MEDICAL POLICY UPDATE

April 2023

HIGHMARK. WESTERN NEW YORK

IN THIS ISSUE

Policy

Policy Title	Anticipated Issue Date	30 Day Notification Information
E-20 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults	05/29/2023	This policy is up for annual review. Administrative changes made. Criteria updated to align with BCBSA. This policy will publish on May 29, 2023.
I-6 - Approved Drugs and Biological	05/29/2023	This policy is up for annual review. There are no indications for a change in coverage at this time. Policy will publish on May 29, 2023.
I-9 Gaucher Disease	06/12/2023	This policy is scheduled for annual review. Update includes change of initial authorization period to 12 months. Policy will publish June 12, 2023.
I-19 Intravenous Antibiotic Therapy for Lyme Disease	06/05/2023	This policy is scheduled for annual review. There is no change in coverage. Policy will publish June 5, 2023.
I-32 Intravenous Anesthetics for Off-Label Indications	06/12/2023	This policy is up for an annual review. Coverage criteria were established for IV Ketamine for the diagnosis for treatment resistant depression. Denial statement was updated to NMN. Policy will publish on June 12, 2023.
I-56- Hydroxyprogesterone Caproate Injection as a	05/01/2023	Makena has been removed from the market by the FDA. Policy will be archived as of May 1, 2023.

Policy Title	Anticipated Issue Date	30 Day Notification Information
Technique to Reduce Preterm Birth in High-Risk Pregnancies		
I-58 Enzyme Replacement Therapies	08/01/2023	This policy is being updated with the addition of olipudase alfa-rpcp (Xenpozyme) to Site of Care program. MPU is required. Policy will publish August 1, 2023.
I-126 Alpha1-Proteinase Inhibitors	06/05/2023	This policy is scheduled for annual review. Minor revisions to policy language were made. Policy will publish June 5, 2023.
I-143 Inhalation Products for the Management of Cystic Fibrosis	05/29/2023	This policy was scheduled for annual review. Denial statement updated. Policy will publish on May 29, 2023.
I-161 Irinotecan Liposomal (Onivyde)	05/29/2023	This policy was scheduled for annual review. Denial statement updated. Policy will publish on May 29, 2023.
I-201 Treatment of Hereditary Amyloidosis	05/29/2023	This policy was scheduled for annual review. Denial statement update. Policy will publish on May 29, 2023.
I-203 - Polymerized Sucralfate Malate Paste (ProThelial)	05/29/2023	This policy will be archived as of May 29, 2023.
I-212 Esketamine (Spravato)	06/05/2023	This policy is up for an annual review. There are no indications for a change in coverage at this time. The denial statement is being updated to not medically necessary. Policy will publish on June 5, 2023.
I-226 Tafasitamab-cxix (Monjuvi)	06/12/2023	This policy is scheduled for annual review. Policy updates include replacement of nccn criteria with recommendation statement and diagnosis code updates. Policy will publish June 12, 2023.
I-227 - Inebilizumab-cdon (Uplizna)	06/05/2023	This policy is up for an annual review. There are no indications for a change in coverage at this time. Denial statement is being updated to NMN. Policy will publish on June 5, 2023.
I-232 Viltolarsen (Viltepso)	05/29/2023	This policy is up for an annual review. There are no indications for a change in coverage at this time. Policy will remain E/I. Policy will publish on May 29, 2023.
M-13 Intraoperative Neurophysiologic Monitoring (Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring)	04/24/2023	This policy is being updated with pre-pay logic to support the policy criteria. The policy will publish April 24, 2023.
M-23 Esophageal pH Monitoring	06/05/2023	This policy is scheduled for annual review. There is no change in coverage. The policy is expected to publish on June 5, 2023.

