LifeWise
Health Plan of Washington

Medical Policy and Coding Updates
October 6, 2022

Special notices

Effective January 6, 2023

Services Reviewed Using InterQual® Criteria, 10.01.530
Acute adult
See InterQual® for medical necessity criteria
Services added

- Electroconvulsive therapy (ECT)
- Total ankle replacement

Total Ankle Replacement, 7.01.577
Policy deleted
Now included in **Services Reviewed Using InterQual® Criteria, 10.01.530**

Effective December 1, 2022

Botulinum Toxins, 5.01.512
New policy replaces InterQual® criteria
Drugs added

- Botox® (onabotulinumtoxinA)
  - Prevention of chronic migraine headaches in adults age 18 years and older
  - Treatment of overactive bladder (OAB) in adults age 18 years and older
  - Treatment of urinary incontinence due to overactivity of the detrusor muscle in adults age 18 years and older
  - Treatment of neurogenic detrusor overactivity (NDO) in patients age 5 to 17 years of age
  - Treatment of cervical dystonia in adults age 18 years and older
  - Treatment of adults with dystonia that results in functional impairment and/or pain
  - Treatment of blepharospasm with dystonia in patients age 12 years and older
  - Treatment of chronic anal fissure
  - Treatment of esophageal achalasia

        - Treatment of Hirschsprung disease
        - Treatment of lower and upper limb spasticity in patients age 2 years and older
        - Treatment of strabismus in patients age 12 years and older
    - Dysport® (abobotulinumtoxinA)
        - Treatment of cervical dystonia in adults age 18 years and older
        - Treatment of adults with dystonia that results in functional impairment and/or pain
        - Treatment of chronic anal fissure
        - Treatment of esophageal achalasia
        - Treatment of Hirschsprung disease
        - Treatment of lower and upper limb spasticity in patients age 2 years and older
    - Jeuveau™ (prabotulinumtoxinA-xvfs)
        - For cosmetic use and not covered
    - Myobloc® (rimabotulinumtoxinB)
        - Treatment of cervical dystonia in adults age 18 years and older
        - Treatment of adults with dystonia that results in functional impairment and/or pain
        - Treatment of chronic hypersalivation in adults
    - Xeomin® (incobotulinumtoxinA)
        - Treatment of upper limb spasticity in patients age 2 to 17 years
        - Treatment of cervical dystonia in adults age 18 years and older
        - Treatment of adults with dystonia that results in functional impairment and/or pain
        - Treatment of blepharospasm in patients age 18 years and older
        - Treatment of chronic anal fissure
        - Treatment of chronic hypersalivation in patients age 2 years and older
        - Treatment of esophageal achalasia
        - Treatment of Hirschsprung disease
        - Treatment of upper limb spasticity in adults

Pharmacologic Treatment of Gout, 5.01.616

Medical necessity criteria updated

Krystexxa® (pegloticase) must be given with oral methotrexate 15 mg weekly, unless there is a medical reason why methotrexate can't be taken

Pharmacotherapy of Inflammatory Bowel Disorder, 5.01.563

Medical necessity criteria updated

- Tysabri® (natalizumab)
    - Patient must have tried and failed treatment with one or more TNF blockers

Temporomandibular Joint Disorder, 2.01.535

- Botulinum toxin is considered investigational as a nonsurgical treatment for temporomandibular joint disorder

- For dates of service starting on and after December 1, 2022, codes for botulinum toxin will require review for medical necessity and prior authorization (see also the **Coding updates** section)

Treatment of Hyperhidrosis, 8.01.519

- Botulinum toxin is considered:
  - Medically necessary as a treatment for primary focal hyperhidrosis when criteria are met
  - Investigational as a treatment for severe secondary gustatory hyperhidrosis
- For dates of service starting on and after December 1, 2022, codes for botulinum toxin will require review for medical necessity and prior authorization (see also the **Coding updates** section)

Effective November 4, 2022

Authorization for Observation versus Inpatient Admission Level of Care, 10.01.534

New policy

Criteria and medical conditions added for observation stays for adults and children

Immune Globulin Therapy, 8.01.503

Site of service review added

- Cutaquig® (immune globulin subcutaneous [human] - hipp)

