Coverage Policy Unit (CPU) - Monthly Newsletter

Effective August 15, 2023 (unless otherwise noted)

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

New Medical Coverage Policies

- No new policies for August 2023.

Modified Medical Coverage Policies

- Gender Dysphoria Treatment - (0266)
  - Important **changes** in coverage criteria:
    - Removed requirement for 6 months of pre surgical hormone treatment prior to reconstructive procedures.
    - Added medical necessity criteria for mastectomy for individuals aged 15 to < 17 yrs.
    - Added not medically necessary statement for mastectomy procedures for individuals less then age 15 yrs.
  - Minor **changes** in coverage criteria:
    - Added reference to "nonbinary individual diagnosed with gender dysphoria" in the policy statement.
    - Added "Head and /or Neck" to Facial Feminization /Masculinization Procedures Table 2 and policy statement.
- Gynecomastia Surgery - (0195)
  - Advance notification of important **changes** in coverage criteria **effective 11/15/2023:**
    - Limited coverage by adding requirement of preoperative frontal and lateral photographs confirming the presence of at least Grade II gynecomastia.
- Head and Neck Ultrasound - 0549
  - Important **change** in coverage:
    - Added coverage for E83.52 Hypercalcemia.
- Stem Cell Transplantation: Blood Cancers- (0533)
  - Advance notification of important changes in coverage **effective 11/15/2023**:
    - Restricted coverage for autologous hematopoietic stem cell transplantation (HSCT) for Myelodysplastic Syndromes
    - Expanded coverage for the following:
      - autologous HSCT for Amyloidosis.
      - non-myeloablative allogeneic HSCT in Non-Hodgkin Lymphoma (NHL) in children.
      - allogeneic HSCT in Acute Myeloid Leukemia (AML) to include intermediate risk individuals.

        - Updated the sources of 'risk' definitions for several cancer types to current industry standards.

- Tissue Engineered Skin Substitutes - (0068)
    - Important **changes** in coverage criteria:
        - Added coverage for AmnioBand for venous stasis ulcers.
        - Added 14 products as not covered.

Retired Medical Coverage Policies

- No policies retired for August 2023.

New Cigna-American Specialty Health (ASH) Cobranded Clinical Practice Guidelines (CPGs)

- No new CPGs for August 2023.

Modified Cigna-ASH Cobranded CPGs

- Electric Stimulation for Pain, Swelling and Function in a Clinic Setting (CPG272)
    - Important **change** in coverage:
        - Removed requirement for electrical stimulation for "an individual who has not responded to other modalities and treatments".

New Cigna-eviCore Cobranded Guidelines

- No new guidelines for August 2023.

Modified Cigna-eviCore Cobranded Guidelines

- Cobranded eviCore-Cigna guideline Homepage
    - Important **changes to** Cobranded High-tech Radiology (HTR) / Cardiology Imaging guidelines effective **August 15th:**
        - **Breast**
            - MRI Breast Indications (BR-5.1)

        - **Cardiac – General**
            - General Guidelines (CD-1.0), Table - 1 Clinical pretest probability of CAD in individuals with stable chest pain symptoms
            - Stress Testing with Imaging – Indications (CD-1.4)
            - Myocardial Perfusion Imaging (MPI) (CD-3.1)(CD-3.2)
            - Cardiac PET – Absolute Quantitation of Myocardial Blood Flow (AQMBF) (CD-6.3)
            - Stable Symptomatic Suspected or Established Coronary Artery Disease (CD-7.3.3)
            - Pulmonary Hypertension (PH) (CD-8.1)
            - New section: Maternal Imaging in Cardiovascular Disease.

        - **Head – Pediatric**
            - PEDHD-19.4 Neurometabolic and Neurogenetic Disorders.

        - **Oncology – General**
            - Surveillance/Follow- Up (ONC-11.4): Same changes as described under Breast guideline.

- **Preface**
  - Clinical Information (Preface-3.1). Added to MRI subsection:

- Cobranded eviCore-Cigna guideline Homepage
- Important **change**s posted May 31, 2023, effective **August 16th**:
  - Breast Imaging guideline: expanded coverage, updated age to begin annual screening MRI for ATM and CHEK2 genetic mutation from 40 to 30 years of age.

  - MRI Breast Indications (BR-5.1): MRI screening to begin at age determined by gene mutation.

New Administrative Policies

- No new policies for August 2023.

Modified Administrative Policies

- No updates for August 2023.

New Drug and Biologic Coverage Policies: Effective August 1, 2023 unless otherwise noted

- **Supports pharmacy prior authorization:**
  - Sparsentan (IP0565)

Modified Drug and Biologic Coverage Policies: Updates in this section effective August 1, 2023 unless otherwise noted

- Afamelanotide (IP0159)
  - Minor **changes** in coverage criteria/policy:
    - Added dosing information.
    - Updated format to current template and language standards.

