HIGHMARK

January 2024

MEDICAL POLICY UPDATE

IN THIS ISSUE

Policy

Policy Titles	Anticipated Issue Date	30 Day Notification Information
AC-A-0623-001 CG Heart Transplant Rejection Gene Expression Profiling (eg AlloMap) and Donor derived cell free DNA (eg AlloSure)	03/04/2024	This policy is up for annual review. There are no indications for a change in coverage at this time. The policy will publish on March 4, 2024.
E-5 - Tumor Treatment Fields (TTF)	03/04/2024	This policy is scheduled for annual review. Administrative updates only. This policy will publish on March 4, 2024.

I-3 - Allergy Immunotherapy	03/04/2024	This policy is up for annual review. There are no indications for a change in coverage at this time. Policy will publish on March 4, 2024.
I-14 - Immune Globulin Therapy	03/04/2024	This policy is up for annual review. Newly approved IVIG product Alyglo was added to the policy. The criteria for ITP was revised to remove the requirement for a splenectomy. Policy will publish on March 4, 2024.
I-85 - Natalizumab (Tysabri®)	02/05/2024	This policy is scheduled for annual review. Policy is being updated with new to market Tyruko- a biosimilar to Tysrabi Policy will publish February 5, 2024.
I-86 - Bevacizumab (Avastin®)	02/05/2024	This policy is being updated with the addition of new to market biosimilar Avzivi- a biosimilar to Avastin. Policy will publish February 5, 2024.
I-88 - Granulocyte Colony-Stimulating Factors	02/05/2024	This policy was updated with the addition of new to market Ryzneuta. This is being added as as non-preferred product to Neulasta, Fulphila, and Ziextenzo. Policy will publish February 5, 2024.
I-128 - Dcitabine (Dacogen)	03/11/2024	This policy is scheduled for annual review. There are no indications for change in coverage. Policies will publish March 11, 2024.
I-201 - Treatment of Hereditary Amyloidosis	03/11/2024	This policy is up for annual review. Removing criteria associated with Tegsedi as it is self-administered medication. No additional changes in coverage being made. Policy will publish on March 11, 2024.
I-211 - Givosiran (Givlaari)	03/11/2024	This policy is up for annual review. There are no indications for a change in coverage at this time. Denial statement is being updated too not medically necessary. Policy will publish on March 11, 2024.
I-221- Isatuximab-irfc (Sarclisa)	03/11/2024	This policy is scheduled for annual review. There are no indications for change in coverage. Policy will publish March 11, 2024.
I-251 - Sutimlimab-jome (Enjaymo)	03/04/2024	This policy is up for annual review. There are no indications for a change in coverage at this time. Denial statement is being updated to not medically necessary. Policy will publish on March 4, 2024.

I-271- Valoctocogene Roxaparvovec-rvox (Roctavian)	01/22/2024	This policy was revised to adjust the age criteria to 18 years of age or older. Policy will publish on January 22, 2024.
I-273- ADAMTS13, recombinant-krhn (Adzynma)	02/05/2024	This policy is created to establish criteria for new to market therapy ADAMTS13, recombinant-krhn (Adzynma). Policy will publish February 5, 2024.
I-281 - Exagamglogene autotemcel	01/22/2024	This is a new policy for the recently FDA approved gene therapy Casgevy for the treatment of sickle cell disease. Policy will publish on January 22, 2024.
I-282 - Lovotibeglogene autotemcel (Lyfgenia)	01/22/2024	This is a new policy for the recently FDA approved gene therapy Lyfgenia for the treatment of sickle cell disease. Policy will publish on January 22, 2024.
L-261 - Experimental/Investigational Laboratory Services	03/11/2024	This policy is scheduled for annual review. Administrative changes made. This policy will publish on March 11, 2024.
M-61 - Autonomic Nervous System Function Testing	03/04/2024	This policy is scheduled for annual review. No indications for change in coverage at this time. Administrative updates were made. The policy will publish March 4, 2024.
Q-5 - Air Ambulance Services	03/04/2024	This policy is scheduled for annual review. Administrative changes made. This policy will publish on March 4, 2024.
R-107-001 Image-Guided Superficial Radiotherapy	03/11/2024	This is a new policy created to address IGSRT with BCC and SCC. The policy is in accordance with the Position Statement of the American Academy of Dermatology association. The policy is scheduled to publish March 11, 2024.
S-32 - Implantable Hormone Replacement Pellets	03/04/2024	This policy is up for annual review. There are no indications for a change in coverage at this time. Policy will publish on March 4, 2024.
S-109 - Transcatheter Arterial Chemoembolization	03/04/2024	This policy is scheduled for annual review. Coding and NCCN statements have been updated. The policy will publish March 4, 2024.
S-116 - Corneal Transplantation	03/04/2024	This policy is scheduled for annual review. There are no indications for a change in coverage at this time. Administrative updates were made. The policy will publish on March 4, 2024.

