Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective November 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
Colorectal Cancer Screening and Surveillance - (0148)	Update	**Changes** in coverage criteria: • Added coverage for narrow band imaging in inflammatory bowel diseases to align with professional societies. • Removed confocal fluorescent endomicroscopy from CP because code 88375 came off precert 7/28/23.
Diabetes Equipment and Supplies - (0106)	Update	**Changes** in coverage criteria/policy: • Added coverage for Guardian Sensor 4 and quantity limit for Medtronic transmitter. • Expanded coverage for insulin pumps. • Removed policy statement for home glycated serum protein (GSP) monitor.
Gynecomastia Surgery - (0195)	Update	**Changes** in coverage criteria **Posting 8/15/23, Effective 11/15/2023:** • Limited coverage by adding requirement of preoperative frontal and lateral photographs confirming the presence of at least Grade II gynecomastia.

Minimally Invasive Spine Surgery Procedures and Trigger Point Injections - (0139)	Update	**Changes** in coverage criteria**:** • Expansion of coverage to allow Intracept (Basivertebral nerve ablation) to greater than a single level (to allow up to three adjacent vertebral bodies (i.e., between L3-S1) • Added a not medically necessary statement for Intracept, • Added clarification psych clearance for Intracept criteria must be from someone not involved in the recommended treatment plan
Stem Cell Transplantation: Blood Cancers - (0533)	Update	**Changes** in coverage criteria **Posting 8/15/23, Effective 11/15/2023:** • Restricted coverage for autologous hematopoietic stem cell transplantation (HSCT) for Myelodysplastic Syndromes • Expanded coverage for autologous HSCT for Amyloidosis. • Expanded coverage for non-myeloablative allogeneic HSCT in Non-Hodgkin Lymphoma (NHL) in children. • Expanded coverage for allogeneic HSCT in Acute Myeloid Leukemia (AML) to include intermediate risk individuals. • Clarification: Update the sources of 'risk' definitions for several cancer types to current industry standard
Cochlear and Auditory Brainstem Implants 0190	Update	No change in coverage.

Dermabrasion and Chemical Peels 0505	Update	No change in coverage
		Please note:
		• Content from CP 0031 Phototherapy, Photochemotherapy, and Excimer Laser Therapy for Dermatologic Conditions was combined with CP 0505 Dermabrasion and Chemical Peels.
		  ○ Title change to reflect combined scope.
		  ○ CP #0031 has been retired.
		  ○ No change to policy statements.
		• CP #0505 will be retained.

Discography 039	Update	No change in coverage.

Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds – 0004	Update	No change in coverage.
Gastric Pacing Gastric Electrical Stimulation (GES) – 0103	Update	No change in coverage.
Pressure Reducing Surfaces 0042	Update	No change in coverage. Please note: • Content from CP 0273 Hospital Beds and Accessories was combined with CP 0042 Pressure Reducing Surfaces. • Title changed to “Hospital Beds and Pressure Reducing Support Surfaces” to reflect combined scope
Transcatheter Closure of Cardiovascular Defects 0011	Update	No change in coverage.
Transplantation Donor Charges 0132	Update	No change in coverage.
Varicose Vein Treatments	Update	No change in coverage.
Phototherapy, Photochemotherapy, and Excimer Laser Therapy for Dermatologic Conditions 0031	Retired	Content combined with CP 0505 - Dermabrasion and Chemical Peels

Hospital Beds and Accessories 0273	Retired	Retired effective 11/12/2023 • Coverage policy consolidated with CP 0042 Pressure Reducing Surfaces
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Biofeedback CPG 294	Update	No change in coverage.
Physical Performance Test or Measurement CPG 295	Update	No change in coverage.
Electric Stimulation for Pain, Swelling and Function in a Clinic Setting - (CPG272)	Update	**Changes** in coverage criteria: • Minor change: content from CP 0160 Electrical Stimulation Therapy and Devices in a Home Setting for transcutaneous electrical modulation pain reprocessing (TEMPR) was moved into this CPG since this modality is used int eh clinic setting rather than the home setting. No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded High-tech Radiology (HTR) / Cardiology Imaging Guidelines	Update	No change in coverage. Posting and Effective date **November 3, 2023**: Cigna-eviCore Cobranded Guidelines Homepage Updated informational document: • Preface to the Imaging Guidelines New informational documents:

		• Cigna-eviCore Co-branded Guideline Definitions • Medicaid and Medicare Hierarchy and Application
Cobranded High-tech Radiology (HTR) / Cardiology Imaging Guidelines	Update	Important **changes** in coverage criteria. Posting **November 3, 2023**, Effective date **February 1, 2024**: Cigna-eviCore Cobranded Guidelines Homepage **The updated guidelines included:** Informational document: • Preface to the Imaging Guidelines Five guidelines had an expansion of coverage: • Abdomen Imaging Guidelines • Pediatric Abdomen Imaging Guidelines • Pediatric Cardiac Imaging Guidelines • Pediatric Chest Imaging Guidelines • Pediatric Peripheral Vascular Disease Imaging Guidelines One guideline had adverse changes in coverage: • Spine Imaging Guidelines 15 guidelines had positive and adverse changes in coverage: • Breast Imaging Guidelines • Cardiac Imaging Guidelines • Chest Imaging Guidelines • Head Imaging Guidelines • Musculoskeletal Imaging Guidelines • Neck Imaging Guidelines • Oncology Imaging Guidelines • Pelvis Imaging Guidelines • Peripheral Nerve Disorders Imaging Guidelines • Peripheral Vascular Disease Imaging Guidelines • Pediatric Head Imaging Guidelines • Pediatric Musculoskeletal Imaging Guidelines • Pediatric Neck Imaging Guidelines • Pediatric Oncology Imaging Guidelines • Pediatric Spine Imaging Guidelines

		The remaining two guidelines had no changes in coverage: • Pediatric Pelvis Imaging Guidelines • Pediatric Peripheral Nerve Disorders Imaging Guidelines
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Preventive Care Services - (A004)	Update	• Added RSV as routine preventive immunization as recommended by the Advisory Committee of Immunization Practices/Centers for Disease Control and Prevention • Added cabotegravir injection (Apretude) as a preventive service for Pre-exposure Pprophylaxis (PrEP) pas prevention of human immunodeficiency virus (HIV) infection as recommended by the US Preventive Services Task Force.
Drug & Biologic Coverage Policy	**New, Updated, or Retired?**	**Comments** **All policy changes effective October 1, 2023, unless otherwise stated**
Aflibercept – (IP0540)	Update	Important **changes** in coverage criteria: • Eylea HD added to the policy. • Policy aligned to current template and language standards • Effective date **11/1/2023**
Armodafinil / Modafinil - (IP0075)	Update	Important **changes** in coverage criteria: • Updated the sleep testing requirements. • Policy aligned to current template and language standards • Effective date **11/15/2023**
Beremagene geperpavec-svdt – (IP0572)	Update	Important **changes** in coverage criteria/policy: • Revised reauthorization criteria • Effective **11/1/2023**

Brands with Bioequivalent Generics - (IP0011)	Update	**Important changes** in coverage criteria/policy: • Latuda, Pentasa 500 mg, Suprep, Taytulla and Toviaz for all IFP formularies added to the policy, effective 1/1/2024. • Policy effective date **11/1/2023**.
COVID-19 Drug and Biologic Therapeutics - (2016)	Update	**Updates made**
Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Standard, Performance, or Legacy Prescription Drug List - (1601)	Update	**Important changes** in coverage criteria/policy: • Vowst, Meclizine 50mg, and Atropine 1%ophthalmic preservative-free added to the policy. • Effective date **11/15/2023**.
Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Value, Advantage, or Cigna Total Savings Prescription Drug List - (1602)	Update	**Important changes** in coverage criteria/policy: • Vowst, Meclizine 50mg, and Atropine 1%ophthalmic preservative-free added to the policy. • Effective date **11/15/2023**.
Lisdexamfetamine for Individual and Family Plans - (IP0584)	New	This is a **new** coverage policy. • The policy supports medical necessity review for lisdexamfetamine products for Individual and Family Plans. • Effective date **11/1/2023**.
Oxybate - IP0103)	Update	Important **change** in coverage criteria: • Lumryz added to the policy. • Updated the Cataplexy sleep testing requirements. • Expanded the cataplexy sequencing of care options to include products that are recommended for excessive daytime sleepiness.

