LifeWise
Health Plan of Washington

Medical Policy and Coding Updates
July 2, 2020

Special notices

Effective October 2, 2020

Miscellaneous Oncology Drugs, 5.01.540

New drugs added to policy

- Kyprolis® (carfilzomib)
  - Treatment of multiple myeloma
- Velcade® (bortezomib)
  - Treatment of multiple myeloma and mantle cell lymphoma

Pharmacotherapy of Arthropathies, 5.01.550

Site of service review added

- Avsola™ (infliximab-axxq)

Pharmacotherapy of Inflammatory Bowel Disorder, 5.01.563

Site of service review added

- Avsola™ (infliximab-axxq)

Pharmacologic Treatment of Infertility, 5.01.610

New policy

The following drugs may be considered medically necessary when criteria are met:

- Brand Chorionic Gonadotropin
- Bravelle® (urofollitropin)
- Follistim® AQ (follitropin beta)
- Pregnyl® (chorionic gonadotropin)

Prostate Cancer Targeted Therapies, 5.01.544

New drugs added to policy

- Jevtana® (cabazitaxel)
- Xofigo® (radium Ra 223 dichloride)

Rituximab Non-Oncologic and Miscellaneous Uses, 5.01.556

Site of service review added

- Ruxience™ (rituximab-pvvr)

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Site of Service: Infusion Drugs and Biologic Agents, 11.01.523

New drug added to policy

- Avsola™ (infliximab-axxq)

Effective September 4, 2020

Folate Antimetabolites, 5.01.617

New policy

The following drugs may be considered medically necessary when criteria are met:

- Alimta® (pemetrexed)
  - In combination with Keytruda® (pembrolizumab) and platinum chemotherapy for the initial treatment of metastatic non-squamous non-small cell lung cancer (NSCLC)
  - In combination with cisplatin for the initial treatment of locally advanced or metastatic, non-squamous NSCLC
  - As a single agent for the maintenance treatment of locally advanced or metastatic, non-squamous NSCLC in patients whose disease has not progressed after four cycles of platinum-based first-line chemotherapy
  - As a single agent for the treatment of recurrent, metastatic non-squamous, NSCLC after prior chemotherapy
  - Initial treatment, in combination with cisplatin, of malignant pleural mesothelioma in patients whose disease can't be surgically treated or who are not candidates for curative surgery
- Folotyn® (pralatrexate) for the treatment of relapsed or refractory peripheral T-cell lymphoma (PTCL)

Pharmacologic Treatment of Gout, 5.01.616

New policy

The following drug may be considered medically necessary when criteria are met:

- Krystexxa® (pegloticase)
  - Treatment of chronic gout in patients age 18 and older

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**

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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 FiO2 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**

- Artificial Pancreas Device Systems, 1.01.30
- 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
- Hip Arthroplasty in Adults, 7.01.573
- Hospital Beds and Accessories, 1.01.520
- 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
- 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
- Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers, 1.01.18
- Power Operated Vehicles (Scooters) (Excluding Motorized Wheelchairs), 1.01.527
- 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
- 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
- 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

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

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

Site of Service – Select Surgical Procedures, 11.01.524

- See policy for specific procedures that will be moving to InterQual® medical necessity criteria
- This policy will be used for the site of service review only for those services

Medical policies

New medical policies Effective July 1, 2020

Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions, 7.01.48

New policy

- This policy replaces Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions, 7.01.569
- Includes criteria for site of service review
- All other statements remain unchanged

Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures, 7.01.85

New policy

- This policy replaces Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures, 7.01.571
- All other statements remain unchanged

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Revised medical policies
Effective July 1, 2020

SARS-CoV-2 Serology (Antibody) Testing, 2.04.518
Medical necessity criteria updated
To align with Centers for Disease Control (CDC) interim guidelines issued May 23, 2020

Effective June 10, 2020

Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions, 7.01.569
Policy reinstated (was to be deleted 7/1/20)
- Medical necessity criteria remain unchanged
- Includes criteria for site of service review

Meniscal Allografts and Other Meniscal Implants, 7.01.15
Policy reinstated (was to be deleted 7/1/20)
- Medical necessity criteria remain unchanged
- Includes criteria for site of service review

Reconstructive Breast Surgery/Management of Breast Implants, 7.01.533
Policy reinstated (was to be deleted 7/1/20)
Medical necessity criteria updated
Removal of breast implants with breast implant-associated anaplastic large cell lymphoma (BIA-ALCL)

Pharmacy policies

New pharmacy policies
Effective July 1, 2020

Chimeric Antigen Receptor Therapy for Hematologic Malignancies, 8.01.63
This is a new policy. The following drugs have been moved from Adoptive Immunotherapy, 8.01.01, added to this policy, and may be considered medically necessary when criteria are met:
- Kymriah™ (tisagenlecleucel)
- Yescarta™ (axicabtagene ciloleucel)

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Revised pharmacy policies
Effective July 1, 2020

