Blue Cross and Blue Shield of Nebraska 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: VII.68 Myoelectric Upper Limb Prosthesis
Effective: 05/01/2023
Preauthorization Required: Yes
Policy Statement:

I. Myoelectric upper-limb prosthetic components may be considered **medically necessary** when the **ALL** the following conditions are met:

A. The prosthetic device is ordered or provided by a physician or under the direction of a physician, **AND**

B. Amputee is evaluated by an independent qualified professional (prosthetist/orthoptist) to determine the most appropriate prosthetic components and control mechanism.

(e.g., body-powered, myoelectric, or combination of body-powered and myoelectric), **AND**

C. The patient has an amputation or missing limb at the wrist or above (e.g., forearm, elbow) due to trauma or congenital absence, **AND**

D. Standard body-powered prosthetic devices cannot be used or are insufficient to meet the functional needs of the individual in performing activities of daily living AND use of

the limb for employment/school environment or extracurricular activities is not sufficient evidence for prescription of this device over standard prosthetic application, **AND**

E. The remaining musculature of the arm(s) contains the minimum microvolt threshold to allow operation of a myoelectric prosthetic device, **AND**

F. The patient has demonstrated sufficient neurologic and cognitive function to operate the prosthesis effectively, **AND**

G. The patient is free of comorbidities that could interfere with function of the prosthesis (e.g., neuromuscular disease), **AND**

H. Functional evaluation indicates that with training, use of a myoelectric prosthesis is likely to meet the functional needs of the individual (e.g., gripping, releasing,

holding, coordinating movement of the prosthesis) when performing activities of daily living. This evaluation should consider the patient's needs for control, durability (maintenance),

function (speed, work capability), and usability.

II. Myoelectric prostheses are contraindicated, and therefore considered **not medically necessary** for:

A. ADLs that require frequent lifting of heavy objects (16lbs or greater), **OR**

B. Environments involve frequent contact with dirt, dust, grease, water, and solvent, **OR**

C. When neuromas and/or phantom limb pain are exacerbated with the use of the prosthesis.

III. High-definition silicone used to make a prosthesis resemble a patient's skin is considered **not medically necessary** and cosmetic.

IV. Upper-limb prosthetic components **investigational** under all other conditions because their effectiveness has not been established, including but not limited to:

A. Advanced upper-limb prosthetic components with both sensor and myoelectric control (e.g., LUKE Arm).

B.A prosthesis with individually powered digits, including but not limited to a partial hand prosthesis (e.g., ProDigits).

C. Myoelectric controlled upper-limb orthoses.

D. Implantable myoelectric sensors for upper limb prostheses and hand prostheses.
E. Transcranial direct current stimulation for enhancing performance of myoelectric prostheses.
F. Adjustable click systems (e.g., Revo and Boa click systems).
G. Targeted muscle re-innervation for improved control of myoelectric upper limb prostheses and treatment of painful post-amputation **neuroma**.
H. Myo-electric hand prostheses.

Medical Policy: I.212 Sympathetic Nerve Blocks
Effective: 05/01/2023
Preauthorization Required: Yes
Policy Statement:

I. Sympathetic blocks using fluoroscopic or ultrasound guidance for stellate ganglion or fluoroscopic guidance for lumbar sympathetic block may be considered medically necessary for the following indications:

A. Complex regional pain syndrome (CRPS) > 4 weeks in duration when the following criteria are met:

1. Failed conservative treatment which includes **ALL** the following.
   a. Antidepressant **OR** anticonvulsants ≥ 4 weeks, **AND**
   b. Physical therapy, occupational therapy, or home exercise program ≥ 4 weeks; **AND**
2. Initial successful diagnostic injection results in a 50% reduction in pain and improvement in function for the duration of the local anesthetic used.
3. Following a successful initial diagnostic block, three (3) additional blocks may be performed with the first 2 weeks of the initial block to diagnose the individual's pain and assess therapeutic response.
4. Additional therapeutic regional sympathetic blocks may be considered medically necessary for up to a total of six (6) blocks. Not to exceed 10 regional sympathetic blocks in 12 months (4 diagnostic, 6 therapeutic).

II. The use of a sympathetic block (stellate ganglion block and lumbar sympathetic block) are considered **investigational** for all other indications, including, but not limited to;

A. Ulcerative colitis
B. Treatment of Long COVID symptoms (including, but not limited to anosmia (lack of sense of smell), parosmia (distorted sense of smell), or ageusia (loss of taste)
C. Post-Traumatic Stress Disorder (PTSD)
D. Anxiety
E. Cervicalgia, cervical facet joint syndrome
F. Headache
G. Neuropathic pain (other than CRPS)
H. Occipital and trigeminal neuralgia
I. Postherpetic neuralgia
J. Vasomotor symptoms
K. Treatment of ventricular tachycardia or ventricular fibrillation

Medical Policy: Transcatheter Aortic Valve Replacement
Effective: 05/01/2023
Preauthorization Required: Yes
Policy Statement:

I. Transcatheter aortic valve replacement with an U.S. Food and Drug Administration (FDA) approved transcatheter heart valve system (e.g., the Edwards Sapien 3, Edwards Sapien XT, Edwards Sapien transcatheter heart valve, Medtronic CoreValve System) may be considered medically necessary for patients with native valve aortic stenosis when **ALL** the following conditions are present:

A. Severe aortic stenosis with a calcified aortic annulus with **1 or more** of the following:

- An aortic valve area of less than or equal to 1 cm^2
- An aortic valve area index of less than or equal to 0.6 cm^2/m^2
- A mean aortic valve gradient greater than or equal to 40 mmHg
- A peak aortic-jet velocity greater than or equal to 4.0 m/s.