Site of Service: Infusion Drugs and Biologic Agents, 11.01.523

Site of service review added

- Cutaquig® (immune globulin subcutaneous [human] - hipp)

Medical policies

New medical policies Effective October 1, 2022

Prescription Digital Health Diagnostic Aid for Autism Spectrum Disorder, 3.03.01

Prescription digital health technologies used as a diagnostic aid for autism spectrum disorder are considered investigational

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Revised medical policies
Effective October 1, 2022

Custom-made Knee Orthoses (Braces), Ankle-Foot-Orthoses, and Knee-Ankle-Foot-Orthoses, 1.03.501

Policy renamed

From "Knee Orthoses (Braces), Ankle-Foot-Orthoses, and Knee-Ankle-Foot-Orthoses" to "Custom-made Knee Orthoses (Braces), Ankle-Foot-Orthoses, and Knee-Ankle-Foot-Orthoses"

Removed from policy

Criteria for prefabricated braces for knee, ankle-foot, and knee-ankle-foot

Medical necessity criteria updated

A custom-made functional knee brace is considered not medically necessary when a prefabricated functional knee brace can be custom fit and adjusted

Electrical Stimulation Devices, 1.01.507

Investigational criteria updated

Transcutaneous electrical nerve stimulation of the wrist for treatment of essential tremor has been added to the list of services that are considered investigational

Hyperbaric Oxygen Therapy, 2.01.505

Medical necessity criteria updated

Compromised skin grafts and flaps, and necrotizing soft tissue infections have been added to the list of medically necessary conditions for systemic hyperbaric oxygen pressurization therapy

Intraoperative Neurophysiologic Monitoring, 7.01.562

Medical necessity criteria updated

- Multilevel cervical artificial disc arthroplasty has been added to the list of medically necessary conditions
- Intraoperative neurophysiologic monitoring is considered not medically necessary for the following:
  - During single-level cervical artificial disc arthroplasty
  - During epidural injections
  - During sacroiliac injections
  - During facet joint injections or medial branch blocks
  - During radiofrequency ablation/denervation procedures
  - During placement of spinal cord or dorsal root ganglion stimulators
  - During placement of an intrathecal pain pump
  - During placement of hypoglossal nerve stimulator

Myoelectric Prosthetic and Orthotic Components for the Upper Limb, 1.04.502

Investigational criteria updated

A prosthesis with individually powered digits, including but not limited to an electrically powered partial hand prosthesis, is considered investigational

Services Reviewed Using InterQual® Criteria, 10.01.530

Acute adult

See InterQual® for medical necessity criteria

Services added

- Capsule endoscopy
- Capsule endoscopy, colon
- Capsule endoscopy, small bowel or esophageal

Acute pediatrics

See InterQual® for medical necessity criteria

Service added

- Capsule endoscopy

Durable Medical Equipment (DME)

See InterQual® for medical necessity criteria

- Negative pressure wound therapy (NPWT) pump
- Negative pressure wound therapy pumps

Pharmacy policies

New pharmacy policies

No updates this month

Revised pharmacy policies Effective October 1, 2022

Advanced Therapies for Pharmacological Treatment of Pulmonary Arterial Hypertension, 5.01.522

Drugs added

Indication: Treatment of pulmonary arterial hypertension (PAH)

- Tadalafil and ambrisentan combination therapy as a first-line treatment for patients who have WHP Functional Class Groups II and III disease and who have not ever received treatment for PAH

Drug added

- Tyvaso DPI™ (treprostinil) (inhalation via dry powder)
  - Treatment of pulmonary arterial hypertension (PAH/WHO Group 1)

Investigational criteria updated

The use of Tyvaso® (treprostinil) and Tyvaso DPI™ (treprostinil) is considered investigational for the treatment of any other conditions or subtypes of PH, except WHO Groups 1 and 3

ALK Tyrosine Kinase Inhibitors, 5.01.538

Medical necessity criteria updated

Indication: Treatment of ALK-positive inflammatory myofibroblastic tumor (iMT)

- Xalkori® (crizotinib)
  - This drug may be used in people age 1 year and older with when ALK-positive iMT can't be treated with surgery, has returned, or has not responded to treatment

Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma, 8.01.63

Indication added

- Yescarta™ (axicabtagene ciloleucel)
  - Treatment of adults with large B-cell lymphoma that has not responded to first-line chemoimmunotherapy or that returns within 12 months of first-line chemoimmunotherapy

Chimeric Antigen Receptor Therapy for Multiple Myeloma, 8.01.66

Drug added

- Carvykti® (ciltacabtagene autoleucel)
  - Treatment of adults with multiple myeloma that has returned or has not responded to four or more prior lines of treatment

Continuity of Coverage for Maintenance Medications, 5.01.607

Continuation of maintenance medications for new to plan member

Medical necessity criteria updated

Criteria for this policy are used when the member does not meet the standard Medical Policy criteria for medication

Continuation of maintenance medications for current plan member

Medical necessity criteria updated

For continuation of maintenance medications, the plan notification criterion now includes the member's prescriber, and letter has been changed to notification

Drugs for Rare Diseases, 5.01.576

Medical necessity criteria updated

- Adakveo® (crizanlizumab-tmca)
  - The criterion that the person has not received blood transfusion therapy within the prior 6 weeks has been removed

Indication added

- Imcivree™ (setmelanotide)
  - Treatment of chronic weight management for adults and children age 6 years and older with obesity due to Bardet-Biedl syndrome (BBS)

Reauthorization criteria updated

- Imcivree™ (setmelanotide)
  - For adults only, requires that the patient has lost ≥ 5% of baseline body weight
  - For people age 6 – 17 years, requires that the person shows continued improvement

Excessively High Cost Drug Products with Lower Cost Alternatives, 5.01.560

Drug added

- Brand metformin 625 mg
  - Treatment of type 2 diabetes mellitus in people age 10 years and older

Gonadotropin Releasing Hormone (GnRH) Analogs, 5.01.625

Indication added

- Myfembree® (relugolix/estradiol/norethindrone acetate)
  - Treatment of moderate to severe pain associated with endometriosis in premenopausal people age 18 years or older

Medical necessity criteria updated

Indication: Endometriosis

- Orilissa® (elagolix)
  - The person must be age 18 years or older
  - The patient must be premenopausal

Medical necessity criteria updated

Indication: Prostate cancer

Criteria added based on unfavorable risk stratification

Reauthorization criteria updated

Indication: Uterine fibroids

- Myfembree® (relugolix/estradiol/norethindrone acetate)
- Oriahnn® (elagolix/estradiol/norethindrone acetate)

- Ongoing use of these drugs beyond 24 months is considered not medically necessary

Herceptin® (trastuzumab) and Other HER2 Inhibitors, 5.01.514

Indications added

- Enhertu® (fam-trastuzumab deruxtecan-nxki)
  - Treatment of adults with HER2-low breast cancer that can't be treated with surgery or that has spread to other parts of the body
  - Treatment of adults with non-small cell lung cancer (NSCLC) that can't be treated with surgery or that has spread to other parts of the body

Management of Opioid Therapy, 5.01.529

Short-acting opioid step therapy

Quantity limits updated

Quantities are limited to a 3-day supply for opioid-naïve people under age 18 years without prior authorization

Short-acting opioid, greater than 3-day supply

New policy section

Medical necessity criteria added

Medical necessity criteria added for more than a 3-day supply for people under age 18 years

Short-acting opioid therapy drugs

Added to policy

- Qdolo®
- Seglentis®

Removed from policy

- Synalgos® -DC
- Hycet®
- Verdrocet®
- Vicodin ES®
- Xodol®
- Reprexain™
- Vicoprofen®
- Xylon™
- Simplist Dilaudid®
- Meperitab™
- Oxy IR®
- Oxycodone HCL Acetaminophen AvPak™
- Percodan®

- FusePaq Synapryn™
  - These products are no longer available

Long-acting opioid therapy drugs

Removed from policy

- Fentanyl Transdermal System Novaplus
- Ionsys®
- Exalgo®
- Arymo® ER
- Opana® ER
- Embeda® ER
- Ultram® ER
  - These products are no longer available

