Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective April 15, 2024 (unless otherwise noted)

Note – Log-in is needed for policy update sections marked with an asterisk *. Use this link to log-in, Cigna for Health Care Professionals > Resources > Reimbursement and Payment Policies.

Medical Coverage Policy	New, Updated, or Retired?	Comments
Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift (0045)	Update	Minor **changes** in coverage criteria/policy: • clarification of required criteria to be met for UPPER eyelid reconstructive blepharoplasty • clarification of required criteria to be met when requesting a combination of medically necessary procedures
Bone Mineral Density Measurement (0300)	Update	Minor changes in coverage criteria/policy: • No change in coverage. • Added policy statement for ultrasound-based radiofrequency echographic multi-spectrometry (REMS) (CPT® 0815T) (We currently considered EIU, just there is a new specific code now. No change in coverage.) • Removed obsolete technology peripheral single energy x-ray absorptiometry (SXA) (HCPCS code G0130)
Intraoperative Monitoring (0509)	Update	Minor **changes** in coverage criteria/policy:

		• Added not covered statement for electrodiagnostic studies performed for the evaluation of neural integrity as part of a non-covered surgical procedure, in the absence of intraoperative monitoring.
Miscellaneous Musculoskeletal Procedures (0515)	Update	Important **changes** in coverage criteria: • Added not covered statement for medial knee implanted shock absorbers. • Revised statement for articular cartilage repair for non-knee indications from "experimental, investigational or unproven" to "not medically necessary". • Removed statements for focal resurfacing of the knee joint and allograft bone substitutes for isolated facet fusion.
Otoplasty and External Ear Reconstruction (0335)	Update	Important **changes** in coverage criteria: • Minor change to clarify the 3rd bullet under external ear reconstruction by adding the words "current" and "deficit" to be clear that external ear reconstruction is medically necessary when there is a current visual deficit and not because the individual may need corrective eyewear in the future. • Limited coverage by removing the statement for "functional need for eyewear use" in the non-surgical external ear molding section of the policy statement because ear molding is only effective in neonates up until about sex weeks of age. • Mino change to clarify coverage in the otoplasty section fo the policy by adding a bullet point for increasing comfort level while wearing protective or assistive equipment to be clear that this is a cosmetic indication.
Recurrent Pregnancy Loss: Diagnosis and Treatment (0284)	Update	Important **changes** in coverage criteria: • Minor change to clarify the word "antenatal" by adding "(during pregnancy)" in the treatment section of the policy to improve understanding of the content. • Minor change to clarify the intent behind "prior failed or contraindication to transvaginal cerclage" in the treatment section for antenatal transabdominal cervical cerclage by adding specific examples instead to be clear on what is meant for "prior failed or contraindication to transvaginal cerclage". • Expanded coverage to the treatment section by adding a bullet and criteria for prophylactic (i.e., before pregnancy) transabdominal cervical cerclage to align with standard practice.
Speech Generating Devices (0049)	Update	Minor change. • Removal of coverage statements related to codes removed from precertification 7/2023.

Transcatheter Ablation for the Treatment of Supraventricular Tachycardia in Adults (0529)	Update	Important **changes** in coverage criteria: • Limited coverage by adding a not medically necessary statement for inappropriate sinus tachycardia (IST) and premature atrial contraction (PAC) because the evidence does not support the safety and efficacy of transcatheter ablation for these conditions. • Limited coverage by adding an EIU statement for cardio-neuroablation because the evidence does not support the safety and efficacy of cardio-neuroablation for any indication.
Wheelchairs/Power Operated Vehicles (0030)	Update	Important **changes** in coverage criteria: • Changed from not covered to covered with criteria for power seat elevation systems for power wheelchairs.
Balloon Sinus Ostial Dilation for Chronic Sinusitis and Eustachian Tube Dilation (0480)	Update	No change in coverage.
Drug-Eluting Devices for Use Following Endoscopic Sinus Surgery (481)	Update	No change in coverage.
Gait Analysis (0315)	Update	No change in coverage.
Glaucoma Surgical Procedures (0035)	Update	No change in coverage.
Scar Revision - (0328)	Update	No change in coverage.
Interspinous Process Spacer Devices (0448)	Update	No change in coverage.
Speech Therapy - (0177)	Update	No changes in coverage.
Surgical Treatment of Chest Wall Deformities (0309)	Update	No change in coverage.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Acupuncture (CPG024)	Update	No change in coverage.