AND

B. New York Heart Association heart failure class II, III, or IV symptoms; **AND**

C. Left ventricular ejection fraction greater than 20%; **AND**

D. Patient does not have unicuspid or bicuspid aortic valves.

II. Transcatheter aortic valve replacement with an U.S. Food and Drug Administration (FDA) approved transcatheter heart valve system (e.g., Medtronic CoreValve System, and the Sapien 3) for use for repair of a degenerated bioprosthetic valve (valve-in-valve) may be considered **medically necessary** when **ALL** the following conditions are present:

A. Failure (stenosed, insufficient, or combined) of a surgical bioprosthetic aortic valve **AND**

B. New York Heart Association heart failure class II, III, or IV symptoms; **AND**

C. Left ventricular ejection fraction greater than 20%; **AND**

D. Patient is not an operable candidate for open surgery, as judged by at least 2 cardiovascular specialists (cardiologist and/or cardiac surgeon); or patient is an operable candidate but is at high risk for open surgery

III. Transcatheter aortic valve replacement is considered **investigational** for all other indications.

Medical Policy: I.213 Interrogation for Implantable Cardioverter-Defibrillator (ICD)
Effective: 05/01/2023
Preauthorization Required: Yes
Policy Statement:

I. Implantable cardioverter-defibrillator (ICD) Interrogation is allowed 4 times per year (approximately every 3 months) for every patient with ICD or cardio resynchronization therapy (CRT). However, in each of these circumstances 1 more interrogation follow up may be added in these circumstances

A. Device nearing its end of battery life, **OR**

B. Any suspected system or lead problem, **OR**

C. After every single or multiple ICD shock.

II. Defibrillation threshold testing (DFT) is **not medically necessary**

UM Policy: Methadone Treatment
Effective: 05/01/2023
Policy Statement:

I. Admission to a Methadone Treatment facility may be considered **medically necessary** if the following applies:
   A. Methadone Program must be a Federally Certified Opioid treatment facility, **AND**
   B. Admission Criteria includes **ALL** the following:
      1. Patient needs to be a voluntary admission, **AND**
      2. Diagnosis of addiction not less than 1 year before admission. Except pregnancy or previously treated patients or released from prison within 6 months, **AND**
      3. If under the age of 18 needs two prior attempts at detox or drug free treatment within the last year, **AND**
      4. If under the age of 18 needs a parent or guardian's consent to admission, **AND**
      5. Patient will not be admitted for more than two (2) detox treatments at a methadone treatment facility within a year.

NEW PHARMACY MEDICAL POLICIES

Medical Policy TBD: Hemgenix
Effective: 3/1/2023
Preauthorization Required: Yes
Policy Statement: Medically necessary for the treatment of adults with hemophilia B (congenital Factor IX deficiency).

Medical Policy TBD: Relyvrio
Effective: 3/1/2023
Preauthorization Required: Yes
Policy Statement: Medically necessary for the treatment of amyotrophic lateral sclerosis (ALS) in adults.

Medical Policy TBD: Leqembi
Effective: 3/1/2023
Preauthorization Required: Yes
Policy Statement: The use of Leqembi is considered investigational as the clinical benefit of decreased amyloid beta plaques in the brain has not been established.

Medical Policy TBD: Tzield
Effective: 3/1/2023
Preauthorization Required: Yes
Policy Statement: Medically necessary to delay the onset of Stage 3 type 1 diabetes in adults and pediatric patients 8 years of age and older with Stage 2 type 1 diabetes.

Medical Policy TBD: Furoscix
Effective: 3/1/2023
Preauthorization Required: Yes
Policy Statement: Medically necessary for the treatment of congestion due to fluid overload in adult patients with New York Heart Association (NYHA) Class II and Class III chronic heart failure.

Medical Policy TBD: IV Iron Step Therapy

Effective: 3/1/2023
Preauthorization Required: Yes
Policy Statement: IV Iron agents (Monferric; Injectafer) are medically necessary for use in respective FDA approved indication after inadequate response or contraindication to oral iron therapy for at least 3 months.

REVISED PHARMACY MEDICAL POLICIES

Medical Policy X.180- updates to SMN2 copies allowed for therapy.

Medical Policy X.153 -Intravitreal Injections for Retinal Conditions - addition of Cimerli

Medical Policy X.124 -Self-Administered Oncology Agents- addition of Lytgobi and Rexlidhia

Medical Policy I.0 -Procedures for Medical Review - addition of Tecvayli and Imjudo

Medical Policy X.122 -Therapeutic Alternatives - addition of Ermeza, Relexxii, Xelstrym, Hyftor, Zonisade

Medical Policy X.179 -Pegfilgrastim - addition of Fyneltra as non-preferred