Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective December 15, 2023 (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
Benign Prostatic Hyperplasia (BPH) Treatments CP – (0159)	Update	Important **changes** in coverage criteria: • Title change to reflect that these are "surgical" procedures. • Expanded coverage by removing the "EIU" procedures from the list that we do not manage.
Electrical Stimulation Therapy and Devices in a Home Setting – (0160)	Update	**Changes** in coverage criteria **Posting and effective 12/3/2023** • Minor change for clarification: added transcutaneous afferent patterned stimulation (TAPS) neuromodulation therapy (e.g., Cala Trio; Cala kIQ™) to list of experimental, investigational, or unproven therapies. • Removed the following therapies/devices from the policy statement: transcutaneous electrical modulation pain reprocessing; bioelectric nerve block; combination therapy; electrical sympathetic stimulation therapy; electrotherapeutic point stimulation; functional electrical stimulation; H-WAVE electrical stimulation; high-voltage galvanic stimulation; microcurrent electrical nerve stimulation; threshold/therapeutic electrical stimulation; and transcutaneous electrical modulation pain reprocessing (TEMPR) (e.g., Scrambler therapy, Calmare®)

Intensive Behavioral Interventions (EVERNORTH Behavioral Health Coverage Policy) – (EN0499)	Update	Minor **changes** in coverage criteria/policy: • No significant changes in coverage • Some new criteria requirements added to existing policy statements. • New policy statement on Documentation Expectations. • Numerous clarifications
Laboratory Testing for Transplantation Rejection –(0465)	Update	Minor **changes** in coverage criteria/policy: • No significant changes in coverage • Removed examples Clarava™, Tutivia™ from gene expression profiling tests policy statement • Removed policy statement for measurement of donor and third-party-induced CD154+T-cytotoxic memory cells (i.e. Pleximmune™, Pleximark™)
Nonpharmacological Treatments for Atrial Fibrillation – (0469)	Update	Important **changes** in coverage criteria: • expanded coverage for a transcatheter ablation to include a subset of patients with atrial fibrillation that is caused by heart failure. • removed medical necessity criteria for surgical closure of the left atrial appendage as CPT code 33268 was removed from precert. Leaving the medical necessity statement for provider guidance.
Temporomandibular Joint (TMJ) Disorder Surgery - 0156	Update	**Changes** in coverage criteria: • Expanded coverage by reducing required length of intervention for noninvasive therapies prior to surgery from six months to six weeks. • Minor change to remove FDA approval language from policy statement for total or partial prosthetic temporomandibular joint replacement.
Transcatheter Heart Valve Procedures – (0501)	Update	Minor **changes** in coverage criteria: • Expand coverage with the addition of the SAPIEN 3/Alterra Prestent System to the list of FDA approved devices covered for transcatheter pulmonary valve implantation. • Alterra Prestent System no longer considered EIU (see above statement).
Ventricular Assist Devices (VADs), Percutaneous Cardiac Support Systems and Total Artificial Heart – (0054)	Update	Important **changes** in coverage criteria: • Expanded coverage by removing the contraindication policy statement, “malignancy that is expected to significantly limit future survival” for implantable ventricular assist devices. • Expanded coverage by removing the contraindication policy statement, “ a pattern of demonstrated noncompliance… which would place a VAD at serious risk of failure”. • Minor change: Reorganize the policy statements for Percutaneous Ventricular Assist Devices (VADs). • Expanded coverage by removing the policy statement for VADs used as part of an ECMO circuit.

		• Expanded coverage by removing the EIU policy statement for the SynCardia Freedom Driver System.
Adoptive Immunotherapy – (0225)	Retired	Rationale: Code S2107 was removed from Precert 07/28/2023.
Tilt Table Testing - (0066)	Retired	Please note: • Content from CP 0066 was combined with Tilt Table Testing and Computerized Dynamic Posturography - 0270 • Title change to reflect combined scope. ○ Tilt Table Testing and Computerized Dynamic Posturography" • CP #0066 has been retired. • No change to policy statements.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
		• no updates for December 2023
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-eviCore Cardiac Implantable Devices Guidelines	Update	Important **changes** in coverage criteria Posting **December 1, 2023**, Effective **March 1, 2024**: Updates to the guidelines included both positive and adverse changes in coverage: • Added coverage for permanent pacemaker implantation for congenital complete heartblock • Changed from covered to not covered for pacemaker for symptomatic recurrent supraventricular tachycardia (SVT) Cigna-eviCore Cobranded Guidelines Homepage