Adoptive Immunotherapy, 8.01.01

- Specific applications for adoptive immunotherapy for cancer have been moved to a new policy, Chimeric Antigen Receptor Therapy for Hematologic Malignancies, 8.01.63
- All other uses of adoptive immunotherapy are considered investigational

Drugs for Rare Diseases, 5.01.576

New drugs added to policy

- Endari® (L-glutamine)

Medical necessity criteria updated

- Crysvita® (burosumab)

Excessively High Cost Drug Products with Lower Cost Alternatives, 5.01.560

New drug added to policy

- Sitavig® (acyclovir buccal tablets)

Herceptin® (trastuzumab) and Other HER2 Inhibitors, 5.01.514

Drug with new indication

- Nerlynx ® (neratinib)

New drug added to policy

- Tukysa™ (tucatinib)

Immune Checkpoint Inhibitors, 5.01.591

Drugs with new indications

- Imfinzi® (durvalumab)
- Keytruda® (pembrolizumab)
- Opdivo® (nivolumab)
- Tecentriq® (atezolizumab)
- Yervoy® (ipilimumab)

Medical Necessity Criteria for Pharmacy Edits, 5.01.605

New drugs added to policy

- Caplyta™ (lumateperone)
- Ongentys® (opicapone)

Medical necessity criteria updated

- Palforzia™ [peanut (Arachis hypogaea) allergen powder-dnfp]

- Sirturo® (bedaquiline)

Miscellaneous Oncology Drugs, 5.01.540

Dose limits added

- Erivedge® (vismodegib)
- Odomzo® (sonidegib)

Drugs with new indications

- Lynparza® (olaparib)
- Rubraca® (rucaparib)
- Zejula® (niraparib)

New drugs added to policy

- Gleostine® (lomustine)
- Pemazyre™ (pemigatinib)
- Sarclisa® (isatuximab-irfc)
- Trodelvy™ (sacituzumab govitecan-hziy)

Removed from policy

- Lartruvo® (olaratumab)

Multiple Receptor Tyrosine Kinase Inhibitors, 5.01.534

New drug added to policy

- Qinlock™ (ripretinib)

Pharmacologic Treatment of Interstitial Lung Disease, 5.01.555

Policy renamed

- From "Pharmacologic Treatment of Idiopathic Pulmonary Fibrosis" to "Pharmacologic Treatment of Interstitial Lung Disease"

Drug with new indication

- Ofev® (nintedanib)

Medical necessity criteria updated

- Esbriet® (pirfenidone)
- Ofev® (nintedanib)

Pharmacotherapy of Arthropathies, 5.01.550

Medical necessity criteria updated

- Cimzia® (certolizumab pegol)
- Orencia® (abatacept)
- Otezla® (apremilast)

- Simponi® (golimumab)
- Simponi Aria® (golimumab)
- Taltz® (ixekizumab)

Pharmacotherapy of Inflammatory Bowel Disorder, 5.01.563

Medical necessity criteria updated

- Stelara® (ustekinumab)

Pharmacotherapy of Multiple Sclerosis, 5.01.565

Medical necessity criteria updated

- Lemtrada® (alemtuzumab)

New drug added to policy

- Bafiertam™ (monomethyl fumarate)

Rituximab Non-Oncologic and Miscellaneous Uses, 5.01.556

Medical necessity criteria updated

- Rituxan® (rituximab)
- Ruxience™ (rituximab-pvvr)
- Truxima® (rituximab-abbs)

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

Drugs with new indications

- Avastin® (bevacizumab)
- Mvasi™ (bevacizumab-awwb)
- Pomalyst® (pomalidomide)
- Zirabev™ (bevacizumab-bvzr)

Archived policies

No updates this month

Deleted policies

Effective July 1, 2020

Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions, 7.01.569

This policy is replaced with Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions, 7.01.48.

Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures, 7.01.571
This policy is replaced with Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures, 7.01.85.

Coding updates

Added codes
Effective July 2, 2020

Electrostimulation and Electromagnetic Therapy for Treating Wounds, 2.01.57
Now requires review for investigative.

E0769, G0281, G0282, G0295, G0329

InterQual® Criteria: Services Reviewed for Medical Necessity, 10.01.530
Now requires review for medical necessity and prior authorization.

27438, 27442, 36475, 36476, 36478, 36479, 36465, 36466, 36470, 36471, 43235, 43236, 43238, 43239, 43242, 95961, L1907, L1940, L1950, L1960, L1990, L2000, L2010, L2020, L2030, L2034, L2036, L2037, L2038, L2106, L2108, L2126, L2128, L4631

Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease, 2.01.38
Now requires review for medical necessity.

43266

Effective July 1, 2020

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

0172U, 0173U, 0175U, 0177U, 0179U

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

J0791, J0223

Electrical Stimulation Devices, 1.01.507
Now requires review for medical necessity and prior authorization.

E0761

Erythyroid Maturation Agents, 5.01.614
Now requires review for medical necessity and prior authorization.

J0896

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

Q5120

Herceptin (trastuzumab) and Other HERS Inhibitors, 5.01.514
Now requires review for medical necessity and prior authorization.