S-118 - Small Bowel, Small Bowel/Liver and Multiviscera	03/11/2024	This Policy is scheduled for annual review. The addition of HIV specific indications were added. The policy will publish on March 11, 2024.
S-137 - Ablation of Miscellaneous Solid Tumors	03/04/2024	This is an annual review. There is no change to coverage criteria. Diagnosis coding has been updated to remove unspecified codes. This policy will publish on March 4, 2024,
S-184 - Gender Reassignment Surgery	03/11/2024	This policy is scheduled for annual review. Criteria will be updated to align with recommendations from WPATH and the Endocrine Society. Coding will be updated to reflect medical necessity criteria. The policy will publish on March 11, 2024.
S-192 - Ultrafiltration in Decompensated Heart Failure	03/04/2024	This policy is being archived. A standard 30-day notification has been provided. This policy will archive effective March 4, 2024.
S-269-004 Per-Oral Endoscopic Myotomy	03/04/2024	This policy is up for annual review. There are no indications for a change in coverage at this time. The policy will publish on March 4, 2024.
Z-104 - Basivertebral Nerve Ablation	03/04/2024	This policy is up for annual review. Adding skeletal maturity to the medically necessary criteria. No additional changes in coverage are warranted at this time. Policy will publish on March 4, 2024.

Coverage Criteria Established for Natalizumab-sztn (Tyruko)

Highmark Blue Cross Blue Shield has established additional criteria for I-85 Natalizumab (Tysabri). This is a policy is being updated with criteria for Natalizumab-sztn (Tyruko), the first biosimilar to Tysabri, indicated for the treatment of relapsing forms of multiple sclerosis.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is February 5, 2024.

Place of Service: Outpatient

Please refer to Medical Policy I-85, Natalizumab (Tysabri), for additional information.

Coverage Criteria Established for Bevacizumab-tnjn (Avzivi)

Highmark Blue Cross Blue Shield has established additional criteria for I-86 Bevacizumab (Avastin) and Bevacizumab Biosimilars. This is policy is being updated with criteria for bevacizumab-tnjn (Avzivi) a biosimilar to Avastin.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is February 5, 2024.

Place of Service: Outpatient

Please refer to Medical Policy I-86, Bevacizumab (Avastin) and Bevacizumab Biosimilars, for additional information.

Coverage Criteria Established for Efbemalenograstim alfa-vuxw (Ryzneuta)

Highmark Blue Cross Blue Shield has established additional criteria for I-88 Granulocyte Colony-Stimulating Factors. This is policy is being updated with criteria for efbemalenograstim alfa-vuxw (Ryzneuta), a new leukocyte growth factor indicated for chemotherapy-induced neutropenia.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is February 5, 2024.

Place of Service: Outpatient

Please refer to Medical Policy I-88, Granulocyte Colony-Stimulating Factors, for additional information.

Coverage Criteria Established for ADAMTS13, recombinant-krhn (Adzynma)

Highmark Blue Cross Blue Shield has established new criteria for I-273, ADAMTS13, recombinant-krhn (Adzynma). This is a new policy creating criteria for Adzynma, a recombinant protein indicated for prophylactic or on-demand enzyme replacement therapy for individuals with congenital thrombotic thrombocytopenic purpura (cTTP).

This new Medical Policy will apply to professional providers and facility claims. The effective date is February 5, 2024.

Place of Service: Outpatient

Please refer to Medical Policy I-273, ADAMTS13, recombinant-krhn (Adzynma). for additional information.

Coverage Criteria Established for Exagamglogene autotemcel (Casgevy)

Highmark Blue Cross Blue Shield has established new guidelines for the newly FDA approved gene therapy exagamglogene autotemcel (Casgevy) for the treatment of sickle cell disease.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is January 22, 2024

Place of Service:

Please refer to Medical Policy I-281, Exagamglogene autotemcel (Casgevy), for additional information.

Coverage Criteria Established for Lovotibeglogene autotemcel (Lyfgenia)

Highmark Blue Cross Blue Shield has established new guidelines for the newly FDA approved gene therapy lovotibeglogene autotemcel (Lyfgenia) for the treatment of sickle cell disease.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is January 22, 2024

Place of Service:

Please refer to Medical Policy I-282, Lovotibeglogene autotemcel (Lyfgenia), for additional information.

Reminder: Cardiology & Radiology Coverage Guideline Update

Highmark Blue Shield is providing a reminder to all providers.

The Cardiology & Radiology coverage guideline will be updated and take effect February 12, 2024. This applies to both professional provider and facility claims.

