



Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective March 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 |
|--|---------------------------|--|
| Ambulatory External and Implantable Electrocardiographic Monitoring (0547) | Update | Important changes in coverage criteria: <ul style="list-style-type: none">• Expanding coverage based on new Jan 2024 ACC guidelines.• Clarifying pediatric coverage with separate policy statement. |
| Breast Reconstruction Following Mastectomy or Lumpectomy (0178) | Update | Important changes in coverage criteria: <ul style="list-style-type: none">• Clarified the intent of the areolar and nipple reconstruction bullet under covered breast reconstruction procedures performed on the diseased breast to be clear that correction of an inverted nipple that occurs as part of a covered mastectomy or lumpectomy is considered a medically necessary procedure.• Added “flat closure chest wall reconstruction” to the list of covered breast reconstruction procedures to clarify that this is an option.• Clarified the intent of the oncoplastic reconstruction bullet under covered breast reconstruction procedures performed on the diseased breast to provide examples of what constitutes “oncoplastic reconstruction”. |

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| | | <ul style="list-style-type: none"> • Added “DuraSorb® Monofilament Mesh/ Polydioxanone Surgical Scaffold™” to the list of EIU products because we are receiving requests for this product used in conjunction with breast reconstruction procedures. • Removed hMatrix and Repriza from the list of EIU products because these products were removed from precert and are no longer managed.. • Added “or tissue protruding at the end of a scar (e.g., dog ear, standing cone)” to the cosmetic lipectomy or excision of redundant skin statement to provide clarification that correction of dog ears or standing cones are considered cosmetic as well. |
| Comparative Genomic Hybridization (CGH)/Chromosomal Microarray Analysis (CMA) for Selected Hereditary Conditions (0493) | Update | <p>Minor changes in coverage criteria/policy:</p> <ul style="list-style-type: none"> • Revised genetic counseling credential verbiage to reflect Clinical Genomics Nurse |
| Genetic Testing for Hereditary Cardiomyopathies and Arrhythmias (0517) | Update | <p>Minor changes in coverage criteria/policy:</p> <ul style="list-style-type: none"> • Revised genetic counseling credential verbiage to reflect Clinical Genomics Nurse |
| Nonpharmacological Treatments for Atrial Fibrillation (0469) | Update | <p>Important changes in coverage criteria:</p> <ul style="list-style-type: none"> • Title change to Atrial Fibrillation: Nonpharmacological Treatments • Tightening coverage for percutaneous transcatheter closure of the left atrial appendage (CPT code 33340) (the Watchman™) • Expanding coverage for <ul style="list-style-type: none"> ➢ catheter ablation (93656, 93657) ➢ surgical ablation (surgical Maze or modified Maze procedure, 33256, 33257, 33259) |
| Peripheral Nerve Stimulation and Peripheral Nerve Field Stimulation (0539) | Update | <p>Minor changes in coverage criteria/policy:</p> <ul style="list-style-type: none"> • Clarified statement for implantable peripheral nerve stimulation. |
| Tissue-Engineered Skin Substitutes (0068) | Update | <p>Minor changes in coverage criteria/policy:</p> <ul style="list-style-type: none"> • Added not covered: Regeneten Bioinductive Implant |
| Site of Care: High-tech Radiology (0550) | Update | <p>Important changes in coverage criteria:</p> <ul style="list-style-type: none"> • Clarified wording for cancer imaging and chronic systemic disease imaging. • Removed ‘Centers of Excellence’ language because it does not have a standardized definition. • Simplified the cancer screening bullet to remove high risk. |
| Orthotic Devices and Shoes (0543) | Update | <p>Minor change in coverage criteria:</p> |