J9358

Immune Globulin Therapy, 8.01.503
Now requires review for medical necessity and prior authorization.

J1558

Irreversible Electroporation (NanoKnife® System), 7.01.572
Now requires review for investigative.

0600T, 0601T

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

J9177

Pharmacologic Treatment of Duchenne Muscular Dystrophy, 5.01.570
Now requires review for medical necessity and prior authorization.

J1429

Pharmacotherapy of Arthropathies, 5.01.550
Now requires review for medical necessity and prior authorization.

Q5121

Pharmacotherapy of Spinal Muscular Atrophy (SMA), 5.01.574
Now requires review for medical necessity and prior authorization.

J3399

Rituximab: Non-oncologic and Miscellaneous Uses, 5.01.556
Now requires review for medical necessity and prior authorization.

Q5119

Removed codes
Effective July 2, 2020

Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions, 7.01.569
No longer requires review for medical necessity and prior authorization.

S2112

Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting, 2.02.24
No longer requires review for investigative.

93701

Chimeric Antigen Receptor Therapy for Hematologic Malignancies, 8.01.63
No longer requires review for medical necessity and prior authorization.

0537T, 0538T, 0539T, 0540T

Coronary Angiography for Known Suspected Coronary Artery Disease, 2.02.507
No longer requires review for medical necessity and prior authorization. This policy is now covered under InterQual® criteria.

93460, 93461

Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate or Dermatologic Tumors, 7.01.92

No longer requires review for investigative.

19105

Deep Brain Stimulation, 7.01.63

No longer requires review for medical necessity and prior authorization. This policy is now covered under InterQual® criteria.

61868

Diagnosis and Treatment of Sacroiliac Joint Pain, 6.01.23

No longer requires review for medical necessity and prior authorization.

27280

Diagnosis and Treatment of Sacroiliac Joint Pain, 6.01.23

No longer requires review for investigative.

64625

Hospital Beds and Accessories, 1.01.520

No longer requires review for medical necessity and prior authorization. This policy is now covered under InterQual® criteria.

E0265, E0266, E0296, E0297, E0300, E0912

In Vitro Chemoresistance and Chemosensitivity Assays, 2.03.01

No longer requires review for investigative and prior authorization.

0564T

Lipid Apheresis, 8.02.04

No longer requires review for investigative and prior authorization.

0342T

Lipid Apheresis, 8.02.04

No longer requires review for medical necessity and prior authorization.

S2120

Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Conditions, 1.01.15

No longer requires review for medical necessity and prior authorization. This policy is now covered under InterQual® criteria.

E0481

Patient Lifts, Seat Lifts and Standing Devices, 1.01.519

No longer requires review for medical necessity and prior authorization. This policy is now covered under InterQual® criteria.

E0642

Percutaneous and Vertebroplasty and Sacroplasty, 6.01.25

No longer requires review for investigational and prior authorization.

0200T, 0201T

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

No longer requires review for medical necessity and prior authorization.

E0675

Power Operated Vehicle (Scooters) (excluding motorized wheelchairs), 1.01.527

No longer requires review for medical necessity and prior authorization. This policy is now covered under InterQual® criteria.

E1230, K0899

Quantitative Assay for Measurement of HER2 Total Protein Expression and HER2 Dimers, 2.04.76

No longer requires review for investigative and prior authorization.

0009U

Recombinant and Autologous Platelet Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions, 2.01.16

No longer requires review for investigative.

G0460, S9055

Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome, 7.01.101
No longer requires review for investigative.

41512, 41530

Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome, 7.01.101
No longer requires review for investigative and prior authorization.

S2080

Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome, 7.01.101
No longer requires review for medical necessity and prior authorization.

21685, 42950

Total Artificial Hearts and Implantable Ventricular Assist, 7.03.11
No longer requires review for medical necessity and prior authorization.

33981, 33982, 33983

Total Artificial Hearts and Implantable Ventricular Assist, 7.03.11
No longer requires review for investigative.

33990, 33991, 33992, 33993

Wheelchairs (Manual or Motorized), 1.01.501
No longer requires review for medical necessity and prior authorization. This policy is now covered under InterQual® criteria.

E0950, E0955, E1012, E1014, E1031, E1037, E1038, E1039, E1050, E1060, E1070, E1083, E1084, E1085, E1086, E1087, E1088, E1089, E1090, E1092, E1093, E1100, E1110, E1130, E1140, E1150, E1160, E1170, E1171, E1172, E1180, E1190, E1195, E1200, E1220, E1221, E1222, E1223, E1224, E1225, E1226, E1229, E1240, E1250, E1260, E1270, E1285, E1290, E1295, E2227, E2228, E2230, E2291, E2292, E2293, E2294, E2295, E2300, E2310, E2311, E2331, E2341, E2342, E2343, E2351, E2398, E2603, E2604, E2605, E2606, E2607, E2608, E2610, E2613, E2614, E2615, E2616, E2620, E2621, E2622, E2623, E2624, E2625, K0003, K0004, K0009, K0010, K0011, K0012, K0014, K0830, K0831, K0898, K0900