Axial/Spinal Decompression Therapy/Mechanical Traction (Provided in a Clinic Setting) (CPG275)	Update	No change in coverage.
Home Traction Devices – Cervical and Lumbar (CPG265)	Update	No change in coverage.
Low-Level Laser and High-Power Laser Therapy (CPG030)	Update	No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-eviCore Gastrointestinal Endoscopic Procedure Guidelines	Update	Posted **January 2, 2024**. Effective **April 1, 2024**. Important **changes** in coverage criteria. Guideline with expansion of coverage: • Capsule Endoscopy Guideline with positive and adverse changes in coverage: • Esophagogastroduodenoscopy (EGD)
Cobranded Cigna-eviCore High-Tech Imaging Guidelines	Update	Posted **January 2, 2024**. Effective **April 1, 2024**. Important **changes** in coverage criteria. Guideline with positive and adverse changes in coverage: • Pediatric Oncology Imaging Posted **January 19, 2024**, Effective date **April 1, 2024**: Informational document; no change to coverage: • Preface to the Imaging Guidelines

Cobranded Cigna-EviCore Interventional Pain Management Guidelines	Update	Posting **April 1, 2024**. Effective **May 1, 2024:**
		
		Important **change** in coverage criteria.
		• Guideline with positive change in coverage:
		  ○ CMM-211 Spinal Cord and Dorsal Root Ganglion Stimulation
		  ▪ Removed noncoverage statement for closed loop dual-mode dorsal column stimulators
		
		Posting **April 1, 2024**. Effective **August 1, 2024:**
		
		The following guidelines underwent annual review with editorial updates and minor updates for clarification; no changes to coverage:
		• CMM-200 Epidural Steroid Injections
		• CMM-201 Facet Joint Injections/Medial Branch Blocks
		• CMM-203 Sacroiliac Joint Procedures
		• CMM-204 Prolotherapy
		• CMM-207 Epidural Adhesiolysis
		• CMM-208 Radiofrequency Joint Ablations/Denervations
		• CMM-209 Regional Sympathetic Blocks
		• CMM-210 Implantable Intrathecal Drug Delivery System

Cobranded Cigna-EviCore Radiation Oncology – Proton Beam Therapy Guideline	Update	Posting **April 1, 2024**. Effective **May 1, 2024**. Important **changes** in coverage criteria. • Added coverage for proton beam therapy for several Group 1 indications; Group 2 indications updated accordingly. • Minor change to list additional examples of noncovered (Group 3) indications
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Preventive Care Services (A004)	Update	Effective April 1, 2024: • Added the following HCPCS code to the policy: • HPCPS A9293- Fertility cycle (contraception & conception) tracking software application, fda cleared, per month, includes accessories (e.g., thermometer)

