Blue Cross and Blue Shield of Nebraska (BCBSNE) is proud to work with our provider network to serve your patients, our members. We are updating several medical policies. Please review the changes and effective dates outlined here:

New Medical Policies

Medical Policy Varicose Veins
Effective Date: 03/01/2023
Preauthorization Required: Yes
Policy statement:

A new policy will be created, and a preauthorization will be required for varicose vein procedures. Draft will be online by 02/01/2023

Medical Policy Cardiac Ablation for arrhythmias
Effective Date: 03/01/2023
Preauthorization Required: Yes
Policy statement:

I. Transcatheter radiofrequency ablation (RFA) or cryoablation to treat atrial fibrillation may be considered **medically necessary** as a treatment for either of the following indications, which have failed to respond to adequate trials of antiarrhythmic medications:

A. Symptomatic paroxysmal or symptomatic persistent atrial fibrillation; **OR**
B. As an alternative to atrioventricular nodal ablation and pacemaker insertion in individuals with class II or III congestive heart failure and symptomatic atrial fibrillation.

II. Transcatheter RFA or cryoablation to treat atrial fibrillation may be considered **medically necessary** as an initial treatment for individuals with recurrent symptomatic paroxysmal atrial fibrillation (>1 episode, with ≤4 episodes in the previous 6 months) in whom a rhythm-control strategy is desired.

III. Repeat RFA or cryoablation may be considered **medically necessary** in individuals with recurrence of atrial fibrillation and/or development of atrial flutter following the initial procedure **(see Policy Guidelines section**).

IV. Transcatheter RFA or cryoablation to treat atrial fibrillation is considered **investigational** as a treatment for cases of atrial fibrillation that do not meet the criteria outlined above.

Revised Medical Policies

Medical Policy I.209 Stem Cell Therapy
Effective Date: 03/01/2023
Preauthorization Required: Yes
Adding policy statement:

I. Allograft bone products containing viable stem cells, including but not limited to demineralized bone matrix with stem cells, are considered investigational for orthopedic applications
II. Allograft or synthetic bone graft substitutes that must be combined with autologous blood or bone marrow are considered investigational for all orthopedic applications.

New title: Stem Cell Therapy and Allograft, Bone Substitutes Used with Autologous Bone Marrow

Medical Policy VIII.14 Durable Medical Equipment and Home Medical Equipment
Effective Date: 03/01/2023
Preauthorization Required: Yes
Adding policy statement:

I. Circulating and noncirculating cooling devices utilized in the outpatient setting are considered **not medically necessary**.
II. Combination circulating cooling and compression (cryopneumatic) devices utilized in the outpatient setting are considered **investigational**.

E0218: Fluid circulating cold pad with pump, any type
E0236: Pump for water circulating pad
E0217: Water circulating heat pad with pump [when specified as a cooling/heating combination device]
E0676: Intermittent limb compression device (includes all accessories), not otherwise specified [when specified as a compression cooling device for pain therapy]

Medical Policy I.177 Testing for Vitamin D Deficiency
Effective Date: 03/01/2023
Preauthorization Required: Yes
Updating policy statement:

I. **Two** tests per year for Vitamin D levels in patients with signs and/or symptoms of vitamin D deficiency or toxicity may be Medically Necessary
II. **Two** tests per years for Vitamin D levels in symptomatic patients may be Medically Necessary in the following patient populations.

New Pharmacy Policies

Medical Policy X.204: Skysona
Effective: 12/1/22

Preauthorization Required: Yes
Policy Statement: Skysona is considered medically necessary to slow the progression of neurologic dysfunction in boys 4-17 years of age with early, active cerebral adrenoleukodystrophy.

Medical Policy X.203: Zyntgelo
Effective: 12/1/22
Preauthorization Required: Yes
Policy Statement: Zynteglo is considered medically necessary for the treatment of adult and pediatric patients with β-thalassemia who require regular red blood cell (RBC) transfusions.

Medical Policy X.205: Ztalmy
Effective: 12/1/22
Preauthorization Required: Yes
Policy Statement: Ztalmy is considered medically necessary for the treatment of seizures associated with cyclin-dependent kinase-like (CDKL5) deficiency disorder (CDD) in patients 2 years of age and older.

Revised Pharmacy Policies

Medical Policy X.94 -Chimeric Antigen Receptor (CAR) T-cell Therapy – addition of Carvykti

Medical Policy X.78 -Dupixent – addition of criteria for use in newly approved diagnoses of eosinophilic esophagitis and prurigo nodularis

Medical Policy X.97 -Parathyroid Hormone Analogs for Osteoporosis – updated criteria based on new guideline supported recommendations.

Medical Policy X.42, X.43, X.44 -Biologic Autoimmune Conditions – addition of Olumiant for diagnosis of alopecia areata and as medical benefit for treatment of COVID19 infection; addition of Skyrizi for diagnosis of Crohns Disease; updated Orencia to non-preferred product for diagnosis of RA and PsA (members will need to try/fail Simponi Aria first); as of 7/1/23 preferred infliximab products will be biosimilars Avsola and Inflectra

Medical Policy X.31 -Disease Modifying Therapies for Multiple Sclerosis – addition of Tascenso ODT (as non-preferred product)

Medical Policy X.122 -Therapeutic Alternatives Prior Authorization – addition of venlafaxine ER 112.5mg, Auvelity, and Verkazia

Medical Policy X.1 -Proton Pump Inhibitors – addition of Konvomep (as non-preferred product)

Medical Policy X.175 -Oral Pulmonary Arterial Hypertension (PAH) Therapy – addition of Tadliq Suspension