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: III.243 Orthognathic Surgery
Effective: 06/01/2022
Preauthorization Required: Yes
Policy Statement:

Orthognathic Surgery **may be considered medically necessary** for correction of skeletal deformities of the maxilla or mandible when all the following are met: (1) skeletal dysfunction precludes adequate treatment by dental therapeutics and orthodontics alone, and (2) there is functional impairment, and (3) there is clinical documentation of orthodontic therapy to align the teeth prior to orthognathic surgery where appropriate.

I. Skeletal Dysfunction

A. Anterior-Posterior discrepancies with maxillary/mandibular incisor relationship:

1. Horizontal overjet of +5mm or more or 0 to a negative value (norm 2mm),

2. Anteroposterior molar relationship discrepancy of 4mm or more (norm 0 - 1mm).

Note: these values are 2 standard deviations (SD) or more from published norms.

B. Vertical Discrepancies:

1. Presence of vertical facial skeletal deformity, that is 2SD or more for accepted skeletal landmarks.
2. Open bite
    a. No vertical overlap of anterior teeth
    b. Unilateral or bilateral posterior open bite greater than 2mm

3. Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch.
4. Super-eruption of a dentoalveolar segment due to lack of opposing occlusion creating dysfunction not amenable to conventional prosthetics.

C. Transverse discrepancies

1. Presence of a transverse skeletal discrepancy, which is two or more standard deviations from published norms

2. Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth.

D. Asymmetries

1. Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry.

II. Physical Functional Impairment

A. Masticatory dysfunction due to skeletal deformity (e.g., inability to incise or chew solid foods, loss of food through the lips, intra-oral trauma to soft tissue during chewing); OR

B. Swallowing dysfunction (dysphagia) due to skeletal deformity (e.g., choking on incompletely chewed solid foods); OR

C. Speech impairments (documentation from speech pathologist or speech therapist required) due to severe cleft deformity or skeletal malocclusion that do not respond to orthodontia or speech therapy; OR

D. Mandibular-Maxillary Advancement (MMA) surgical procedure for Obstructive Sleep Apnea (OSA) is addressed in Medical Policy III.62.

III. Orthognathic surgery is considered **not medically necessary:**

A. When criteria for orthognathic surgeries as described above are not met.
B. Orthognathic surgery performed for correction of articulation disorders and other distortions in speech production or speech quality (hyper-nasal or hypo-nasal speech), distortion of sibilant sound class (hissing sound) because these distortions do not cause functional impairments.
C. Temporomandibular joint syndrome/disorders.
D. Persistent myofascial pain despite conservative treatment with physical therapy and splints.
E. When performed for aesthetic/cosmetic impairments with or without psychological symptoms.
F. Genioplasty (surgery of the chin to correct a receding chin with an implant or reduce a prominent chin) when performed in conjunction with orthognathic surgery, for the sole purpose of improving appearance and/or profile, is considered **cosmetic**.
G. When it is a contract exclusion.

IV. 3-D virtual treatment planning or computer-aided three-dimensional simulation and navigation in orthognathic surgery (CASNOS) for orthognathic surgery is considered investigative because its effectiveness has not been established.

V. Condylar positioning devices in orthognathic surgery is considered investigative because its effectiveness has not been established.

Documentation required:

a) Clinical notes with medical history, physical exam, description of skeletal deformity; and
b) Panorex and cephalometric radiographs; and
c) Cephalometric tracings and analysis; and
d) Anterior and posterior radiographs for asymmetry deformities; and
e) Medical records from treating physician documenting evaluation, diagnosis, and previous management of the functional impairments; and

Photographs that demonstrate the skeletal deformity

Medical Policy: III.242 Subchondroplasty
Effective: 06/01/2022
Preauthorization Required: Yes
Policy Statement:

Subchondroplasty is considered **investigational** because there is insufficient evidence to establish the clinical effectiveness and the impact on net health outcomes has yet to be determined.

