizet™ (bempedoic acid and ezetimibe) for the treatment of familial hypercholesterolemia and clinical atherosclerotic cardiovascular disease (ASCVD) in adults ages 18 and older
  - Ezallor™ Sprinkle (rosuvastatin), Flolipid (simvastatin liquid), Livalo® (pitavastatin), Nikita™ (pitavastatin), and Zypitamag™ (pitavastatin) for the treatment of hyperlipidemia

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Archived policies

An archived policy is one that's no longer active and is not used for reviews.

Effective July 2, 2020

Site of Service - Select Surgical Procedures, 11.01.524
Site of service medical necessity review criteria may be found within the applicable medical necessity criteria for the procedure

Deleted policies

Effective April 1, 2020

Cognitive Rehabilitation, 8.03.504

- The policy has been renumbered 8.03.10.
- Policy criteria remain the same.

Postsurgical Home Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis, 1.01.525

- The policy has been renumbered 1.01.28.
- Policy criteria remain the same.

Treatment of Hyperhidrosis, 8.01.519

- The policy has renumbered 8.01.19.
- Policy criteria remain the same.

Ultrasound Accelerated Fracture Healing Device, 1.01.05

- The policy has been renumbered 1.01.531.
- Policy criteria remain the same.

Coding updates

Added codes
Effective July 2, 2020

The Plan will begin reviewing "C" series HCPC codes.

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

C9053, C9056

Granulocyte Colony-Stimulating Factor (G-CSF) Use in Adult Patients, 5.01.551
Now requires review for medical necessity and prior authorization.

C9058

Effective April 1, 2020

AIM Specialty Health® Clinical Appropriateness Guidelines for Genetic Testing
Now requires review for medical necessity and prior authorization.

0169U, 0170U, 0171U

Colorectal Cancer Screening, 10.01.519
Now requires review for investigative.

0002U, 0163U

Removed codes
Effective April 1, 2020

AIM Specialty Health® Clinical Appropriateness Guidelines for Genetic Testing
No longer requires review for medical necessity and prior authorization.

81507

Hematopoietic Cell Transplantation for Waldenström Macroglobulinemia, 8.01.531
No longer requires review for medical necessity and prior authorization.

38242

Transcatheter Aortic Valve Implantation for Aortic Stenosis, 7.01.132
No longer requires review for medical necessity and prior authorization.

33367, 33368, 33369