		• Updated code description for the following CPT code: • 91304 Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5mL dosage, for intramuscular use.
Drug & Biologic Coverage Policy	**New, Updated, or Retired?**	**Comments** **All policy changes effective October 1, 2023, unless otherwise stated**
Abaloparatide (IP0329)	Update	Effective: 4/1/2024 • Added a preferred product step through teriparatide, prior to coverage of Tymlos, for all Employer plans . Update effective 7/1/2024.
Adalimumab (IP0245)	Update	Effective: 4/15/2024 • Added adalimumab-aacf to the policy and listed as a non-preferred product.
Amyloidosis - Tafamidis Products (IP0149)	Update	Effective: 4/1/2024 • Updated the Conditions Not Covered section to include new product, Wainua, for no concomitant use.
Antihyperglycemic Therapy (Non-Insulin) (P0098)	Update	Important **changes** in coverage criteria: • Moved Farxiga, Invokana, Invokamet, Invokamet XR, Jardiance, Segluromet, Steglatro, Synjardy, Synjardy XR and Xigduo XR) to CP IP0592. • Effective date 4/1/2024.
Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Employer Group Plans (IP0477)	Update	Effective: 4/1/2024 • Added diagnosis requirement to Adzenys XR-ODT, Cotempla XR ODT, Dyanavel XR, Evekeo ODT, Quillichew ER, and Quillivant XR. • Updated the number of preferred alternatives required to be up to 4 formulary alternatives where 4 are available • Added new strengths for brand name Relexxii (18mg, 27mg, 36mg, and 54mg)
Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Individual and Family Plans (IP0584)	Update	Effective: 4/1/2024 • Added criteria for dextroamphetamine immediate-release tablets, methylphenidate ER tablets (45mg, 63mg, and 72mg), Relexxii, and Zenzedi.

Beremagene geperpavec-svdt (IP0572)	Update	Effective: 4/15/2024 • Revised specialist requirement • Updated conditions not covered section
Complement Inhibitors – Fabhalta (IP0614)	New	Effective: 4/1/2024 • New coverage policy
Cyanocobalamin Nasal Spray (IP0170)	Update	Effective 4/1/2024 • Added generic cyanocobalamin nasal spray to the policy • Updated existing Employer Group Nascobal verbiage from "inadequate response" to "failure" • Added Individual and Family Plans Preferred Product table to include both generic and branded (Nascobal) products
Diabetes – Tzield IP0537)	Update	Effective: 4/1/2024 • Updated coverage policy title. • Updated criterion definition of fasting plasma glucose value. • Added criterion screening A1C. • Removed criterion one biological relative with type 1 diabetes diagnosis. • Remo**ved** coding information from policy.
Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Standard, Performance, or Legacy Prescription Drug List (1601)	Update	Effective: 4/15/2024 • Added Cabtreo - effective 5/15/2024 • Added Firvanq - effective 7/1/2024 • Added and updated vancomycin solution (AG for Firvanq)- effective 7/1/2024 • Updated Flovent HFA, responsive to new clinical guidance - effective 4/15/2024 • Updated Fluticasone propionate HFA, responsive to new clinical guidance - effective 4/15/2024 • Added Zituvio - effective 5/1/2024 • Added Qtern - effective 7/1/2024 • Added Steglujan - effective 7/1/2024
Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review	Update	Effective: 4/15/2024 • Added Cabtreo - effective 5/15/2024 • Added Firvanq - effective 7/1/2024 • Added and updated vancomycin solution (AG for Firvanq)- effective 7/1/2024 • Updated Flovent HFA, responsive to new clinical guidance - effective 4/15/2024