Policy Title	Anticipated Issue Date	30 Day Notification Information
O-13 Cranial Orthosis for Plagiocephaly	06/05/2023	This policy is scheduled for annual review. There is no change in coverage. This policy is expected to publish on June 5, 2023.
Q-4 Private Duty Nursing	05/29/2023	This policy is an annual review. Current coverage criteria maintained. Policy will publish on May 29, 2023.
S-124 Kidney Transplant	05/29/2023	This is an annual review. There is no change in coverage criteria. This policy will publish on May 29, 2023.
S-271 Hematopoietic Cell Transplantation: Experimental/Investigational Services	05/28/2023	This policy is an annual review. There are no changes to coverage criteria. This policy will publish on May 28, 2023.
S-272 Hematopoietic Cell Transplantation: Blood Cancers	05/29/2023	This policy is an annual review. There is no change to coverage criteria. This policy will publish on May 29, 2023.
S-273 Hematopoietic Cell Transplantation: Solid Tumors	05/29/2023	This policy is an annual review. There is no change to coverage criteria. This policy will publish on May 29, 2023.
S-274 Hematopoietic Cell Transplantation: Non-Cancer Diseases	05/29/2023	This policy is an annual review. There is no change to coverage criteria. This policy will publish on May 29, 2023.
S-280 Surgical Treatments for Obstructive Sleep Apnea	04/10/2023	This is a new policy. This policy is being created for surgical options for sleep apnea. This policy is scheduled to publish April 10, 2023.
Y-5 Vision Therapy (Orthoptics and Pleoptics)	06/05/2023	This policy is scheduled for annual review. There are no changes in coverage criteria. The policy will publish on June 5, 2023.
Z-8 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	04/10/2023	This policy is being updated due to language and coding changes. Surgical portions of the policy are being moved to new policy S-280 Surgical Treatment of Obstructive Sleep Apnea. This policy is scheduled to publish April 10, 2023.
Z-64 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	04/10/2023	This policy is being updated due to language and coding changes. Surgical portions of the policy are being moved to new policy S-280 Surgical Treatment of Obstructive Sleep Apnea. This policy is scheduled to publish April 10, 2023.

Reminder: Laboratory Management Coverage Guideline Update

Highmark Blue Cross Blue Shield of Western New York is providing a reminder to all providers.

The Laboratory Management coverage guideline will be updated and take effect January 01, 2023. This applies to both professional provider and facility claims.

The changes to the Laboratory Guidelines are as follows:

New: Three (3) guidelines

Guideline Name	Guideline #	Procedure Codes Addressed by Guideline	Summary of change (to be reviewed in conjunction with actual GL)
Erythrocyte Sedimentation Rate	MOL.CS.329.X	85651, 85652	New guideline for management of erythrocyte sedimentation rate testing
Prealbumin Testing	MOL.CS.393.X	84134	New guideline for management of prealbumin testing
Multi-Cancer Early Detection Screening	MOL.TS.396.A	81599, 81479	New guideline for management of multi-cancer early detection screening tests (MCEDs)

Retired: One (1) guideline

Guideline Name	Guideline #	Procedure Codes Addressed by Guideline	Summary of change (to be reviewed in conjunction with actual GL)
CellSearch Circulating Tumor Cell Count for Breast Cancer Prognosis	MOL.TS.147.A	86152, 86153	This test was moved to the Investigational and Experimental guideline (MOL.CU.117)

Criteria Changed with Impacts: Nine (9) guideline

Guideline Name	Guideline #	Procedure Code Impacted by Update, if applicable	Summary of change (to be reviewed in conjunction with actual GL)

Somatic Mutation Testing-Solid Tumors	MOL.TS.230.A	84155	Criteria: Added medical necessity criteria for Tumor Mutation Burden (TMB) testing Guidelines and Evidence: updated; CPT Code Table: added new PLA code 0379U (Solid Tumor Expanded Panel, Quest Diagnostics)
Molecular Respiratory Infection Pathogen Panel (RIPP) Testing	MOL.CS.293.A	87633	Criteria: Updated criteria for panels of fewer than 6 pathogens. These panels are now coverable for individuals with acute respiratory symptoms, regardless of age/immunocompetency given the need to include SARS-CoV-2, flu, and RSV in most cases. Clarified intent of additional criteria to apply to larger panels (6 or more pathogens). Also updated Criteria to separate out Billing & Reimbursement section. Updated language in Billing and Reimbursement section. ICD table: Added new code Z79.6X Long term (crnt) use of immunomodulator & immunosuppressant; CPT Code Table: added Respiratory Pathogen with ABR (RPX) 0373U
Whole Genome Sequencing	MOL.TS.306.A	81425, 81426, 81427, 0094U	Criteria: added medical necessity criteria for rapid WGS in critically ill infants while under inpatient care.
Somatic Mutation Testing - Hematological Malignancies	MOL.TS.313.A	0364U	Criteria: added medical necessity criteria for clonoSeq MRD (minimal residual disease) assay based on ESMO and NCCN recommendations CPT Code Table: added clonoSeq (0364U); Guidelines and Evidence: updated; References: updated
Special Circumstances Influencing Coverage Determinations	MOL.AD.364.A	varies by state	Criteria: Added the following states and bills: IL HB 5334, LA SB 154, WSR 21-16-076, CT SB 358; Background: updated