		• Added Lumryz to the concomitant use of Xyrem and/or Xywav statement in the Conditions Not Covered section. • Policy aligned to current template and language standards • Effective date **11/15/2023**
Pitolisant - (IP0292)	Update	Important **changes** in coverage criteria: • Updated the Cataplexy sleep testing requirements. • Expanded the cataplexy sequencing of care options to include products that are recommended for excessive daytime sleepiness. • Added dextroamphetamine, dexmethylphenidate, methylphenidate as additional sequence of care options for Narcolepsy Type 2 • Policy aligned to current template and language standards • Effective date **11/15/2023**
Pulmonary Hypertension (PH) Therapy - (6121)	Update	Minor **changes** in coverage criteria/policy: • Liqrev added to the policy • Updated experimental, investigational, or unproven section to reflect that Adempas is currently the only product indicated and covered for chronic thromboembolic pulmonary hypertension. • Effective date **11/1/2023**.
Pegunigalsidase Alfa - (IP0570)	Update	**Important changes** in coverage criteria/policy: • Added a preferred product prerequisite step through Fabrazyme. • Effective date **11/15/2023**.
Phenylbutyrate - (IP0169)	Update	Important **changes** in coverage criteria: • Olpruva added to the policy. • Pheburane medical necessity requirements aligned to the other products in the policy. • Pheburane preferred product requirements updated responsive to updated formulary exception criteria. • Policy aligned to current template and language standards. • Effective **11/15/2023**.
Progesterone – Employer Group Plans - (IP0548)	Update	Important **changes** in coverage criteria: • Removed Crinone 8% from the policy responsive to a shortage of Endometrin. • Policy aligned to current template and language standards • Effective date **11/1/2023**

Solriamfetol - (IP0102)	Update	Important **changes** in coverage criteria: • Updated the sleep testing requirements. • Added dextroamphetamine, dexmethylphenidate, methylphenidate as additional sequence of care options for the treatment of excessive daytime sleepiness associated with narcolepsy • Policy aligned to current template and language standards • Effective date **11/15/2023**
Sotagliflozin - (IP0582)	New	This is a **new** coverage policy. • This is a new policy supporting pharmacy prior authorization of sotagliflozin [Inpefa]. • Effective date **11/15/2023**.
Tascenso ODT - (IP0514)	Update	No **changes** in coverage criteria: • Updated dates, instructions for use, background, references, and copyright statement only. • Effective date: **11/15/2023**.
Tofersen – (IP0567)	New	This is a **new** coverage policy. • The policy supports medical necessity review for tofersen intrathecal injection (Qalsody). • Effective date **11/15/2023**.
Trofinetide - (IP0578)	New	This is a **new** coverage policy. • This is a new policy supporting pharmacy prior authorization of trofinetide oral solution [Daybue]. • Effective date **11/1/2023**.
Vigabatrin – (IP0049)	Update	Important **change** in coverage criteria: • Added the product, Vigadrone (vigabatrin), to the criteria • Effective date **11/1/2023**
Isavuconazonium (Oral)- (IP0305)	Update	Important **changes** in coverage criteria: • Added expanded indication for Cresemba to include prophylaxis against systemic fungal infection in an individual with Graft-versus-Host based on NCCN guidelines & updates made to the P&T approved ESI policy.

		• Indication for prophylaxis against systemic fungal Infection in an individual at risk of Neutropenia was revised to prophylaxis against systemic fungal Infection in an individual with Cancer and Neutropenia to align with NCCN language. • Updated initial approval and reauthorization approval duration to include new indication. • SME consulted and in agreement with draft • Approved through E-vote • Effective date **11/1/2023**.
Posaconazole PowderMix for Delayed-Release Oral Suspension for Individual and Family Plans - (IP0536)	Update	Important **changes** in coverage criteria: • Added expanded indication for Noxafil PowderMix Kit to include prophylaxis against systemic fungal infection in an individual with Graft-versus-Host based on NCCN guidelines & updates made to the P&T approved ESI policy. • Indication for prophylaxis against systemic fungal Infection in an individual at risk of Neutropenia was revised to prophylaxis against systemic fungal Infection in an individual with Cancer and Neutropenia to align with NCCN language. • Updated authorization duration to include new indication. • SME consulted and in agreement with draft • Approved through E-vote • Effective date **11/1/2023**.
Voriconazole (Oral) - (IP0306)	Update	Important **changes** in coverage criteria: • Added expanded indication for voriconazole to include prophylaxis against systemic fungal infection in an individual with Graft-versus-Host based on NCCN guidelines & updates made to the P&T approved ESI policy. • Indication for prophylaxis against systemic fungal Infection in an individual at risk of Neutropenia was revised to prophylaxis against systemic fungal Infection in an individual with Cancer and Neutropenia to align with NCCN language. • SME consulted and in agreement with draft • Approved through E-vote Effective date **11/1/2023**.
Long-Acting Muscarinic Antagonists (Nebulized) - (IP0089)	Update	Minor **changes** in coverage criteria • Removed Lonhala from criteria due to market withdrawal • Removed the Lonhala Magnair preferred product step requirement for Yupelri. • Effective **11/1/2023**