- Cabotegravir-Rilpivirine (IP0123)
  - Important **changes** in coverage criteria/policy:
    - Added dosing information.
    - Updated the following:
      - Initial criteria by removing the weight restriction (criterion [B]), the duplicative diagnostic statement (criterion [C]) and the requirement for lead-in with Vocabria or at least 4 months of stable antiviral therapy (criterion [E]).
      - "Conditions Not Covered" with the removal of Human Immunodeficiency Virus (HIV), Antiretroviral Treatment-Naïve Patients.
    - Updated to current template and language standards.

- Cinacalcet for Individual and Family Plans – (IP0464)
  - Minor **changes** in coverage criteria/policy:
    - No changes in coverage criteria.
    - Updated dates, instructions for use, background, references, and copyright statement only.

- Collagenase Clostridium Histolyticum - (IP0143)
  - Minor **changes** in coverage criteria/policy:
    - Added dosing information to the policy.
    - Simplified curvature deformity related criteria for Peyronie's disease.

- Updated format to current template and language standards.

- Cysteamine Bitartrate Delayed-Release – (IP0046)
  - Minor **changes** in coverage criteria/policy:
    - No changes in coverage criteria.
    - Updated dates, instructions for use, background, references, and copyright statement only.

- Cysteamine Bitartrate for IFP – (IP0466)
  - Minor **changes** in coverage criteria:/policy:
    - Added Procysbi to coverage policy with no changes to clinical content of non-formulary criteria.

- Cysteamine Ophthalmic Solution – (IP0082)
  - Minor **changes** in coverage criteria/policy:
    - No changes in coverage criteria.
    - Updated dates, instructions for use, background, references, and copyright statement only.

- Dabigatran (IP0033)
  - Important **changes** in coverage criteria/policy:
    - Added the following:
      - Dabigatran capsules to the policy overview section.
      - Exceptions for patients receiving Pradaxa for treatment of thrombosis or the prophylaxis of deep vein thrombosis or pulmonary embolism after orthopedic surgery.
      - Coverage, identical to the Pradaxa capsule approach, for the Treatment or Prevention of Other Thromboembolic-Related Conditions.
    - Decreased the initial authorization duration for Pradaxa Oral Pellets, from 12 months to 2 months.
    - Removed Eliquis as a prerequisite option.
    - Updated the following:
      - Pradaxa Capsule approach to current P&T guidance (3/27/2023).
      - Policy format to current template/language format.
    - Updated to current P&T guidance (3/27/2023) and added to the policy Pradaxa Oral Pellets criteria.

- Denosumab (Xgeva) - (IP0332)
  - Important **changes** in coverage criteria **effective 8/15/2023**:
    - Updated criteria for hypercalcemia of malignancy and prevention of skeletal related events (related to prostate cancer) to remove bisphosphonate (zoledronic acid) requirement.

- Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Standard, Performance, or Legacy Prescription Drug List (1601) and
- Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Value, Advantage, or Cigna Total Savings Prescription Drug List (1602)
  - Minor **changes** in coverage criteria/policy:
    - Added Primidone 125 mg oral tablet and Xaciato (clinamycin) 2% vaginal gel to the policy.

- Emapalumab-lzsg - (IP0113)
  - Minor **changes** in coverage criteria/policy:
    - Added dosing to the policy.
    - Updated format to current template and language standards.

- Epinephrine Injection (Self-Administered) – (IP0385)
  - Minor **changes** in coverage criteria/policy:
    - No changes in coverage criteria:
    - Updated dates, instructions for use, background, references, and copyright statement only.

- Fertility Medications – (1012)
  - Important **changes** in coverage criteria/policy:
    - Coverage policy supports medical precertification criteria for fertility injectables.
    - Added Overview, Reauthorization Criteria and Authorization Duration sections to policy.
    - Enhanced Gonal-f criteria to allow an exception/approval for planned oocyte preservation.
    - Updated to current template/formatting standards, table updates, and simplified criteria.

- Glecaprevir-Pibrentasvir – (IP0187)
  - Important **changes** in coverage criteria/policy:
    - Revised initial approval criteria section to include criteria for all genotypes or unknown genotype status.
    - Updated authorization duration section.

- Hereditary Angioedema - Berotralstat – (IP0096)
  - Important **changes** in coverage criteria/policy:
    - Added *ANGPT1, PLG* and *KNG1* genes to genetic confirmation criteria.
    - Simplified specialist prescriber criterion.
    - Updated policy format to current template/formatting standards.

- Hereditary Angioedema – C1 Esterase Inhibitors (IV) – (IP0315)
- Hereditary Angioedema – C1 Esterase Inhibitors (SC) – (IP0316)
- Hereditary Angioedema – Ecallantide – (IP0336)
- Hereditary Angioedema – Icatibant – (IP0335)
- Hereditary Angioedema – Lanadelumab-flyo – (IP0334)
  - Important **changes** in coverage criteria/policy:
    - Removed the statement “History of recurrent angioedema in the absence of concomitant urticaria and no concomitant use of medication known to cause angioedema”.
    - Simplified specialist prescriber requirement.

