

# Medical Policy and Coding Updates

## May 7, 2020

### Special notices

## Effective August 16, 2020

Updates to [AIM Specialty Health® Clinical Appropriateness Guidelines](#)

Effective for dates of service on and after August 16, 2020, the following updates by will apply to the [AIM Specialty Health® Clinical Appropriateness Guidelines for Radiology: Chest Imaging](#)

### Updates by section

#### *Tumor or Neoplasm*

- Allowed follow up of nodules less than 6 mm in size seen on incomplete thoracic CT, in alignment with follow up recommendations for nodules of the same size seen on complete thoracic CT
- Added new criteria for which follow up is indicated for mediastinal and hilar lymphadenopathy
- Separated mediastinal/hilar mass from lymphadenopathy, which now has its own entry

#### *Parenchymal Lung Disease – not otherwise specified*

Removed as it is covered elsewhere in the document (parenchymal disease in “Occupational lung diseases” and pleural disease in “Other thoracic mass lesions”)

#### *Interstitial lung disease (ILD), non-occupational, including idiopathic pulmonary fibrosis (IPF)*

- Defined criteria warranting advanced imaging for both diagnosis and management

#### *Occupational lung disease (Adult only)*

- Moved parenchymal component of asbestosis into this indication
- Added Berylliosis

#### *Chest Wall and Diaphragmatic Conditions*

- Removed screening indication for implant rupture due to lack of evidence indicating that outcomes are improved
- Limited evaluation of clinically suspected rupture to patients with silicone implants

Effective for dates of service on and after August 16, 2020, the following updates by will apply to the [AIM Specialty Health® Clinical Appropriateness Guidelines for Radiology: Oncologic Imaging](#)

## Updates by section

### *MRI breast*

- New indication for BIA-ALCL
- New indication for pathologic nipple discharge
- Further define the population of patients most likely to benefit from preoperative MRI

### *Breast cancer screening*

- Added new high risk genetic mutations appropriate for annual breast MRI screening

### *Lung cancer screening*

- Added asbestos-related lung disease as a risk factor

Effective for dates of service on and after August 16, 2020, the following updates by will apply to the [AIM Specialty Health® Clinical Appropriateness Guidelines for Sleep Disorder Management](#)

## Updates by section

### *Bi-Level Positive Airway Pressure Devices*

- Change in BPAP FiO<sub>2</sub> from 45 to 52 mmHg based on strong evidence and aligns with Medicare requirements for use of BPAP

### *Multiple Sleep Latency Testing and/or Maintenance of Wakefulness Testing*

- Style change for clarity

## Effective August 7, 2020

### [IL-5 Inhibitors, 5.01.559](#)

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

- Cinqair® (reslizumab)
  - As an add-on maintenance treatment of severe asthma for patients ages 18 and older

### Re-authorization criteria added

- A decrease in requirement for oral steroids
- Exacerbation frequency, ER and urgent care visits, and hospitalizations or a decrease in the frequency and severity of asthma symptoms OR
- An increase in quality of life measures and ability to perform activities of daily living

## 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 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](#)
- [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](#)
- [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](#)
- [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 Non-Hodgkin Lymphoma, 8.01.529](#)

- Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma and POEMS Syndrome, 8.01.17
- Hematopoietic Cell Transplantation in the Treatment of Germ-Cell Tumors, 8.01.532
- Hip Arthroplasty in Adults, 7.01.573
- Hospital Beds and Accessories, 1.01.520
- Hyperbaric Oxygen Therapy, 2.01.505
- Interspinous and Interlaminar Stabilization/Distractor Devices (Spacers), 7.01.107
- Interspinous Fixation (Fusion) Devices, 7.01.138
- 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
- Reconstructive Breast Surgery/Management of Breast Implants, 7.01.533
- Reduction Mammoplasty for Breast-Related Symptoms, 7.01.503\*
- Responsive Neurostimulation for the Treatment of Refractory Focal Epilepsy, 7.01.143
- Rhinoplasty, 7.01.558
- Sacral Nerve Neuromodulation/Stimulation, 7.01.69
- Semi-Implantable and Fully Implantable Middle Ear Hearing Aids, 7.01.84
- Spinal Cord and Dorsal Root Ganglion Stimulation, 7.01.546
- 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

### Medical policies

## New medical policies Effective May 1, 2020

### Implantable Bone-Conduction and Bone-Anchored Hearing Aids, 7.01.03

- This policy replaces policy 7.01.547; policy renumbered
- The medical necessity criterion for non-implanted bone conduction (bone-anchored) hearing aids with a Softband has been removed from the policy
- All other statements remain unchanged

## Revised medical policies Effective May 1, 2020

### Allogeneic Hematopoietic Cell Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms, 8.01.21

- Medical necessity criteria have been updated
- The definition of reduced-intensity conditioning allogeneic hematopoietic cell transplantation (allo-HCT) has been revised to include the term “risk-adapted” for myeloproliferative neoplasms in patients who are at high risk of intolerance of a myeloablative conditioning regimen