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| | | <ul style="list-style-type: none"> The change extends the window for a prior physical exam from six months to twelve months for an orthotic device. This is a favorable update. |
| Ablative Treatments for Malignant Breast Tumors (0540) | Update | No change in coverage. |
| Diagnostic Nasal/Sinus Endoscopy, Functional Endoscopic Sinus Surgery (FESS) and Turbinectomy (0554) | Update | No change in coverage. |
| Inflammatory Bowel Disease - Testing for the Diagnosis and Management (0121) | Update | No change in coverage. |
| Panniculectomy and Abdominoplasty (0027) | Update | No change in coverage. |
| Site of Care: Outpatient Hospital for Select Musculoskeletal Procedures (0553) | Update | No change in coverage |
| Stem Cell Therapy for Orthopedic Applications (0552) | Update | No change in coverage |
| Transcranial Magnetic Stimulation (0383) | Update | No change in coverage. |
| Vitamin D Testing (0526) | Update | No change in coverage. |
| ASH Guidelines | New, Updated, or Retired? | Comments |
| | | No policy updates in March 2024 |
| eviCore Guidelines | New, Updated, or Retired? | Comments |

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| Cobranded Cigna-eviCore Cardiac Implantable Devices Guidelines | Update | <p>Important changes in coverage criteria Posted December 1, 2023, Effective March 1, 2024:</p> <p>Updates to the guidelines included both positive and adverse changes in coverage:</p> <ul style="list-style-type: none"> • Added coverage for permanent pacemaker implantation for congenital complete heartblock • Changed from covered to not covered for pacemaker for symptomatic recurrent supraventricular tachycardia (SVT) |
| Cobranded Cigna-eviCore Sleep Disordered Breathing Diagnosis and Treatment Guidelines | Update | <p>Important changes in coverage criteria Posted March 1, 2024, Effective June 15, 2024:</p> <p>Updates to the guidelines included both positive and adverse changes in coverage, including:</p> <ul style="list-style-type: none"> • Added covered sleep-related signs and symptoms (e.g., presence of atrial fibrillation or systolic congestive heart failure) • Added coverage for testing in a subset of pediatric individuals with Down Syndrome |
| Administrative Policy | New, Updated, or Retired? | Comments |
| Abortion (A006) Administrative Policy | Update | No change in coverage. |
| Drug & Biologic Coverage Policy | New, Updated, or Retired? | Comments All policy changes effective October 1, 2023, unless otherwise stated |
| Alemtuzumab (IP0213) | Update | <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> • Tyruko (natalizumab-sztn intravenous infusion), Briumvi (ublituximab-xiij intravenous infusion), and Mavenclad (cladribine) were added to the list allowing an exception with previous use. • Effective 3/1/2024. |
| Antiseizure Medications (IP0031) | Update | <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> • Policy renamed to Antiseizure Medications. • Motpoly XR (lacosamide extended-release capsules) added to the policy. • Policy aligned to current template and language standards. • Effective 3/15/2024. |
| Brands with Bioequivalent Generics (IP0011) | Update | <p>Brands with Bioequivalent Generics (IP0011)</p> <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> • Removed Absorica from the policy. |

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| | | <ul style="list-style-type: none"> The following products were added to the policy effective 7/1/2024: Avodart, Canasa, Ciprodex, Dyrenium, Jalyn, Mestinon, Procardia XL, Prometrium, Risperdal, Risperdal Consta, and Tekturna. Effective 3/15/2024. |
| Cipaglucosidase alfa-atga (IP0591) | Update | <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> Updated coverage policy supporting medical necessity review for Employer Group benefit plans for alignment with related policy IP0598 Opfolda. Effective 3/15/2024. |
| Clobazam (IP0106) | Update | <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> Fintepla (fenfluramine oral solution) added an example of a prerequisite option to the Lennox-Gastaut Syndrome requirements. All instances of <i>antiepileptic drug(s)</i> were replaced with <i>antiseizure medication(s)</i>. Policy aligned to current template and language standards. Effective 3/1/2024. |
| Cyclosporine Ophthalmic Products (IP0026) | Update | <p>Cyclosporine Ophthalmic Products (IP0026)</p> <p>Important change to coverage criteria:</p> <ul style="list-style-type: none"> Added Vevye (cyclosporine 0.10% ophthalmic drops) to the policy Effective 3/15/2024. |
| Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review - Employer Group Plans: Standard, Performance, or Legacy Prescription Drug List (1601) | Update | <p>Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Standard, Performance, or Legacy Prescription Drug List (1601)</p> <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> Added Likmez (effective 4/15/2024) and Xultophy (effective 7/1/2024) to the policy. Updated (brand) Condylox criteria (effective 5/1/2024). Effective 3/15/2024. |
| Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review - Employer Group Plans: Value, Advantage, or Cigna Total Savings Prescription Drug List (1602) | Update | <p>Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Value, Advantage, or Cigna Total Savings Prescription Drug List (1602)</p> <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> Added Likmez (effective 4/15/2024) and Xultophy (effective 7/1/2024) to the policy. Updated (brand) Condylox criteria (effective 5/1/2024). Effective 3/15/2024. |
| Faricimab (IP0542) | Update | <p>Faricimab (IP0542)</p> <p>Important changes to coverage criteria:</p> |