Transmucosal Fentanyl Citrate Products

Removed from policy

- Onsolis™
  - This product is no longer available

Medical Necessity Criteria for Pharmacy Edits, 5.01.605

Angiotensin II Receptor Blockers (ARBs), Brand

Medical necessity criteria updated

- For brand drugs, the number of generic ARBs drugs that must be tried first has been increased from one to two generic ARBs
- Criteria has been added for brand valsartan solution

Angiotensin II Receptor Blocker (ARB) Combinations, Brand

New policy section

Drugs added

- Atacand® HCT (candesartan/HCTZ)
- Avalide® (irbesartan/HCTZ)
- Benicar® HCT (olmesartan/HCTZ)
- Diovan® HCT (valsartan/HCTZ)
- Edarbyclor® (azilsartan/chlorthalidone)
- Hyzaar® (losartan/HCTZ)
- Micardis® HCT (telmisartan/HCTZ)
- Tekturna® HCT (aliskiren/HCTZ)

Anticonvulsants

Medical necessity criteria updated

- Vimpat® (lacosamide)
  - Generic lacosamide must be tried before this drug can be prescribed

- The requirement for a trial and failure of two generic anti-seizure medications has been revised to a trial and failure of at least one additional anti-seizure medication

Antipsychotics, Second Generation
Drug added
- Brand quetiapine
- Lybalvi™ (olanzapine and samidorphan)

Brand Drugs for ADHD and Stimulants for Other Psychiatric Conditions
Medical necessity criteria updated
- Qelbree™ (viloxazine extended-release)
  - The age criterion has been changed from age 6 to 17 years to age 6 years or older

Continuous Glucose Monitoring (CGM) Supplies
Product added
- Freestyle® Libre 3 Sensor

Inhaled Corticosteroids
Drugs added
- Armonair® Digihaler™ (fluticasone propionate)
- Brand fluticasone propionate inhalation aerosol

Muscle Relaxants
Drug added
- Lyvispah™ (baclofen oral granules)

Proton Pump Inhibitors
Drug added
- Konvomep™ (omeprazole/sodium bicarbonate)

Rifamycin Antibiotics
Medical necessity criteria updated
Indication: Small Intestinal Bacterial Overgrowth (SIBO)
- The requirement for prior therapy with two other antibiotic agents now includes an exception if the patient has documented allergies or medical reasons why they cannot use two other antibiotics

Ulcerative Colitis Agents
Note updated
- The note for the use of Pentasa® (mesalamine) for inflammatory bowel disease has been revised to Crohn's disease

Pharmacotherapy of Miscellaneous Autoimmune Diseases, 5.01.564

Medical necessity criteria updated

- Benlysta® (belimumab) IV
- Benlysta® (belimumab) SC
  Indication: Systemic Lupus Erythematosus (SLE)
  - A trial and failure of standard induction therapy has been revised to Benlysta® (belimumab) being used as an add-on therapy following standard induction therapy

Medical necessity criteria updated

- Benlysta® (belimumab) IV
  Indication: Active lupus nephritis
  - The age requirement has been revised from 18 years or older to 5 years or older

Pharmacotherapy of Type I and Type II Diabetes Mellitus, 5.01.569

Glucagon-like Peptide-1 (GLP-1) Receptor Agonists

Medical necessity criteria updated

- Adlyxin® (lixisenatide)
- Victoza® (liraglutide)
  - Mounjaro™ (tirzepatide) has been added to the list of drugs that must be tried before the above drugs may be prescribed

Glucose-Dependent Insulinotropic Polypeptide (GIP) Receptor and Glucagon-like Peptide-1 (GLP-1) Receptor Agonists

Drug added to preferred

- Mounjaro™ (tirzepatide)

Phosphoinositide 3-kinase (PI3K) Inhibitors, 5.01.592

Indication added

- Piqray® (alpelisib)
  - Treatment of PIK3CA-Related Overgrowth Spectrum (PROS) in people age 18 years and older

Drug added

- Vijoice® (alpelisib)
  - Treatment of PIK3CA-Related Overgrowth Spectrum (PROS) in people age 2 years and older

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Archived policies

Effective October 1, 2022

Allograft Injection for Degenerative Disc Disease, 7.01.166

Bronchial Thermoplasty, 7.01.127

Endovascular Therapies for Extracranial Vertebral Artery Disease, 7.01.148

Facet Arthroplasty, 7.01.120

Myocardial Sympathetic Innervation Imaging in Patients with Heart Failure, 6.01.56

