Review important medical policy updates

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 UTLITIZATION MANAGEMENT POLICY

Effective 03/01/2022

BCBS NE will require prior authorization for any inpatient hip, knee, or shoulder arthroplasty. Outpatient hip, knee, or shoulder arthroplasties will not require prior authorization. Please refer to BCBS benefits to determine if the arthroplasty itself requires prior authorization.

NEW MEDICAL POLICIES

Medical Policy: III.233 Benign Prostatic Hyperplasia (BPH) Treatments (New Title)
Effective: 03/01/2022
Preauthorization Required: Yes
Policy Statement:
Urolift

I. Use of prostatic urethral lift in individuals with moderate-to-severe lower urinary tract obstruction due to benign prostatic hyperplasia **may be considered Scientifically Validated** with specific criteria. **Please see policy that will be posted by 02/01/2022**
II. Repositioning of the stents or repeat procedures will be reviewed for medical necessity.
III. The following procedures are considered **investigational** as their clinical effectiveness has not been established
    - Endoscopic balloon dilation of the prostatic urethra
    - Prostatic arterial embolization (PAE)
    - Cryosurgical ablation for the treatment for BPH
    - Plasma Kinetic Vaporization (e.g., PlasmaKinetic™ Tissue Management System)
    - Aquablation/transurethral waterjet ablation (e.g., AquaBeam System)
    - Water-induced thermotherapy (WIT) (also known as hot-water balloon thermoablation and thermourethral hot-water therapy)
    - Absolute ethanol injections.
    - High-intensity focused ultrasound (HIFU) for benign prostatic hyperplasia (BPH)
    - Histotripsy (Vortx Rx System)
    - Interstitial laser coagulation (ILC)
    - Transrectal thermal therapy
    - Transurethral ultrasound-guided laser incision of the prostate (TULIP)
    - ITind device implant

Adding Water Vapor Therapy (Rezum) for Benign Prostatic Hyperplasia (Medical Policy III.233)

Medical Policy: III.241 Intravitreal and Punctum Corticosteroid Implants.
Effective: 03/01/2022
Preauthorization Required: Yes
Policy Statement:

The following will require a medical necessity review with criteria:

- fluocinolone acetonide intravitreal implant
- fluocinolone acetonide intravitreal implant 0.19 mg (Iluvien®)
- dexamethasone intravitreal implant 0.7 mg (Ozurdex™)
- punctum dexamethasone inserts 0.4 mg (Dextenza®)
- luocinolone acetonide intravitreal implant 0.59 mg (Retisert®) or 0.19 mg (Iluvien®)
- dexamethasone intravitreal implant 0.7 mg (Ozurdex™)
- fluocinolone acetonide intravitreal implant 0.18 mg (Yutiq®)

Medical Policy: III.239 Lower Esophageal Myotomy for treatment of Achalasia
Effective: 01/01/2022
Preauthorization Required: Yes
Policy Statement:

- Peroral endoscopic myotomy is considered **investigational** as a treatment for pediatric and adult esophageal achalasia.

Medical Policy: III.240 Apheresis
Effective: 03/01/2022
Preauthorization Required: Yes
Policy Statement:

- Plasmapheresis and LDL apheresis **may be considered Scientifically Validated** for specific indications and criteria. Please see policy that will be posted by 02/01/2022

Medical Policy: VIII.14 Durable Medical Equipment
Effective: 03/01/2022
Preauthorization Required: Yes
Policy Statement

- Durable medical equipment (DME) may be eligible for reimbursement consideration by BCBSNE when all the following criteria are met:

    - The individual has the benefit for the item.
    - The item meets BCBSNE's definition of DME.
    - The item is not considered experimental/investigational by BCBSNE.
    - The item is considered medically necessary for the treatment of, or as an aid in the treatment of, a medical or surgical condition.
    - The item is ordered by an eligible qualified healthcare professional.
    - The item is provided by a DME provider or, in limited circumstances, by another eligible provider type as allowed by BCBSNE.

Medical Policy: I.210 Electroconvulsive Therapy (ECT)
Effective: 03/01/2022
Preauthorization Required: Yes
Policy Statement:

- Electroconvulsive Therapy (ECT) **may be considered medically necessary** with specific criteria. Pease see policy that will be posted by 02/01/2022

REVISED MEDICAL POLICIES

Medical Policy: V.67 Genetic Testing: Gastrointestinal (Non-Cancerous)
Effective: 03/01/2022
Preauthorization Required: Yes

Additional Policy Statement:

- *MCM6* variant analysis for the prediction of lactase insufficiency is considered **investigational**.
- Inflammatory bowel disease diagnostic algorithmic tests are considered investigational.
- Inflammatory bowel disease prognostic algorithmic tests are considered **investigational**
- Genetic testing for inflammatory bowel disease, including Crohn's disease, via a multigene panel is considered **investigational**