Employer Group Plans: Value, Advantage, or Cigna Total Savings Prescription Drug List (1602)		• Updated Fluticasone propionate HFA, responsive to new clinical guidance - effective 4/15/2024 • Added Zituvio - effective 5/1/2024 • Added Qtern - effective 7/1/2024 • Added Steglujan - effective 7/1/2024
Eculizumab (IP0549)	Update	Effective 4/15/2024 • Updated conditions not covered
Citalopram 30mg Oral Capsule (IP0416)	Update	Important **changes** in coverage criteria: • Updated the medical necessity criteria • Effective date **4/1/2024**.
Dupilumab (IP0453)	Update	Effective: 4/15/2024 • **Eosinophilic Esophagitis**: The age of approval was reduced from ≥ 12 years of age to ≥ 1 year of age. Also, weight requirement was reduced from ≥ 40 kg to ≥ 15 kg • **Chronic Rhinosinusitis with Nasal Polyps:** The condition of approval was updated from "Chronic Rhinosinusitis with Nasal Polyposis" to as listed. The duration of the intranasal corticosteroid requirement was changed from 3 months to 4 weeks.
Gabapentin Extended-Release (IP0317)	Update	Effective 4/1/2024 • Removed Criteria for Gralise (gabapentin extended-release tablets).
HIV Products (P0050)	Update	Effective 4/1/2024 • Added MSB criteria for Prezista (effective 7/1/2024) and Selzentry (effective 7/1/2024).
Infectious Disease – Prevymis for Individual and Family Plans (IP0426)	Update	Effective: 4/1/2024 • Updated title of policy • Added new criterion for expanded use in adult kidney transplant recipient at high risk (donor CMV seropositive/recipient CMV seronegative [D+/R-])
Inflammatory Conditions – Velsipity (IP0605)	New	• This is a new policy supporting pharmacy prior authorization of etrasimod tablets [Velsipity]. • Effective date **4/15/2024**.

Inotersen (IP0417)	Update	Effective: 4/1/2024 • Updated the Conditions Not Covered section to include new product, Wainua, for no concomitant use.
Inflammatory Conditions – Entyvio Subcutaneous (IP0599)	New	Effective: 4/15/2024 • New coverage policy
Inflammatory Conditions – Entyvio Subcutaneous for Total Savings and Individual and Family Plans – (IP0613)	New	Effective: 4/15/2024 • New coverage policy
Inflammatory Conditions – Omvoh Intravenous – (IP601)	New	Effective: 4/15/2024 • New coverage policy
Inflammatory Conditions – Omvoh Subcutaneous – IP0602)	New	Effective: 4/15/2024 • New coverage policy
LymePak (IP0352)	Update	**Parkinson's disease:** • **Updated** coverage policy title from *Opicapone* to *Parkinson's Disease – Ongentys* • **Removed** criterion requiring patient experience "off" episodes.
Metabolic Disorders – Phenylbutyrate Products	Update	Important changes to coverage criteria: • Buphenyl (sodium phenylbutyrate) powder for oral solution and tablets added to the policy (effective 7/1/2024). • Removed Pheburane preferred product requirements (effective 7/1/2024). • Added Ravicti preferred product requirements (effective 7/1/2024). • Effective **4/1/2024**.
Oncology (Injectable – CAR-T) – Yescarta (IP0198)	Update	Effective 4/1/2024 • Changed Gastric MALT lymphoma to extranodal marginal zone lymphoma of the stomach • Changed Nongastric MALT lymphoma (noncutaneous) to extranodal marginal zone lymphoma of nongastric sites (noncutaneous) • Changed Acquired Immune Deficiency Syndrome (AIDS)-related B-cell lymphoma to Human Immunodeficiency Virus (HIV)-related B-cell lymphoma

		• Added Primary effusion lymphoma as an option for approval • Added dosing information for the treatment of B-cell lymphoma
Oxybate – (IP0103)	Update	Effective: 4/1/2024 • Added a preferred product step, prior to coverage of Xyrem and sodium oxybate oral solution (by Amneal), through sodium oxybate oral solution (by Hikma) for all Employer plans . Update effective 7/1/2024
Pancrelipase (IP0002)	Update	Effective: 4/1/2024 • Added Zenpep criteria for Individual and Family Plan
Patisiran (IP0418)	Update	Effective: 4/1/2024 • Updated the Conditions Not Covered section to include new product, Wainua, for no concomitant use.
Qbrexza (IP0074)	Update	Effective: 4/1/2024 • Removed the sequencing of care step through one aluminum chloride-containing topical antiperspirant on the Standard and Value formularies. Policy title updated to Qbrexza
Ravulizumab-cwvz Intravenous (IP0550)	Update	Effective: 4/15/2024 • Updated conditions not covered
Roflumilast (IP0527)	Update	Effective 4/15/2024 • Added Zoryve 0.3% topical foam criteria
Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors and SGLT-2 / Metformin Combinations (IP0592)	Update	Important **changes** in coverage criteria: • Policy title changed to Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors and SGLT-2 / Metformin Combinations. • The current approach for each Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors and SGLT-2 / Metformin Combination product found in CP P0098 (Invokana, Invokamet, Invokamet XR, Segluromet, and Steglatro) were reconciled with current P&T guidance and added to the policy. • The IFP approaches for Farxiga, Invokana, Invokamet, Invokamet XR, Jardiance, Segluromet, Steglatro, Synjardy, Synjardy XR and Xigduo XR were reconciled with current P&T guidance and added to the policy. • Added preferred product requirement criteria for dapagliflozin and dapagliflozin/metformin ER • Effective date **4/1/2024**.

