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: • 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: • 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”.

		• 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	Minor **changes** in coverage criteria/policy: • Revised genetic counseling credential verbiage to reflect Clinical Genomics Nurse
Genetic Testing for Hereditary Cardiomyopathies and Arrhythmias (0517)	Update	Minor **changes** in coverage criteria/policy: • Revised genetic counseling credential verbiage to reflect Clinical Genomics Nurse
Nonpharmacological Treatments for Atrial Fibrillation (0469)	Update	Important **changes** in coverage criteria: • 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 ➢ 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	Minor **changes** in coverage criteria/policy: • Clarified statement for implantable peripheral nerve stimulation.
Tissue-Engineered Skin Substitutes (0068)	Update	Minor **changes** in coverage criteria/policy: • Added not covered: Regeneten Bioinductive Implant
Site of Care: High-tech Radiology (0550)	Update	Important **changes** in coverage criteria: • 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	Minor change in coverage criteria:

		• 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**

Cobranded Cigna-eviCore Cardiac Implantable Devices Guidelines	Update	Important **changes** in coverage criteria Posted **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)
Cobranded Cigna-eviCore Sleep Disordered Breathing Diagnosis and Treatment Guidelines	Update	Important **changes** in coverage criteria Posted **March 1, 2024**, Effective **June 15, 2024**: Updates to the guidelines included both positive and adverse changes in coverage, including: • 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 March 1, 2024, unless otherwise stated**
Alemtuzumab (IP0213)	Update	Important **changes** to coverage criteria: • 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	Important **changes** to coverage criteria: • 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	Brands with Bioequivalent Generics (IP0011) Important **changes** to coverage criteria: • Removed Absorica from the policy.

		• 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	Important **changes** to coverage criteria: • 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	Important **changes** to coverage criteria: • Fintepla (fenfluramine oral solution) added an example of a prerequisite option to the Lennox-Gastaut Syndrome requirements. • All instances of *antiepileptic drug(s)* were replaced with *antiseizure medication(s).* • Policy aligned to current template and language standards. • Effective **3/1/2024**.
Cyclosporine Ophthalmic Products (IP0026)	Update	Cyclosporine Ophthalmic Products (IP0026) Important **change** to coverage criteria: • 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	Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Standard, Performance, or Legacy Prescription Drug List (1601) Important **changes** to coverage criteria: • 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	Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Value, Advantage, or Cigna Total Savings Prescription Drug List (1602) Important **changes** to coverage criteria: • 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	Faricimab (IP0542) Important **changes** to coverage criteria:

		• 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	Growth Disorders – Ngenla (IP0577) Important **changes** to coverage criteria: • Added preferred product requirements from the Standard, Value and Legacy formularies. • Policy title changed to *Growth Disorders – Ngenla.* • Policy aligned to current template and language standards. • Effective **3/15/2024**.
Growth Disorders – Skytrofa (IP0375)	Update	Growth Disorders – Skytrofa (IP0375) Important **changes** to coverage criteria: • Removed preferred product requirements from the Standard, Value and Legacy formularies. • Policy title changed to *Growth Disorders – Skytrofa.* • Policy aligned to current template and language standards. • Effective **3/15/2024**.
Inflammatory Conditions – Bimzelx (IP0603)	New	• This is a new policy supporting pharmacy prior authorization of bimekizumab-bkzx subcutaneous injection [Bimzelx]. • Effective date **3/1/2024**.
Immune Globulin (5026)	Update	Important **changes** to coverage criteria: • 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	Important **changes** in coverage criteria: • Updated Conditions Not Covered section. • Updated policy format. • Effective date of **3/15/2024**.
Inotersen (IP0417)	Update	Minor **changes** in coverage criteria/policy: • Updated medical necessity criteria to include dosing information. • Policy aligned to current template/ language standards. • Effective **3/15/2024**.
Lodoco (colchicine capsule) ([IP0595)	New	Important points for **new policy**:

		• 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	Minor changes to coverage criteria: • Updated initiated request to include “out of office provider” within the medical necessity criteria • **Effective 3/15/2024.**
Motixafortide (IP0597)	New	Motixafortide (IP0597) Important points for **new policy**: • This is a new policy supporting pharmacy prior authorization of motixafortide. • Effective date **3/15/2024**.
Multiple Sclerosis – Kesimpta (IP0260)	Update	Kesimpta (IP0260) • Policy title changed to *Multiple Sclerosis – Kesimpta*. • 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	Ocrevus (IP0212) • Policy title changed to *Multiple Sclerosis – Ocrevus*. • 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	Important **changes** to coverage criteria: • 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	Nephrology – Jesduvroq (IP0604) Important points for **new policy**: • This is a new policy supporting pharmacy prior authorization of daprodustat tablets [Jesduvroq]. • Effective date **3/15/2024**.
Nonsteroidal Anti-Inflammatory Drugs - (IP0457)	Update	Nonsteroidal Anti-Inflammatory Drugs (IP0457) Important **change** to coverage criteria: • Added Coxanto 300mg capsules to the policy

		• **Effective 3/15/2024**.
Opfolda (miglustat) capsules (IP0598)	Update	Important points for **new policy**: • This is a new policy supporting pharmacy prior authorization of miglustat capsules [Opfolda]. • Effective date **3/15/2024**.
Pegunigalsidase Alfa (IP0570)	Update	Important **changes** to coverage criteria: • 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	Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) (1803) Important **changes** in coverage criteria: • 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	Important **changes** in coverage criteria: • 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	Important **changes** in coverage criteria/policy • 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	Topical Acne – Non-Retinoid Products (IP0166) Important **changes** in coverage criteria/policy: • Aczone 7.5% gel removed from the policy. • Effective date of **3/15/2024**.
Topical Vitamin D Analogs (IP0361)	Update	Topical Vitamin D Analogs (0361) Important **changes** in coverage criteria/policy: • Taclonex suspension removed from the policy. • Effective date of **3/15/2024**.
Vedolizumab Intravenous (IP0326)	Update	Minor **changes** in coverage criteria/policy: • Policy retitled with addition of “Intravenous” to reflect it applies to the intravenous formulation. • Effective date of **3/1/2024**.

Vosoritide (IP0402)	Update	Important **changes** to coverage criteria: • 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 *Concurrent Treatment with Growth Hormone, Long-Acting Growth Hormone, or Insulin-like Growth Factor-1 Agents* condition not covered statement. • Policy aligned to current template and language standards. • Effective **3/1/2024**.
Carbidopa – (IP0523)	Update	• Effective: 3/15/2024
Carbidopa and Levodopa Enteral Suspension – (IP0303)	Update	• Effective: 3/15/2024
Desmopressin Nasal Spray – (IP0132)	Update	No change in coverage criteria. • Effective: 3/15/2024
Dextromethorphan/Quinidine (Nuedexta) for Individual and Family Plans – (IP0324)	Update	No change in coverage criteria. • Effective: 3/15/2024
Entadfi (finasteride and tadalafil) – (IP0519)	Update	No change in coverage criteria. • Effective: 3/15/2024
Fentanyl Transmucosal Products – (IP0381)	Update	No change in coverage criteria. • Effective: 3/15/2024
Glucagon Products – (IP0039)	Update	No change in coverage criteria. Effective: 3/15/2024
Glucose Test Strips – (IP0272)	Update	No change in coverage criteria. Effective: 3/15/2024
Grass Pollen Sublingual Products – (IP0515)	Update	No change in coverage criteria. • Effective: 3/15/2024
Hydroxyprogesterone Caproate – (IP0370)	Update	No change in coverage criteria. Effective: 3/15/2024

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**

		No policy updates in March 2024
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
		No policy updates in March 2024
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