Phrenic Nerve Stimulation for Central Sleep Apnea, 2.02.33

Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension, 7.01.136

Deleted policies

Effective October 1, 2022

Capsule Endoscopy, 2.01.538
Now included in **Services Reviewed Using InterQual® Criteria, 10.01.530**

Negative Pressure Wound Therapy, 1.01.532
Now included in **Services Reviewed Using InterQual® Criteria, 10.01.530**

Coding updates

Added codes
Effective January 6, 2023

See also the **Special notices** section above

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

90870

Effective December 1, 2022

See also the **Special notices** section above

Botulinum Toxins, 5.01.512
Now requires review for medical necessity and prior authorization.

J0585, J0586, J0587, J0588

Temporomandibular Joint Disorder, 2.01.535
Now requires review for medical necessity and prior authorization.

J0585, J0586, J0587, J0588

Treatment of Hyperhidrosis, 8.01.519
Now requires review for medical necessity and prior authorization.

J0585, J0586, J0587, J0588

Effective October 1, 2022

AIM Specialty Health® Genetic Testing
Now reviewed by AIM Specialty Health® and requires prior authorization.

0332U, 0333U, 0334U, 0335U, 0336U, 0339U, 0340U, 0341U, 0343U, 0345U, 0347U, 0348U, 0349U, 0350U

Chimeric Antigen Receptor Therapy for Multiple Myeloma, 8.01.66
Now requires review for medical necessity and prior authorization.

Q2056

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

J1302

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

J9274

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

0337U, 0338U, 0342U, 0344U

Non-covered Services and Procedures, 10.01.517
No longer covered.

T1032, T1033

Percutaneous Balloon Kyphoplasty, Radiofrequency Kyphoplasty, and Mechanical Vertebral Augmentation, 6.01.38
Now requires review for medical necessity.

C1062

Therapeutic Radiopharmaceuticals in Oncology, 6.01.525
Now requires review for medical necessity.

A9607, A9800

Use of Granulocyte Colony-Stimulating Factors (G-CSF), 5.01.551
Now requires review for medical necessity and prior authorization.

Q5125

Vascular Endothelial Growth Factor (VEGF) Receptor, 5.01.620
Now requires review for medical necessity and prior authorization.

J2777

LifeWise
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Removed codes
Effective January 6, 2023

Total Ankle Replacement, 7.01.577
No longer requires review. Policy deleted.

27703

Effective October 1, 2022

AIM Specialty Health® Genetic Testing
No longer requires review. Code terminated.

0012U, 0013U, 0014U, 0056U

Allograft Injection for Degenerative Disc Disease, 7.01.166
No longer requires review. Policy archived.

0627T, 0628T, 0629T, 0630T

Bronchial Thermoplasty, 7.01.127
No longer requires review. Policy archived.

31660, 31661

Drugs for Rare Diseases, 5.01.576
No longer requires review.

C9094

Endovascular Therapies for Extracranial Vertebral Artery Disease, 7.01.148
No longer requires review. Policy archived.

0075T, 0076T

Facet Arthroplasty, 7.01.120
No longer requires review. Policy archived.

0075T, 0076T

Hematopoietic Stem Cell Transplantation for Epithelial Ovarian Cancer, 8.01.23
No longer requires review.

S2140

Miscellaneous Oncology Drugs, 5.01.540
No longer requires review.

C9095

Myocardial Sympathetic Innervation Imaging in Patients with Heart Failure, 6.01.56
No longer requires review. Policy archived.

0331T, 0332T

Phrenic Nerve Stimulation for Central Sleep Apnea, 2.02.33
No longer requires review. Policy archived.

0424T, 0425T, 0426T, 0427T, 0428T, 0429T, 0430T, 0431T, 0432T, 0433T, 0434T, 0435T, 0436T, C1823

Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension, 7.01.136
No longer requires review. Policy archived.

0338T, 0339T

Use of Granulocyte Colony-Stimulating Factors (G-CSF), 5.01.551
No longer requires review. Code terminated.

C9096

Vascular Endothelial Growth Factor (VEGF) Receptor, 5.01.620
No longer requires review. Code terminated.

C9097