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| | | <ul style="list-style-type: none"> Updated policy to include the omitted statement “If, in the professional opinion of the prescriber, the safety of using the repackaged bevacizumab or the supplier of the repackaged bevacizumab is of significant concern” Effective 3/15/2024 |
| Growth Disorders – Ngenla (IP0577) | Update | <p>Growth Disorders – Ngenla (IP0577)</p> <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> Added preferred product requirements from the Standard, Value and Legacy formularies. Policy title changed to <i>Growth Disorders – Ngenla</i>. Policy aligned to current template and language standards. Effective 3/15/2024. |
| Growth Disorders – Skytrofa (IP0375) | Update | <p>Growth Disorders – Skytrofa (IP0375)</p> <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> Removed preferred product requirements from the Standard, Value and Legacy formularies. Policy title changed to <i>Growth Disorders – Skytrofa</i>. Policy aligned to current template and language standards. Effective 3/15/2024. |
| Inflammatory Conditions – Bimzelx (IP0603) | New | <ul style="list-style-type: none"> This is a new policy supporting pharmacy prior authorization of bimekizumab-bkzx subcutaneous injection [Bimzelx]. Effective date 3/1/2024. |
| Immune Globulin (5026) | Update | <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> Removed Preferred Product Criteria Requirements for Panzyga. Panzyga added as a preferred product option to the Asceniv, Gammagard Liquid, For Intravenous (IV) route, and Gammagard S/D IgA ≤ 1 mcg/mL Preferred Product Criteria Requirements. Effective 3/1/2024. |
| Infliximab (IP0242) | Update | <p>Important changes in coverage criteria:</p> <ul style="list-style-type: none"> Updated Conditions Not Covered section. Updated policy format. Effective date of 3/15/2024. |
| Inotersen (IP0417) | Update | <p>Minor changes in coverage criteria/policy:</p> <ul style="list-style-type: none"> Updated medical necessity criteria to include dosing information. Policy aligned to current template/ language standards. Effective 3/15/2024. |
| Lodoco (colchicine capsule) (IP0595) | New | <p>Important points for new policy:</p> |