In-Vitro Allergy Testing	MOL.CS.317.X	83520	Criteria: Tryptase specific information added to the criteria section, updated to separate out Billing & Reimbursement section. Updated language in Billing and Reimbursement section; Background: Added specific Tryptase Information.
Lyme Disease Testing	MOL.CS.332.X	86619, 86618, 86617, 0041U, 0042U, 87476, 87475, 0044U, 0043U, 0316U	Criteria: Removed ICD codes that were related to ONLY insect bites as testing is not considered medically necessary in the absence of symptoms; updated to separate out Billing & Reimbursement section. Updated language in Billing and Reimbursement section; Background: admin update; References; updated
Immunohistochemistry (IHC)	MOL.CS.104.A	88341, 88342, 88344	Criteria: previously had a flat unit denial, updated with specific unit limits, added non-covered indications. Also updated with specific billing and reimbursement rules. Updated to separate out Billing & Reimbursement section. Updated language in Billing and Reimbursement section.
Investigational and Experimental Laboratory Testing	MOL.CU.117.XK	Added: 0376U, 0368U, 0386U, 0377U, 0384U, 0365U, 0366U, 0367U, 0375U, 0385U, 0371U, 0372U, 0374U, 86152, 86153; Deleted: 0324U, 0325U	Added: ArteraAI Prostate Test (0376U) ColoScape Colorectal Cancer Detection (0368U) Envisage (0386U) Liposcale (0377U) NaviDKDTM Predictive Diagnostic Screening for Kidney Health (0384U) Oncuria Detect (0365U) Oncuria Monitor (0366U) Oncuria Predict (0367U) OvaWatch (0375U) PromarkerD (0385U) Qlear UTI (0371U) Qlear UTI - Reflex ABR (0372U) Urogenital Pathogen with Rx Panel (UPX) (0374U) CELLSEARCH CTC Test (86152, 86153);

			Moved: clonoSEQ Assay (81479, now 0364U; moved to Somatic Mutation – Hematological Malignancies and is now covered with criteria) Deleted (retired codes): 3D Predict Ovarian Doublet Panel (0324U) 3D Predict PARP Panel (0325U)

There are an additional 42 coverage guidelines for which criteria were changed with no impacts including administrative updates, content edits, and background updates.

As of January 1, 2023, coverage guidelines can be accessed utilizing the live link from the medical policy website.

If you wish to see the updates prior to the implementation date, please go to eviCore website under the Future tab for Laboratory Management 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→ Laboratory Management →*Search Health Plan* by typing in Highmark→Click on Highmark and then click on magnifying glass→Click on FUTURE→ Click on the Laboratory Management Guideline

Reminder: Musculoskeletal Coverage Guideline Update

Highmark Blue Cross Blue Shield of Western New York is providing a reminder to all providers.

The Musculoskeletal coverage guideline will be updated and take effect May 31, 2023. This applies to both professional provider and facility claims.

The updates to the Musculoskeletal guideline are as follows:

The significant changes are indicated below and affect:

- Spine Surgery Guidelines
  - CMM-600: Preface to Spine Surgery Guidelines
  - CMM-601: Anterior Cervical Discectomy and Fusion (ACDF)
  - CMM-604: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) with or without Fusion
- Pain Management Guidelines
  - CMM 200: Epidural Steroid Injections (ESI)
  - CMM 201: Facet Joint Injections/ Medial Branch Blocks

- CMM-208: Ablations/Denervations of Facet Joints and Peripheral Nerves
- CMM-209: Regional Sympathetic Blocks
- CMM-211: Spinal Cord Stimulators (SCS)
- CMM-402: Greater Occipital Nerve Block

- Joint Surgery Guidelines
  - CMM-311: Knee Replacement – Arthroplasty
  - CMM-313: Hip Replacement/Arthroplasty

To see any further editorial updates, follow the pathway provided below.