### Surgical Treatments for Lymphedema and Lipedema, 7.01.567

- Lipectomy or liposuction for the treatment of lymphedema or lipedema has been changed from investigational to medically necessary when criteria are met
- New medical necessity criteria include documentation of the following: significant physical impairment; no response to at least 3 consecutive months of conservative treatment; continued use of compression garments post-operation.
- Patients with lipedema must have the following symptoms documented in their medical record:
  - Bilateral symmetric adiposity in the extremities
  - Non-pitting edema
  - Tissue in affected areas that is soft and tender to palpation

## Pharmacy policies

## Revised pharmacy policies Effective May 1, 2020

### Medical Necessity Criteria for Pharmacy Edits, 5.01.605

All drugs listed below may be considered medically necessary when criteria are met.

#### *Anticonvulsants*

- Epidiolex® (cannabidiol) has a new medical necessity criterion. Patients must have tried and failed at least one generic anti-seizure medication.
- Valtoco® (diazepam nasal spray) has been added to the policy for the treatment of epilepsy in patients ages 6 and older

#### *Brand Topical Acne or Rosacea Agents*

The following drugs have been added to the policy for the treatment of acne:

- Benzoyl Peroxide/Clindamycin/Niacinamide
- Benzoyl Peroxide/Clindamycin/Tretinoin
- Clindamycin/Niacinamide
- Clindamycin/Niacinamide/Spirolactone/Tretinoin
- Dapsone
- Dapsone/Niacinamide
- Dapsone/Niacinamide/Spirolactone
- Dapsone/Niacinamide/Spirolactone

### *Chelating Agents*

The following drugs have been added to the policy:

- Generic trientine for the treatment of Wilson's disease
- Syprine® (trientine) for the treatment of Wilson's disease

### *Constipation*

- All drugs in this policy section have updated medical necessity criteria to include coverage when on existing therapy
- Pizensy™ (lactitol oral solution) has been added to the policy for the treatment of adult patients with chronic idiopathic constipation (CIC)

### *Corticosteroids*

The statement “policy does not target kit and combination packages” has been removed

### *Homozygous Familial Hypercholesterolemia Agents*

- Juxtapid® (lomitapide) has been removed from this policy and moved to [Pharmacologic Treatment of High Cholesterol, 5.01.558](#)
- Kynamro™ (mipomersen) has been removed from this policy. This drug has been withdrawn from the market.

### *Muscle Relaxants*

- New policy section
- Ozobax™ (baclofen oral solution) has been added to the policy

### *Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) and Combinations*

- Generic naproxen/esomeprazole has been added to the policy

### **Pharmacologic Treatment of High Cholesterol, 5.01.558**

- Juxtapid® (lomitapide) and Kynamro™ (mipomersen) have been moved from Medical Necessity Criteria for Pharmacy Edits, 5.01.605, and added to this policy
- Kynamro™ (mipomersen) has been withdrawn from the market and medical necessity criteria for this drug were not added to the policy



- Juxtapid® (lomitapide) may be considered medically necessary for the treatment of homozygous familial hypercholesterolemia in adults ages 18 and older when criteria are met
- The brand simvastatin oral suspension, an HMG-CoA inhibitor, has been added to the policy and may be considered medically necessary for the treatment of hyperlipidemia
- Medical necessity criteria for Vascepa® (icosapent ethyl) have been updated to include a daily dose requirement of 4 grams per day

### Pharmacotherapy of Multiple Sclerosis, 5.01.565

- Drug indications in the policy have been updated to include reference to clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease where applicable based on the drug's prescribing information
- Zeposia® (ozanimod), a sphingosine 1-phosphate receptor modulator, has been added to the policy and may be considered medically necessary as a first-line treatment for relapsing forms of multiple sclerosis when criteria are met
- Medical necessity criteria for Ocrevus® (ocrelizumab) have been updated to include an EDSS score of less than 7 and the use of Ocrevus® without any other multiple-sclerosis disease-modifying drugs

### 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 May 1, 2020

### Implantable Bone-Conduction and Bone-Anchored Hearing Aids, 7.01.547

The policy has been renumbered 7.01.03.

## Coding updates

### **Added codes Effective May 1, 2020**

#### **Amniotic Membrane and Amniotic Fluid, 7.01.149**

Now requires review for investigative.

Q4205, Q4206, Q4208, Q4209, Q4210, Q4211, Q4212, Q4213, Q4214, Q4215, Q4216, Q4217, Q4218, Q4219, Q4221

### **Revised codes Effective May 17, 2020**

Reviews for the code listed below are delayed until dates of service on and after May 17, 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

### **Removed codes Effective May 1, 2020**

#### **Implantable Bone-Conduction and Bone-Anchored Hearing Aids, 7.01.13**

No longer requires review for medical necessity and prior authorization.

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