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| | | <ul style="list-style-type: none"> This is a new policy supporting pharmacy prior authorization of colchicine 0.5 mg capsules [Lodoco]. Effective date 3/1/2024. |
| Medication Administration Site of Care (1605) | Update | <p>Minor changes to coverage criteria:</p> <ul style="list-style-type: none"> Updated initiated request to include “out of office provider” within the medical necessity criteria Effective 3/15/2024. |
| Motixafortide (IP0597) | New | <p>Motixafortide (IP0597)</p> <p>Important points for new policy:</p> <ul style="list-style-type: none"> This is a new policy supporting pharmacy prior authorization of motixafortide. Effective date 3/15/2024. |
| Multiple Sclerosis – Kesimpta (IP0260) | Update | <p>Kesimpta (IP0260)</p> <ul style="list-style-type: none"> Policy title changed to <i>Multiple Sclerosis – Kesimpta</i>. Clarified that the Individual and Family Plans preferred product requirements will apply to any multiple sclerosis treatment naïve individual. Policy aligned to current language and template standards. Effective date 3/1/2024. |
| Multiple Sclerosis -Ocrevus (IP0212) | Update | <p>Ocrevus (IP0212)</p> <ul style="list-style-type: none"> Policy title changed to <i>Multiple Sclerosis – Ocrevus</i>. Clarified that the Individual and Family Plans preferred product requirements will apply to any multiple sclerosis treatment naïve individual. Policy aligned to current language and template standards. Effective date 3/1/2024. |
| Natalizumab (IP0215) | Update | <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> Added examples of Immunosuppressant Agents to the first condition not covered (Concurrent Use with an Immunosuppressant Agent). Effective 3/1/2024. |
| Nephrology – Jesduvroq (IP0604) | New | <p>Nephrology – Jesduvroq (IP0604)</p> <p>Important points for new policy:</p> <ul style="list-style-type: none"> This is a new policy supporting pharmacy prior authorization of daprodustat tablets [Jesduvroq]. Effective date 3/15/2024. |
| Nonsteroidal Anti-Inflammatory Drugs - (IP0457) | Update | <p>Nonsteroidal Anti-Inflammatory Drugs (IP0457)</p> <p>Important change to coverage criteria:</p> <ul style="list-style-type: none"> Added Coxanto 300mg capsules to the policy |

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| | | <ul style="list-style-type: none"> • Effective 3/15/2024. |
| Opfolda (miglustat) capsules (IP0598) | Update | <p>Important points for new policy:</p> <ul style="list-style-type: none"> • This is a new policy supporting pharmacy prior authorization of miglustat capsules [Opfolda]. • Effective date 3/15/2024. |
| Pegunigalsidase Alfa (IP0570) | Update | <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> • Removed the preferred product prerequisite step through Fabrazyme for all Employer and IFP formularies. • Effective 3/1/2024. |
| Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) (1803) | Update | <p>Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) (1803)</p> <p>Important changes in coverage criteria:</p> <ul style="list-style-type: none"> • Step Therapy removed from Absorica (effective 3/15/2024). • Step Therapy removed from Risperdal (effective 7/1/2024). • Step Therapy removed from Trintellix (effective 4/1/2024). • Policy effective 3/15/2024. |
| Testosterone (Oral, Topical, and Nasal) (IP0350) | Update | <p>Important changes in coverage criteria:</p> <ul style="list-style-type: none"> • Updated criteria for individuals currently receiving therapy to address circumstances where records are available or where there is a loss of records or inability to provide them. • Incorporated criteria for Individual and Family Plans. • Updated policy format. • Effective date 3/1/2024. |
| Topical Acne – Non-Retinoid Products (IP0166) | Update | <p>Important changes in coverage criteria/policy</p> <ul style="list-style-type: none"> • Update to included new A-rated generic for Onexton to policy • Added a new IFP table to include rows for A-rated generic of Onexton and brand Onexton. • Effective 3/1/2024. |
| Topical Acne – Non-Retinoid Products (IP0166) | Update | <p>Topical Acne – Non-Retinoid Products (IP0166)</p> <p>Important changes in coverage criteria/policy:</p> <ul style="list-style-type: none"> • Aczone 7.5% gel removed from the policy. • Effective date of 3/15/2024. |
| Topical Vitamin D Analogs (IP0361) | Update | <p>Topical Vitamin D Analogs (0361)</p> <p>Important changes in coverage criteria/policy:</p> <ul style="list-style-type: none"> • Taclonex suspension removed from the policy. • Effective date of 3/15/2024. |
| Vedolizumab Intravenous (IP0326) | Update | <p>Minor changes in coverage criteria/policy:</p> <ul style="list-style-type: none"> • Policy retitled with addition of “Intravenous” to reflect it applies to the intravenous formulation. • Effective date of 3/1/2024. |