Spine Surgery Guideline:

Section Name / Policy Name	Section Number	Summary of change
CMM-600: Preface to Spine Surgery Guidelines		Defined Direct Lumbar Decompression and Indirect Lumbar Decompression Defined surgical approaches: Direct Visualization; Endoscopic Spinal Procedures; Indirect Visualization; Open Spinal Procedures; Percutaneous Spinal Procedures
CMM-601: Anterior Cervical Discectomy and Fusion (ACDF)	CMM 601.3	Repeat ACDF at the Same Level: Incorporated bullet *"Painful pseudarthrosis documented by confirmatory imaging that is unresponsive to 6 months of non-surgical treatment"* with associated conditions of unremitting neck pain, radiculopathy, and myelopathy as there would not be a reason for a repeat fusion unless pseudoarthrosis was present (or a failure of hardware which is addressed separately). • The *"unresponsive to 6 months of non-surgical treatment*" portion of the above incorporated bullet was not applied to the associated conditions due to the individual would have already been waiting 6 months for postoperative imaging to confirm pseudoarthrosis. Therefore, the 6 months of non-surgical treatment was not incorporated and the original 6 weeks of treatment required remains for unremitting neck pain and for radiculopathy.

CMM-601: Anterior Cervical Discectomy and Fusion (ACDF)	CMM 601.5	ACDF Following Failed Cervical Disc Arthroplasty Surgery: Added conservative treatment type required for unremitting neck pain to also include "Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician". This aligns with treatment types in other sections and for other conditions (e.g. CMM-601.3 Repeat ACDF for Unremitting Neck Pain, and for Radiculopathy in both CMM-601.3 and CMM-601.5
CMM-604: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) with or without Fusion	CMM 604.1	General Guidelines - Urgent/Emergent Indications/Conditions: Clarified the x-ray criteria options for demonstration of instability. General Guidelines - Urgent/Emergent Indications/Conditions: Removed two conditions that did not apply because presence of the imaging finding alone is not an urgent indication for surgery: "Congenital cervical stenosis (AP canal diameter ≤ 10 mm)"; and, "Ossification of the posterior longitudinal ligament at three (3) or more levels"
CMM-604: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) with or without Fusion	CMM 604.3 and 604.6	Added bullet requiring documentation of nicotine-free status in the following sub-sections and associated conditions: • 604.3: Initial Primary Posterior Cervical Decompression with Initial Posterior Cervical Fusion: Concurrent Stabilization Procedure; Clinical Conditions with an Increased Incidence of Congenital and/or Acquired Cervical Spinal Instability; Other Symptomatic Instability or Spinal Cord/Root Compression Requiring Posterior Fusion • 604.6: Posterior Cervical Fusion: Symptomatic Pseudoarthrosis from a Prior Anterior or Posterior Fusion (Unremitting Neck Pain and Radiculopathy sections);

CMM-604: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) with or without Fusion	CMM 604.4 and 604.5	Did not include bullet "Initial relief of symptoms following previous posterior cervical decompression procedure at same level" to allow for instances where there was an issue with the initial procedure that prevented an initial relief of symptoms.
CMM-604: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) with or without Fusion	CMM 604.5	Repurposed 4 criteria from Initial Posterior Decompression with Initial Posterior Cervical Fusion (Other Symptomatic Instability section). This will now allow an option for the procedure when the individual does not meet the original X-ray finding criteria (that aligned with urgent instability findings).
CMM-604: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) with or without Fusion	CMM 604.6	Clinical Conditions with an Increased Incidence of Congenital and/or Acquired Cervical Spinal Instability: • For consistency, repurposed 4 criteria from 604.3: Initial Posterior Decompression with Initial Posterior Cervical Fusion (Other Symptomatic Instability section) • Did not include condition "Klippel-Feil syndrome" as this is not an applicable condition for which a posterior cervical fusion without decompression would be performed solely based on the condition. Symptomatic Pseudoarthrosis from a Prior Anterior or Posterior Fusion: For consistency in cervical fusion spine surgery guidelines, added 3 sub-categories: Unremitting Neck Pain with Pseudoarthrosis; Radiculopathy with Pseudoarthrosis; and, Myelopathy with Pseudoarthrosis. These sub-categories had criteria repurposed from CMM-601.3: Repeat ACDF.