Medical Policy: V.66 Genetic Testing Cardiac Disorders
Effective: 03/01/2022
Preauthorization Required: Yes

Updated Policy Statements:

- Known familial variant analysis for cardiac disorders
- Comprehensive cardiomyopathy panels
- Comprehensive arrhythmia panels
- Arrhythmogenic right ventricular cardiomyopathy panels
- Restrictive cardiomyopathy panels
- Comprehensive arrhythmia and cardiomyopathy (sudden cardiac or unexplained death) panels are considered investigational.
- Congenital Heart Malformation Panels

Medical Policy: V.63 Genetic Testing: Hematologic Conditions (Non-Cancerous)
Effective: 03/01/2022
Preauthorization Required: Yes
Additional Policy Statements:

- G6PD variant analysis to confirm or establish a diagnosis of glucose-6-phosphate dehydrogenase deficiency is considered investigational

- GP1BA and/or VWF variant analysis to confirm or establish a diagnosis of Von-Willebrand disease is considered investigational.

Medical Policy: V.69 Genetic Testing; Kidney Disorders
Effective: 03/01/2022
Preauthorization Required: Yes
Additional Policy Statement:

- Targeted Variant Analysis to establish a diagnosis of autosomal dominant polycystic kidney disease may be considered medically necessary.

Medical Policy: V.71 Genetic Testing: Eye Disorders
Effective: 03/01/2022
Preauthorization Required: Yes
Additional Policy Statement:

- Targeted Mutation Analysis for a known familial variant for an eye disorder may be considered medically necessary

Medical Policy: V.65 Genetic Testing: Epilepsy, Neurodegenerative & Neuromuscular Conditions
Effective: 03/01/2022
Preauthorization Required: Yes
Additional Policy Statements for the following indications:

- DMD Sequencing and/or Deletion/Duplication Analysis
- Hereditary Dystonia Multigene panel
- Parkinson Disease Sequencing and/or Deletion/Duplication Analysis
- Hereditary Spastic Paraplegia Multigene Panel
- Congenital Myasthenic Syndromes Multigene Panel
- Myotonia Congentia Sequencing and/or Deletion/Duplication Analysis
- Hypokalemic Periodic Paralysis Sequencing and/or Deletion/Duplication Analysis

Medical Policy: V.58 Oncology: Prognostic & Algorithmic Testing
Effective: 03/01/2022
Preauthorization Required: Yes
Additional Policy Statement:

- Pancreatic cyst risk assessment algorithmic tests (e.g., pancraGEN) (81479) are considered investigational.

Medical Policy: V.73 Genetic Testing: Aortopathies & Connective Tissue Disorders
Effective: 03/01/2022
Preauthorization Required: Yes
Additional Policy Statement:

- Targeted mutation analysis for a known familial variant (81403) maybe considered medically necessary.
- Retinal Dystrophy/Leber Congenital Amaurosis Multigene panel
- Genetic testing for glaucoma is considered investigational

Genetic Testing Policies
Effective: 01/01/2022
Preauthorization Required: Yes
Minor Changes

V.30 Genetic Testing: Pregnancy loss & Prenatal Diagnosis
V.36 Whole Exome & Whole Genome Sequencing for Diagnosis of Genetic Disorders
V.57 Oncology: Cancer Screening
V.58 Oncology: Prognostic & Algorithmic Testing
V.59 Genetic Testing: Hereditary Cancer Susceptibility
V.60 Oncology: Molecular Analysis of Solid Tumors and Hematologic Conditions
V.62 Genetic Testing: Multisystem Inherited Disorders, Intellectual Disabilities and Developmental Delays
V.65 Genetic Testing: Epilepsy, Neurodegenerative & Neuromuscular Disease
V.69 Genetic Testing: Kidney Disorders
V.70 Genetic Testing: Lung Disorders
V.71 Genetic Testing: Eye Disorders
V.72 Genetic Testing: Immune Disorders
V.73 Genetic Testing: Aortopathies & Connective Tissue Disorders
V.74 Genetic Testing: General Approach to Genetic Testing & Panels
V.76 Genetic Testing: Skeletal Dysplasia & Rare Bone Disorders

Please see policies @ https://www.nebraskablue.com/en/Providers

Medical Policy: III.203 Percutaneous Left Atrial Appendage Closure Device for Stroke Prevention
Effective: 11/10/2021
Preauthorization Required: Yes
Adding Policy Statement:

Adding Amplatzer Amulet as a covered device with no changes to criteria.

Medical Policy: III. 202 Implantable Bone Conduction & Bone Anchored Hearing Aid
Effective: 03/01/2021
Preauthorization Required: Yes
Adding Policy Statement:

Med-El Adhere Device (L8692) is not an FDA approved medical device; therefore, this is considered **investigational.**

Medical Policy: I.125 Inhaled Nitric Oxide as Treatment of Hypoxic Respiratory Failure
Effective: 12/15/2021
Preauthorization Required: Yes
Adding Policy Statement

Measurement of exhaled breath condensate is considered **investigational** in the diagnosis and management of asthma and all other respiratory disorders including but not limited to chronic obstructive pulmonary disease and chronic cough.