Pozelimab-bbfg - (IP0587)	News	This is a **new** coverage policy. • The policy supports medical precertification of pozelimab-bbfg (Veopoz). • Effective date: **11/3/2023**
Zavegepant - (IP0573)	New	This is a **new** coverage policy. • This is a new policy supporting pharmacy prior authorization of zavegepant [Zavzpret]. • Effective date **11/15/2023**.
Bimatoprost Ophthalmic Implants – (IP0218)	Update	No change in coverage.
Brexanolone – (IP0270)	Update	No change in coverage policy criteria. • Effective date: **11/15/2023**
Colchicine Oral Solution – (IP0268)	Update	No change in coverage.
Eliglustat – (IP0441)	Update	No change in coverage.
Epoetin Alfa Products – (IP0296)	Update	No change in coverage policy criteria. • Effective date: **11/15/2023**

Ganaxolone – (IP0508)	Update	No change in coverage policy criteria. Effective date: **11/15/2023**
Compounded Medications – (IP0251)	Update	No change in coverage.
HMG-CoA Reductase Inhibitors (Statins) and Combination Products – (IP0064)	Update	No change in coverage policy criteria. Effective date: **11/15/2023**
Iron Chelating Agents (Oral) – IP0271	Update	No change in coverage policy criteria.
Ivabradine – (IP0286)	Update	No change in coverage policy criteria. Effective date: **11/15/2023**
Nintedanib – (IP0312)	Update	No change in coverage policy criteria. Effective date: **11/15/2023**
Progesterone (Endometrin) for Individual and Family Plans – (IP0091)	Update	No change in coverage policy criteria.
Romosozumab – (IP0179)	Update	No change in coverage policy criteria.

Topical Doxepin Cream – (IP0207)	Update	No change in coverage policy criteria.
Vaginal Estrogen Products and Ospemifine – (IP0216)	Update	No change in coverage policy criteria. Effective date: **11/15/2023**
Weight Loss – Liraglutide (Saxenda) - IP0206	Update	No change in coverage.
Weight Loss – Semaglutide (Wegovy) - IP0521	Update	No change in coverage.
Attention Deficit Hyperactivity Disorder Non-Stimulant Medications - IP0217	Update	No change in coverage.
Tetracycline Antibiotics - IP0396	Update	No change in coverage.
Topical Antivirals - IP0276	Update	No change in coverage.
HIV Products – (P0050)	Update	No change in coverage.
Pegcetacoplan Subcutaneous Injection – (IP0194)	Update	No change in coverage.
Erenumab – (IP0503)	Update	No change in coverage.
Fremanezumab – (IP0504)	Update	No change in coverage.
Galcanezumab – (IP0505)	Update	No change in coverage.
Eptinezumab – (IP0506)	Update	No change in coverage.
Tolvaptan (Jynarque®) – (IP0287)	Update	No change in coverage.
Risdiplam – (IP0063)	Update	No change in coverage.

Fostemsavir – (IP0083)	Update	No change in coverage.
Topical Corticosteroids – (IP0281)	Update	No change in coverage.
Lasmiditan – (IP0114)	Update	No change in coverage.
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 in November 2023
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Anesthesia Professional Services - (R39)	Update	
Global Maternity/Obstetric Package - (R11)	Update	
Professional Bundled Services - (R44)	Update	
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		No updates in November 2023

ClaimsXten Documents*	New, Updated, or Retired?	Comments
		No updates in November 2023