Administrative Policy	New, Updated, or Retired?	Comments
		• no updates for December 2023
Drug & Biologic Coverage Policy	**New, Updated, or Retired?**	**Comments** **All policy changes effective December 1, 2023, unless otherwise stated**
Apomorphine (Apokyn) – (IP0530)	Update	Minor **changes** in coverage criteria/policy: • Removed Kynmobi from the policy due to market withdrawal of the product. • Effective date **12/1/2023**.
Valbenazine - (IP0080)	Update	Important **changes** in coverage criteria ○ Added the condition Chorea Associated with Huntington's Disease as a newly approved indication granted by the Food and Drug Administration (FDA) ○ SMEs consulted and in agreement with draft ○ Effective **12/1/2023**
Azathioprine - (IP0337)	Update	Minor **changes** in coverage criteria/policy: • No content changes to clinical criteria. • Updated format to current template and language standards. • Effective: **12/15/2023.**
Bempedoic Acid – (IP0248)	Update	Important **changes** in coverage criteria: • Added new criteria for primary hyperlipidemia. • Updated reauthorization criteria. • Updated policy format. • Effective date **12/15/2023**.
Bempedoic Acid/Ezetimibe – (IP0249)	Update	Important **changes** in coverage criteria: • Updated reauthorization criteria. • Updated policy format. • Effective date **12/15/2023**.

Canakinumab – (IP0235)	Update	Important **changes** in coverage criteria: • Added criteria for new expanded indication for treatment of acute gout flare. • Removed gout from the Conditions Not Covered section. • Effective date **12/15/2023.**
Ivermectin - (IP0300)	Update	Minor **changes** in coverage criteria/policy: • No content changes to clinical criteria. • Updated format to current template and language standards. • Effective: **12/15/2023.**
Neurology – Leqembi (lecanemab-irmb) - (IP0547)	New	This is a **new** coverage policy: • That supports non-coverage of lecanemab (Leqembi) • Effective date: **12/15/2023**
Methoxy Polyethylene Glycol-Epoetin Beta – (IP0297)	Update	Minor **changes** in coverage criteria/policy: • No content changes to clinical criteria. • Added dosing in-alignment with ESI UM coverage policy. • Updated format to current template and language standards. • Effective: **12/15/2023**
Muscular Dystrophy – Gene Therapy – Elevidys (delandistro – gene) moxeparvovec-rokl) intravenous infusion – (IP0571)	New	This is a **new** coverage policy. • This is a new policy supporting non-covereage of delandistrogene moxeparvovec-rokl (Elevidys). • Effective date **12/15/2023.**
Odevixibat - (IP0363)	Update	Important **changes** in coverage criteria: • Added new criteria for Alagille syndrome. • Updated reauthorization criteria. • Effective date **12/15/2023**.
Otic Antibiotics (IP0366)	Update	Minor **changes** in coverage criteria/policy: • No content changes to clinical criteria. • Updated format to current template and language standards. • Effective: **12/15/2023.**

Pancrelipase (IP0002)	Update	Minor **changes** in coverage criteria/policy: • No content changes to clinical criteria. • Updated format to current template and language standards. • Effective: **12/15/2023.**
Perfluorohexyloctane Ophthalmic Solution (IP0583)	New	This is a **new** coverage policy. • The policy supports pharmacy prior authorization of perfluorohexyloctane ophthalmic solution [Miebo]. • Effective date **12/15/2023**.
Roflumilast – (IP0527)	Update	Important change in coverage criteria: • Revised age criteria down to 6 years of age or older in medical necessity criteria • Effective date **12/15/2023**.
Topical Corticosteroids – (IP0281)	Update	Minor **changes** in coverage criteria/policy: • Added amcinonide to coverage policy • Effective 12/15/2023
Weight Loss – Tirzepatide (Zepbound™) - [IP0593]	New	This is a **new** coverage policy. • The policy supports pharmacy prior authorization of tirzepatide subcutaneous injection [Zepbound]. • Effective date **12/15/2023**.
Apomorphine (Kynmobi) – (IP0488)	Retired	▪ Policy to be retired due to market withdrawal of Kynmobi ▪ Effective date **12/15/2023**
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• All updates are reflected in the Medical and Drug and Biologics policies

Precertification Policy*	New, Updated, or Retired?	Comments
		• No updates for December 2023
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
		• No updates for December 2023
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No updates for December 2023
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
		• No updates for December 2023