Medical Policy: I.178 Autism Spectrum Disorders/ABA Therapy
Effective: 03/01/2022
Preauthorization Required: Yes

This is a summary of the additional criteria. Please see the draft policy for all updates to this policy.
This draft policy will be available on 01/01/2022

- Additional criteria for continuation of ABA therapy for goals in the individual-specific treatment plan: significant improvement, evidence of progression, treatment is not for convenience, custodial care, or respite care. Comprehensive medical records will be required.
- ABA services are provided by a BCBA, or line therapist supervised face to face by a BCBA/ AS, certified in Nebraska. Supervision should be 2 hours per 10 hours of direct treatment.
- Services provided in a daycare setting are an exclusion of the member's contract and are excluded. Services must be delivered in an office setting or thru telehealth.
- Note: Additional services of Physical therapy, Occupational therapy and Speech therapy are not allowed if 40 hours of ABA therapy are billed.

Medical Policy: V.21 Measurement of Serum Antibodies to Infliximab, Adalimumab and Vedolizumab
Effective: 03/01/2022
Preauthorization Required: Yes
Policy Statement:

No changes to criteria adding CPT codes: 80230 80145 80280

NEW PHARMACY POLICIES

Medical Policy X.184: Kerendia
Effective: 12/06/2021
Preauthorization Required: Yes
Policy Statement: Medically necessary to reduce the risk of sustained eGFR decline, end-stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure in adult patients with chronic kidney disease (CKD) associated type 2 diabetes (T2D).

Medical Policy X.183: Ileal Bile Acid Transporter (IBAT) Prior Authorization and Quantity limit
Effective: 11/10/2021
Preauthorization Required: Yes
Policy Statement: Bylvay is medically necessary for the treatment of pruritis in patients 3 months of age and older with progressive familial intrahepatic cholestasis (PFIC). Livmarli is medically necessary for the treatment of cholestatic pruritus in patients with Alagille syndrome (ALGS) 1 year of age and older.

Medical Policy X.181: Accrufer
Effective: 11/10/2021
Preauthorization Required: Yes
Policy Statement: Accrufer is not medically necessary for the treatment of iron deficiency as to date there are no studies proving it is more efficacious or cost effective than other commercially available RX and OTC iron supplementation products.

Medical Policy TBA: Authorized Generic of Symbicort
Effective: 11/10/2021
Preauthorization Required: Yes
Policy Statement: Budesonide/formoterol inhalation aerosol is not medically necessary as there is no published clinical literature that indicates patients have improved outcomes with this medication compared to the preferred product, brand Symbicort (budesonide/formoterol)

Medical Policy TBA: SGLT-2
Effective: 11/10/2021
Preauthorization Required: Yes
Policy Statement: Invokana, Invokamet, Invokamet XR, Qtern, Segluromet, Steglatro, and Steglujan are not medically necessary as there is no published clinical literature that indicates patients have improved outcomes with these medications compared to other preferred SGLT2 products (e.g., Farxiga, Jardiance, Synjardy, Synjardy XR, Trijardy XR, Xigduo XR)

Medical Policy X.180: Spinal Muscular Atrophy
Effective: 11/10/2021
Preauthorization Required: Yes
Policy Statement: Zolgensma, Spinraza, and Evrysdi are medically necessary for the treatment of spinal muscular atrophy. Policy combines these SMA policies into one policy to review for appropriate and consistent use.

Medical Policy X.182: Opzelura
Effective: 12/02/2021
Preauthorization Required: Yes

Policy Statement: Medically necessary for treatment of mild to moderate atopic dermatitis in non-immunocompromised patients 12 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.

Medical Policy TBA: Not Medically Necessary
Effective: 11/10/2021
Preauthorization Required: Yes
Policy Statement: Medications added to this policy will be considered not medically necessary as there is no published clinical literature that indicates patients have improved outcomes with these medications compared to other preferred medications of same class.

REVISED PHARMACY POLICIES

Medical Policy X.105 -Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist Products - addition of new medication, Qulipta (atogepant) of prevention of episodic migraine

Medical Policy X.94 -Chimeric Antigen Receptor (CAR) T-cell Therapy - addition of Abecma and Breyanzi, as well as updates to indications

Medical Policy X.124 -Self-Administered Oncology Agents – addition of Votrient, Nexavar, Sutent, Lynparza, Ibrance, Verzenio, Kisqali, Zejula, Brigatinib, Calquence. Then stand-alone policies for these agents are retired.

Medical Policy X.33 -Benlysta - addition of Saphnelo and rename to Systemic Lupus Erythematosus Policy.

Medical Policy X.95 -Soliris Therapy – combination with Ultomiris policy and addition of Empaveli.