Spinal Muscular Atrophy – Gene Therapy – Zolgensma (IP0185)	Update	**Updated** coverage policy title. • **Removed** coding information from policy.
Step Therapy Individual and Family Plan (1603)	Update	Effective: 4/15/2024 • Updated Alvesco and Qvar • Removed Dulera
Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) (1801)	Update	Effective: 4/1/2024 • Removed step therapy from Trintellix (effective 4/1/2024) and Risperdal and Qtern (effective 7/1/2024).
Step Therapy – Value and Advantage Prescription Drug Lists (Employer Group (1802)	Update	Effective: 4/1/2024 • Removed step therapy from Trintellix (effective 4/1/2024) and Risperdal (effective 7/1/2024).
Thalitone (IP0365)	Update	Important **changes** in coverage criteria: • Updated Medical Necessity Criteria • Effective 4/1/2024
Vutrisiran (IP0478)	Update	Effective: 4/1/2024 • Updated the Conditions Not Covered section to include new product, Wainua, for no concomitant use. • Added dosing to the policy
Alosetron (IP0012)	Update	No change in coverage criteria.
Alpha1-Proteinase Inhibitors – (IP0387)	Update	No change in coverage criteria.
Enzyme Replacement Therapy Revcovi (IP0399)	Update	No change in coverage criteria. • Effective 4/15/2024
Istradefylline (IP0524)	Update	No change in coverage criteria.
Lybalvi (IP0368)	Update	No change in coverage criteria.

		• Effective 4/15/2024
Maxalixibat (IP0341)	Update	No change in coverage criteria.
Methotrexate for Injection (IP0411)	Update	No change in coverage criteria.
Pilocarpine 1.25% Ophthalmic (IP0343)	Update	No change in coverage criteria. • Effective 4/15/2024
Pimavanserin (IP0145)	Update	No change in coverage criteria.
Pretomanid (IP0384)	Update	No change in coverage criteria.
Proton Pump Inhibitors (IP0061)	Update	No change in coverage criteria. Effective 4/15/2024
Selegiline (IP0525)	Update	No change in coverage criteria.
Sodium Thiosulfate – (IP0512)	Update	No change in coverage criteria.
Taparinof (IP0497)	Update	No change in coverage criteria.
Tiopronin (IP0202)	Update	No change in coverage criteria.
Tizanidine (IP0392)	Update	No change in coverage criteria. • Effective 4/15/2024
Topical Acne – Winlevi (IP0173)	Update	No change in coverage criteria. • Effective 4/15/2024
Topical Antifungals (IP0273)	Update	No change in coverage criteria.
Ursodiol (IP0299)	Update	No change in coverage criteria.

CareAllies Medical Necessity Guideline	New, Updated, or Retired?	Comments
		No policy updates in April 2024
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
		No policy updates in April 2024
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
		No policy updates in April 2024
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		No policy updates in April 2024
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
Code Editing Policy and Guidelines	**Update**	On May 11, 2024, ClaimsXten will be updated to Second Quarter Knowledge Base content and NCCI Version 30.1 for all medical and behavioral claims we process.

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