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| Vosoritide (IP0402) | Update | <p>Important changes to coverage criteria:</p> <ul style="list-style-type: none"> • The lower age limit of 5 years of age and the criterion that there is evidence of an annualized growth velocity ≥ 1.5 cm/year were removed from the medical necessity criteria requirements. • Additional examples of long-acting growth hormone products were added to <i>Concurrent Treatment with Growth Hormone, Long-Acting Growth Hormone, or Insulin-like Growth Factor-1 Agents</i> condition not covered statement. • Policy aligned to current template and language standards. • Effective 3/1/2024. |
| Carbidopa – (IP0523) | Update | <ul style="list-style-type: none"> • Effective: 3/15/2024 |
| Carbidopa and Levodopa Enteral Suspension – (IP0303) | Update | <ul style="list-style-type: none"> • Effective: 3/15/2024 |
| Desmopressin Nasal Spray – (IP0132) | Update | <p>No change in coverage criteria.</p> <ul style="list-style-type: none"> • Effective: 3/15/2024 |
| Dextromethorphan/Quinidine (Nuedexta) for Individual and Family Plans – (IP0324) | Update | <p>No change in coverage criteria.</p> <ul style="list-style-type: none"> • Effective: 3/15/2024 |
| Entadfi (finasteride and tadalafil) – (IP0519) | Update | <p>No change in coverage criteria.</p> <ul style="list-style-type: none"> • Effective: 3/15/2024 |
| Fentanyl Transmucosal Products – (IP0381) | Update | <p>No change in coverage criteria.</p> <ul style="list-style-type: none"> • Effective: 3/15/2024 |
| Glucagon Products – (IP0039) | Update | <p>No change in coverage criteria. Effective: 3/15/2024</p> |
| Glucose Test Strips – (IP0272) | Update | <p>No change in coverage criteria. Effective: 3/15/2024</p> |
| Grass Pollen Sublingual Products – (IP0515) | Update | <p>No change in coverage criteria.</p> <ul style="list-style-type: none"> • Effective: 3/15/2024 |
| Hydroxyprogesterone Caproate – (IP0370) | Update | <p>No change in coverage criteria. Effective: 3/15/2024</p> |

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| Levodopa Inhalation Powder – (IP0522) | Update | No change in coverage criteria. |
| Midazolam Nasal Spray – (IP0338) | Update | No change in coverage criteria. Effective: 3/15/2024 |
| Odactra – (IP0516) | Update | No change in coverage criteria. Effective: 3/15/2024 |
| Olipudase alfa-rpcp – (IP0500) | Update | No change in coverage criteria. Effective: 3/15/2024 |
| Oteseconazole – (IP0513) | Update | No change in coverage criteria. Effective: 3/15/2024 |
| Oxymetazoline Ophthalmic Solution – (IP0088) | Update | No change in coverage criteria. Effective: 3/15/2024 |
| Penicillamine – (IP0277) | Update | No change in coverage criteria. Effective: 3/15/2024 |
| Ragwitek – (IP0518) | Update | No change in coverage criteria. Effective: 3/15/2024 |
| Riluzole – (IP0258) | Update | No change in coverage criteria. Effective: 3/15/2024 |
| Rufinamide – (IP0048) | Update | No change in coverage criteria. Effective: 3/15/2024 |
| Satralizumab-(IP0078) | Update | No change in coverage criteria. Effective: 3/15/2024 |
| CareAllies Medical Necessity Guideline | New, Updated, or Retired? | Comments |
| | | No policy updates in March 2024 |
| Precertification Policy* | New, Updated, or Retired? | Comments |

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| | | No policy updates in March 2024 |
| Reimbursement Policy* | New, Updated, or Retired? | Comments |
| | | No policy updates in March 2024 |
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| Other Coding and Reimbursement Documents | New, Updated, or Retired? | Comments |
| | | No policy updates in March 2024 |
| ClaimsXten Documents* | New, Updated, or Retired? | Comments |
| | | No policy updates in March 2024 |

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