The changes to the Cardiology & Radiology guidelines are indicated below:

Head Imaging Guidelines Changes:

Section Name	Section Number/Policy Number	Summary of change
Dementia	HD-8.1	Removed reference to Medicare National Coverage Determination, Section 220.6.20 Updated link from HD-4.3 to HD-4.2 to match the policy number for "Mental Status Change (HD-4.2) Added link to HD-8.5
Dementia	HD-8.1	Updated section for volumetric analysis or Neuro Quant and added title "Quantitative Magnetic Resonance Image (MRI) Analysis of the Brain" Added updated AMA CPT codes for Quantitative analysis of the brain (CPT® 0865T or CPT® 0866T)
Dementia - PET	HD-8.2	For amyloid brain PET, removed reference to Medicare National Coverage Determination, Section 220.6.20 Added link to HD-8.5
Dementia - PET	HD-8.2	Moved the following statement to a level one bullet point, "For Cerebral Amyloid Angiopathy, see Stroke/TIA (HD-21.1)"

Imaging related to Alzheimer's Treatment with Amyloid Reduction Medications	HD-8.5	Imaging and background & supporting information added for consideration of treated or patients currently being treated with Lecenamab (Leqembi) or Aducanumab (Aduhelm)
Multiple Sclerosis (MS)	HD-16.1	Updated section for volumetric analysis or Neuro Quant and added title "Quantitative Magnetic Resonance Image (MRI) Analysis of the Brain" Added updated AMA CPT codes for Quantitative analysis of the brain (CPT® 0865T or CPT® 0866T)
Neuromyelitis Optica and NMO Spectrum Disorders	HD-16.2	Updated section for volumetric analysis or Neuro Quant and added title "Quantitative Magnetic Resonance Image (MRI) Analysis of the Brain" Added updated AMA CPT codes for Quantitative analysis of the brain (CPT® 0865T or CPT® 0866T)
Stroke/TIA	HD-21.1	Removed reference to Medicare National Coverage Determination, Section 220.6.20
Dizziness/Vertigo	HD-23.1	Added the word "is suspected" to the end of the sentence in BG&S information for Dix-Hallpike maneuver
Transcranial Doppler (CPT® 93886)	HD-24.8	Deleted the word "investigational" from the first level bullet point for TCD in background and supporting information where it discusses "not medically necessary"
Tinnitus	HD-27.2	Updated indication for asymmetric or unilateral tinnitus to indicate this should be "non-pulsatile" tinnitus
Neuronavigation	HD-28.2	Updated the statement "It is not indicated to request diagnostic imaging codes for the purpose of registration for neuronavigation." to say, "Diagnostic imaging codes are not indicated for the purpose of registration for neuronavigation" in order to remove the word "appropriate"

Breast Imaging Guideline Changes:

Section Name	Version/ Release Number	Section Number/Policy Number	Summary of change
Breast Imaging Guidelines	v2.0.2024	MRI Breast Indications (BR-5.1) BR.RC.0005.1.A/Alternative Breast Imaging Approaches (BR-8.1) BR.AA.0008.1.A	Added v1.0.2024 Risk Factors from BR-5.1 into BR-8.1. No change in clinical content.

Pelvic Imaging Guideline Changes

Section Name	Version/ Release Number	Section Number/Policy Number	Summary of change
Pelvis	v2. 2024	19	Previously, Prostate Artery Embolization (PAE) Pre-procedure imaging for prostate artery embolization was not supported. However, new evidence has supports: MRA Pelvis (CPT® 72198) or CTA Pelvis (CPT® 72191) can be considered for evaluation of the pelvic vasculature if: Prostate artery embolization is planned

If you wish to see the updates prior to the implementation date, please go to eviCore website under the Future tab for Cardiology & Radiology utilizing the following pathway:

- Provider Resource Center→ Medical Policy Search→ Medical Policies→ EVICORE CLINICAL GUIDELINES (top blue bar)→EVICORE CLINICAL GUIDELINES (body of page)→ Access Guidelines→ Select appropriate Cardiology & Radiology→ *Search Health Plan* by typing in Highmark→ Click on Highmark and then click on magnifying glass→ Click on FUTURE→ Select appropriate guideline.

Reminder: Cardiology & Radiology Coverage Guideline Update

NEWS FOR ALL PROVIDER TYPES

Highmark Blue Shield is providing a reminder to all providers.

The Cardiology & Radiology coverage guideline will be updated and take effect April 1, 2024. This applies to both professional provider and facility claims.