Medical Policy: V.79 WATS3D Procedure
Effective: 06/01/2022
Preauthorization Required: Yes
Policy Statement:
The WATS3D biopsy is considered **investigational** because the safety and/or effectiveness of this procedure cannot be established based on the available published peer-reviewed literature.
Note: There are no biomarkers or panels of biomarkers for clinical use in diagnosing patients who are at increased risk for progression to esophageal adenocarcinoma.

REVISED MEDICAL POLICIES

Medical Policy: VIII.8 Noninvasive positive airway pressure devices and oral appliances
Effective: 06/01/2022
Preauthorization Required: Yes
Policy Statement:

Initial Trial for Home Ventilator

I. Trial of Non-invasive Home Ventilator (mask or chest shell) (E0466) may be considered **medically necessary** when the following criteria are met:
   A. Individual has failed bilevel positive airway pressure (BiPAP), **AND**
   B. Does not require ventilation continuously (24 hours/day), **AND**
   C. Has **ONE** of the following diagnoses:

1. Restrictive Thoracic disorders
    a. Neuromuscular disease (e.g., amyotrophic lateral sclerosis, ALS)
2. Chronic respiratory failure due to COPD
3. Central sleep apnea
4. Complex sleep apnea
5. Hypoventilation syndrome

II. If criteria above are met, the first three (3) months of therapy will be approved.

III. If criteria above are not met, coverage will be denied as not **medically necessary** for the device and related accessories.

Continuation of Home Ventilator

I, Non-invasive home ventilator (mask or chest shell) (E0466) use after the initial trial may be considered medically necessary when ALL of the following criteria are met:

A. Follow up visit within the previous 3 months AND
B. Documentation of relevant symptoms and clinica benefit from continued use AND
C. Relevant test results (pulmonary function, pulse oximetry, PSG) AND
D. Current treatment plan.

Approval for 12 months, after the initial trial if the above criteria is met

II. Services are not medically necessary if the above criteria re not met

Medical Policy: VI.16 Hyperbaric Oxygen Therapy
Effective: 03/17/2022
Preauthorization Required: Yes
Policy Statement:

Adding a new indication of Diabetic foot ulcers

Medical Policy: IV.72 IMRT
Effective: 02/24/2022
Preauthorization Required: Yes
Policy Statement:

I. Intensity Modulated Radiation Therapy (IMRT) may be considered **Scientifically Validated** for the following

Lung cancer when the following criteria are met:

1. radiotherapy is being given with curative intent **AND**
2. three-dimensional conformal radiotherapy will expose greater than 35% of normal lung tissue to more than a 20-Gy dose volume (V20) **AND**
3. IMRT dosimetry demonstrates a reduction in the V20 to at least 10% below the V20 that is achieved with the three-dimensional plan (e.g. from 40% down to 30% or lower) **OR**

4. If necessary to get the heart dose below 20Gy and/or to get volume of the heart that gets more than 50Gy under 25%

Medical Policy: III.57 Cosmetic and Reconstructive Surgery
Effective:
Preauthorization Required: No, but recommended
Policy Statement:

Rhinoplasty

I. Rhinoplasty may **be considered medically necessary** when the following criteria are met:

A. When it is being performed to correct nasal deformity as a result of a traumatic injury (contract lang)

OR

B. to correct chronic non septal nasal airway obstruction due to disease or congenital defect when **ALL** of the following criteria are met:

1. The patient is 18 years or older **AND**
2. Nasal airway obstruction is causing significant difficulty breathing and/or chronic rhinosinusitis that has persisted greater than 12 weeks **AND**
3. Patient as tried and failed conservative management (at least 3 weeks of antibiotic treatment and at least 5 days of oral corticosteroids or 3 weeks of intranasal corticosteroid therapy) **AND**
4. There is documentation that airway obstruction will not respond to septoplasty and turbinectomy alone **AND**
5. Preoperative photographs demonstrate external nasal deformity (preoperative photographs with anterior-posterior views, right and left lateral views and a view from the bottom of nasal septum pointing upwards) **AND**
6. nasal obstruction due to nasal valve stenosis (internal nasal valve collapse) is documented by nasal endoscopy, CT or other appropriate imaging method.