Pain Management

Section Name / Policy Name	Section Number	Summary of change

CMM 200: Epidural Steroid Injections (ESI)		General Guidelines: Clarified that the “12 months” timeframe for the limitations for injections is a “rolling” 12 months Added criteria that advanced diagnostic imaging within 24 months is required for cervical/thoracic interlaminar and transforaminal epidural steroid injections
CMM 201: Facet Joint Injections/ Medial Branch Blocks		Clarified that more than 2 diagnostic blocks at the same level are considered therapeutic.
CMM-208: Ablations/Denervations of Facet Joints and Peripheral Nerves		Non-Indications- Not Medically Necessary: Added a non-indication for when clinical findings and imaging studies suggest other obvious cause of pain.
CMM-209: Regional Sympathetic Blocks		Removed requirement for at least 6 consecutive months of conservative medical management due to the following: • Regional sympathetic blocks may be used to facilitate the involvement in rehabilitation and functional restoration. Thus, a prerequisite of 6 months of conservative care prior to diagnostic or therapeutic intervention is not possible as many patients require the intervention in order to tolerate rehabilitation and functional restoration programs.

CMM-211: Spinal Cord Stimulators (SCS)		Non-Indications - Experimental, Investigational, or Unproven (EIU): Added Dual-mode dorsal column stimulator (DCS) using closed loop as EIU
CMM-402: Greater Occipital Nerve Block		General Guidelines: Clarified that only anesthetic and/or steroid are the allowed injectates based on definition term and CPT code description

Joint Surgery Guidelines

Section Name / Policy Name	Section Number	Summary of change
CMM-311: Knee Replacement - Arthroplasty		Partial Knee Replacement Indications: Clarified that the imaging finding of AVN of the femoral condyles and/or proximal tibia is unicompartmental. Also, changed "intact, stable ligaments, in particular the anterior cruciate ligament" to "Knee stability confirmed by physical examination“ Revision of Knee Replacement-Isolated Polyethylene Liner Exchange (IPE) Indications: For clarity, re-worded the instability criteria bullet because mid-flexion instability is not the only type of instability amenable to polyethylene liner exchange. • Previously read: "Individual with mid-flexion instability without component malrotation or malalignment"; Now reads: "Instability without component malrotation or malalignment".

CMM-313: Hip Replacement/Arthroplasty		Partial Hip Replacement Indications and Total Hip Replacement Indications: For clarity, re-worded bullet: "An impacted fracture, partially displaced fracture, completely displaced or comminuted fracture of the femoral neck or femoral head is present and conservative management or surgical fixation is not considered a reasonable option...". • The types of fractures were removed and the bullet now reads: "A femoral head or femoral neck fracture is present and conservative management or surgical fixation is not considered a reasonable option.“ • Also removed the bullet "A non-displaced intracapsular fracture is present and surgical fixation is not considered a reasonable option". Based on the above change, this bullet is not needed as the above change would be inclusive of this scenario.

At that time, coverage guidelines can be accessed utilizing the live link from the medical policy website.

If you wish to see the updates prior to the implementation date, please go to eviCore website under the Future tab for Musculoskeletal 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 Musculoskeletal guideline→*Search Health Plan* by typing in Highmark→Click on Highmark and then click on magnifying glass→Click on FUTURE→ Click on the chosen Musculoskeletal Guideline

Guidelines Revised for Intravenous Anesthetics for Off-Label Indications

Highmark Blue Cross Blue Shield of Western New York as revised coverage guidelines for Ketamine (Ketalar).

This revised Medical Policy will apply to professional providers and facility claims. The effective date is June 12, 2023.

Place of Service: Inpatient/Outpatient

Please refer to Medical Policy I-32 Intravenous Anesthetics for Off-Label Indications, for additional information.

Injectable Drugs Added to Site of Care

Highmark Blue Cross Blue Shield of Western New York has added the following injectable drugs to site of care criteria:

- Spesolimab (Spevigo)
- Olipudase alfa-rpcp (Xenpozyme)

These revised Medical Policies will apply to both professional providers and facility claims. The effective date will be August 1, 2023.

Place of Service: Outpatient-Infusion

Please refer to Medical Policies I-254 Spesolimab (Spevigo) and I-58 Enzyme Replacement Therapies, for additional information.

Guidelines Revised for Intravenous Anesthetics for Off-Label Indications

Highmark's Medicare Advantage Product has revised coverage guidelines for Ketamine (Ketalar).

This revised Medical Policy will apply to professional providers and facility claims. The effective date is June 12, 2023.

Place of Service: Inpatient/Outpatient

Please refer to Medical Policy I-32 Intravenous Anesthetics for Off-Label Indications, 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.

Write to us at medicalpolicy@highmark.com

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