The changes to the Cardiology & Radiology guidelines are indicated below:

Preface to Imagining Guidelines Changes:

Section Name	Section Number/Policy Number	Summary of change
Preface	5.3	To clarify, the following criteria were added to PET MRI: o The individual meets condition-specific guidelines for PET-MRI OR o The individual meets ALL of the following: -The individual is a pediatric patient or being treated under a pediatric guideline and treatment plan AND

Pediatric Oncology Imaging Guideline Changes:

Section Name	Version/ Release Number	Section Number/Policy Number	Summary of change

PET Imaging in Pediatric Oncology	V2.0.2024	PEDONC-1.4	Added criteria that PET/MRI may be approved when the individual is a pediatric patient or being treated under a pediatric guideline/treatment plan
Histiocytic Disorders - General Considerations	V2.0.2024	PEDONC-18.1	Added statement that PET in histiocytic disorder guidelines refer to FDG radiotracer only
Langerhans Cell Histiocytosis (LCH)	V2.0.2024	PEDONC-18.2	Initial imaging: Updated to allow PET/CT for all. Updated CT Chest imaging criteria to state it is indicated for suspected pulmonary LCH based on findings on other imaging. Removed abdominal ultrasound, chest x-ray, and skeletal survey. Clarified abdominal/pelvic imaging if PET/CT has not been performed
Langerhans Cell Histiocytosis (LCH)	V2.0.2024	PEDONC-18.2	Treatment response: Updated imaging timeframe from 6 weeks to 2-3 cycles Added additional criteria for repeat imaging (after surgical curettage and after radiation therapy) Added PET/CT for inconclusive imaging, disease previously only measurable on PET/CT, or change from active treatment to surveillance. Removed chest x-ray, abdominal ultrasound, skeletal survey.
Langerhans Cell Histiocytosis (LCH)	V2.0.2024	PEDONC-18.2	Surveillance imaging: Reworded imaging timeframe of multifocal bone disease to every 6 months for 2 years. Added that PET/CT may be done if disease was previously only measurable on PET
Langerhans Cell Histiocytosis (LCH)	V2.0.2024	PEDONC-18.2	Removed from background and supporting information statement that additional PET imaging is not indicated once PET/CT shows no remaining FDG-avid lesions
Non-Langerhans Cell Histiocytoses	V2.0.2024	PEDONC-18.4	Updated initial imaging of RDD to state that CT imaging may be performed if PET/CT was not performed or to follow up unclear findings on PET/CT
Non-Langerhans Cell Histiocytoses	V2.0.2024	PEDONC-18.4	Added PET/CT for surveillance of RDD
Non-Langerhans Cell Histiocytoses	V2.0.2024	PEDONC-18.4	ECD initial imaging: Updated to allow nuclear bone scan in lieu of PET if requested. Updated CT imaging to state that it may be performed if PET/CT was not performed or was inconclusive. Updated cardiac MRI to state indicated for clinically suspected cardiac involvement. Updated MRI Brain to state indicated for CNS symptoms Removed CTA and MRA for evaluation of vascular tree involvement
Non-Langerhans Cell Histiocytoses	V2.0.2024	PEDONC-18.4	Removed from background and supporting information statement that PET/CT is not supported for routine surveillance of ECD

If you wish to see the updates prior to the implementation date, please go to eviCore website under the Future tab for Cardiology & Radiology utilizing the following pathway:

- Provider Resource Center→ Medical Policy Search→ Medical Policies→ EVICORE CLINICAL GUIDELINES (top blue bar)→EVICORE CLINICAL GUIDELINES (body of page)→ Access Guidelines→ Select appropriate Cardiology & Radiology→ *Search Health Plan* by typing in Highmark→ Click on Highmark and then click on magnifying glass→ Click on FUTURE→ Select appropriate guideline.

Medicare Advantage

Coverage Criteria Established for Exagamglogene autotemcel (Casgevy)

NEWS FOR ALL PROVIDER TYPES

MA MEDICARE ADVANTAGE

Highmark's Medicare Advantage products have established new guidelines for the newly FDA approved gene therapy exagamglogene autotemcel (Casgevy) for the treatment of sickle cell disease.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is January 22, 2024.

Please refer to Medical Policy I-290, Exagamglogene autotemcel (Casgevy), for additional information.

Coverage Criteria Established for Lovotibeglogene autotemcel (Lyfgenia)

NEWS FOR ALL PROVIDER TYPES

MA MEDICARE ADVANTAGE

Highmark's Medicare Advantage products have established new guidelines for the newly FDA approved gene therapy lovotibeglogene autotemcel (Lyfgenia) for the treatment of sickle cell disease.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is January 22, 2024.

Please refer to Medical Policy I-291, Lovotibeglogene autotemcel (Lyfgenia), for additional information.

Comments on These Medical Policies?

We want to know what you think about our new medical policy changes. Send us an email with any questions or comments that you may have on the new medical policies in this edition of Medical Policy Update.

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