III. Rhinoplasty is considered cosmetic when the above criteria are not met or for any other indications.

Medical Policy: III.57 Cosmetic and Reconstructive Surgery
Effective:
Preauthorization Required: No, but recommended
Policy Statement:

Panniculectomy

I. A panniculectomy (15830) **may be considered medically necessary** when **ALL** the following criteria are met:
   A. Patient is 18 years of age or older AND
   B. Photos documenting the patient has a Grade 2 or greater abdominal panniculus or panniculus that extends below the level of the symphysis pubis **AND**
   C. Medical records and photos documenting **ONE** of the following:
      a. Nonhealing ulceration under the panniculus **OR**
      b. Chronic maceration or necrosis of overhanging skin fold **OR**
      c. Recurrent or persistent skin infection under the panniculus **OR**
      d. Intertriginous dermatitis or cellulitis or panniculitis

   AND
   D. Documentation that the patient has tried and failed 12 weeks or more of local or systemic antibiotic treatment, topical or systemic corticosteroid treatment or topical antifungal treatment.

II. Panniculectomy is considered cosmetic when the above criteria are not met

III. Abdominoplasty (15847) is considered cosmetic

IV. Lipoabdominoplasty and liposuction for lipedema or lymphedema (15876 15877 15878 1579) are considered cosmetic.

NEW PHARMACY POLICIES

Medical Policy X.187: Vyvgart
Effective: 2/16/2022
Preauthorization Required: Yes
Policy Statement:
Medically necessary for the treatment of generalized Myasthenia Gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.

Medical Policy X.189: Leqvio
Effective: 2/16/2022
Preauthorization Required: Yes
Policy Statement:
Medically necessary as adjunct to diet and maximally tolerated statin therapy to reduce low-density lipoprotein cholesterol in adults with heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease (ASCVD), who require additional lowering of low-density lipoprotein cholesterol (LDL-C).

Medical Policy X.190: Voxzogo

Effective: 2/16/2022
Preauthorization Required: Yes
Policy Statement:
Medically necessary to increase linear growth in pediatric patients with achondroplasia.

Medical Policy X.188: Tyrvaya
Effective: 2/16/2022
Preauthorization Required: Yes
Policy Statement:
Medically necessary to treat the signs and symptoms of dry eye disease.

Medical Policy X.191: Rezurock
Effective: 2/16/2022
Preauthorization Required: Yes
Policy Statement:
Medically necessary for the treatment of adult and pediatric patients 12 yrs. and older for chronic graft versus host disease (cGVHD) after failure of at least 2 prior lines of systemic therapy.

Medical Policy TBA: Insulin Glargine-yfgn and Semglee
Effective: 2/16/2022
Preauthorization Required: Yes
Policy Statement:
Medically necessary to improve glycemic control in adults and pediatric patients with type 1 or type 2 diabetes mellitus as preferred agents. Non-preferred products include: Brand Lantus and Brand Lantus Solostar.

REVISED PHARMACY POLICIES

Medical Policy X.182 -Atopic Dermatitis - addition of Adbry, Cibinqo, and Rinvoq

Medical Policy X.124 -Self-Administered Oncology Agents- addition of Scemblix and Exkivity

Medical Policy I.0 -Procedures for Medical Review - addition of Ryplazim and Adcetris

Medical Policy X.153 -Invtravitreal Injections for Retinal Conditions - addition of Susvimo

Medical Policy X.65 -Nucala, Cinqair, Fasenra - addition of Tezspire and requirement of using self-administered agents first.

Medical Policy X.122 -Therapeutic Alternatives - addition of Ryaltris, Entadfi, Tarpeyo, Eprontia, Lyvispah, Seglentis, Vuity, Trudhesa

Medical Policy X.22 -Sedative Hypnotics - addition of Quviviq

Medical Policy X.90 -Korlym - addition of Recorlev, and rename to “Treatment of Cushing Syndrome”

Medical Policy X.82 and X.84 -Ingrezza and Austedo – allow use in tardive dyskinesia