- Leuprolide - Central Precocious Puberty – (IP0108)
  - Minor **changes** in coverage criteria/policy.
    - Added dosing for new strength of Lupron Depot-PED.

- Mannitol (IP0126)
  - Minor **changes** in coverage criteria/policy:
    - No changes in coverage criteria.
    - Updated dates, instructions for use, background, references, and copyright statement only.

- Nitisinone – (IP0146)
  - Minor **change** in coverage criteria/policy:
    - Added nitisinone capsules (generic for Orfadin) to the policy.
    - Removed requirement of elevated serum levels of alpha-fetoprotein (AFP) for diagnosis of Hereditary Tyrosinemia Type 1.

- Peanut (Arachis hypogaea) Allergen Powder-dnfp – (IP0141)
  - Minor **changes** in coverage criteria/policy:
    - No changes in coverage criteria:
    - Updated dates, instructions for use, background, references, and copyright statement only.

- Phenylbutyrate - (IP0169)
  - Minor **changes** in coverage criteria/policy:
    - No changes in coverage criteria.

- sUpdated dates, instructions for use, background, references, and copyright statement only.

- Pregabalin Extended-Release (IP0183)
  - Minor **changes** in coverage criteria/policy:
    - No changes in coverage criteria.
    - Updated dates, instructions for use, background, references, and copyright statement only.

- Sedative Hypnotic Medications - (IP0023)
  - Important **changes** in coverage criteria/policy:
    - Added zolpidem tartrate 7.5 mg capsule to policy; criteria aligned with policy approach for sedative hypnotic medications.

- Sofosbuvir-Velpatasvir – (IP0184)
  - Important **changes** in coverage criteria/policy:
    - Revised initial approval criteria section to include criteria for all genotypes or unknown genotype status.
    - Updated authorization duration section.

- Teprotumumab - (IP0129)
  - Important **changes** in coverage criteria/policy:
    - Added dosing to the policy.
    - Removed requirement for clinical activity score (CAS).
    - Removed requirement for specific confirmatory signs/symptoms of moderate to severe thyroid eye disease and examples.

- Testosterone (Injectables and Implantable Pellets) - (IP0351)
  - Important **changes** in coverage criteria/policy:
    - Added the following:
      - Initial and currently receiving criteria for hypogonadism
      - Criteria for those who have lost records or have no pre-treatment information
      - Dosing to the policy
    - Combined the sections for Aveed/Xyosted with the Testopel.
    - For Xyosted, added “Non-Covered Products and Criteria” table for Individual and Family Plans
    - Updated format to current template and language standards.

- Topical Rosacea Products – (IP0003)
  - Minor **changes** in coverage criteria/policy:
    - No changes in coverage criteria.
    - Updated dates, instructions for use, background, references, and copyright statement only.

- Verkazia – (IP0439)
  - Minor **changes** in coverage criteria/policy:
    - Added Individual and Family Plans Non-Covered Products and Criteria table.
    - Updated format to current template and language standards.

- Upadacitinib – (IP0229)
  - Important **changes** in coverage criteria/policy:
    - Added new medical necessity criteria to support Rinvoq’s expanded indication for treatment of Crohn’s Disease.

Retired Drug and Biologic Coverage Policies: Effective August 1, 2023 unless otherwise noted

- No retired policies for August 2023.

Cigna National Formulary (CNF) Coverage Policies

- Cigna National Formulary (CNF) policies are located on the CNF Policies A-Z Index.
  - Policies are listed alphabetically by document title
    - Document titles include the policy type and may include the drug name, class, and/or condition
  - Policies can also be searched by a product identification (ID) number, which is a unique identifier to a specific product/policy.
    - When applicable, searching by product ID helps locate the corresponding CNF policy.
  - Details of updates to each CNF policy are located under the "Revision History" section.
- More information about Cigna's drug lists can be found at Prescription Drug Lists and Coverage | Cigna
- More information about Cigna's drug lists **changes** can be found at CHCP - Resources - Cigna's Prescription Drug Lists.
  - CNF formulary changes can be found in the Prescription Drug List Changes document under **Cigna National Prescription Drug List**, located at the bottom of the page.

CareAllies Medical Necessity Guidelines

- No updates for August 2023.

* Modified Precertification List – Commercial (Non-Medicare) Business

- No updates for August 2023.

* Modified Precertification List – Medicare Business

- No updates for August 2023.

* New Reimbursement Policies

- MAR36 - Emergency Room Services.
  - Effective 8/15/2023

* Modified Reimbursement Policies

- R04 - Robotic Assisted Surgery
- Modifier 22 - Increased Procedural Services
- Modifier MRG - Modifier Reference Guide
- R39 - Anesthesia Professional Services
  - Effective 10/14/2023:
- R12 - Facility Routine Services, Supplies, and Equipment
  - Effective 10/24/2023

* Other Modified Coding and Reimbursement Documents

- No updates for August 2023.

* ClaimsXten Documents

- No updates for August 2023.