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June 2022

CLINICAL LABORATORY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Pathogen Panel Testing	045	**New medical policy** describing: **New investigational indications** for sepsis panel testing, bloodstream infection panel, panel testing for general screening of microorganisms; and wound panel testing. **Ongoing medically necessary indications** for nucleic acid testing using amplified probe technique (with or without quantification of viral load) for the following microorganisms: Babesiosis; Ehrlichiosis,	September 1, 2022	Commercial Medicare	No action required.

		unspecified; Tick-borne rickettsiosis, unspecified; transferred from MP #555 Identification of Microorganisms Using Nucleic Acid Probes. **Ongoing investigational indications** for urinary tract infection panel. Urinary tract infection panel was transferred from MP #555 Identification of Microorganisms Using Nucleic Acid Probes. **CPT codes 87154 and 0140U will not be covered on or after September 1, 2022.** 87154 Culture, typing; identification of blood pathogen and resistance typing, when performed, by nucleic acid (DNA or RNA) probe, multiplexed amplified probe technique including multiplex reverse transcription, when performed, per culture or isolate, 6 or more targets 0140U Infectious disease (fungi), fungal pathogen identification, DNA (15 fungal targets), blood culture, amplified probe technique, each target reported as detected or not detected			
Identification of Micro-organisms Using Nucleic Acid Probes	555	**Policy clarified.** **Ongoing medically necessary** indications for nucleic acid testing using amplified probe technique (with or without quantification of viral load) for the	September 1, 2022	Commercial Medicare	No action required.

		following microorganisms: Babesiosis; Ehrlichiosis, unspecified; Tick-borne rickettsiosis, unspecified; transferred to MP #045 Pathogen Panel Testing. **Ongoing investigational indications** for urinary tract infection panel. Urinary tract infection panel; transferred to MP #045 Pathogen Panel Testing.			

HEMATOLOGY AND ONCOLOGY – GENETIC TESTING

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Expanded Molecular Panel Testing of Cancers to Identify Targeted Therapies	790	**Policy retired**. Effective September 4, 2022, we will be using AIM's Clinical Appropriateness Guidelines for Molecular Testing of Solid and Hematologic Tumors and Malignancies. Providers may access and download a copy of AIM's current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com	September 4, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

INFERTILITY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Uterus Transplan-tation for Absolute Uterine Factor Infertility	060	**New policy** describing **i**nvestigational statement on uterus transplantation for absolute uterine factor infertility.	September 1, 2022	Commercial Medicare	No action required.

ORTHOPEDIC REHABILITATION MEDICINE

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions	111	**Policy clarified.** The word "focal" was added under the Osteochondral Fresh Allografting section.	May 19, 2022	Commercial Medicare	No action required.
Medical Technology Assessment Non-Covered Services List	400	**Policy clarified** to include ZetrOZ™ ZTX Ultrasonic Diathermy Low Intensity Therapeutic Ultrasound Device.	May 3, 2022	Commercial Medicare	No action required.

PULMONOLOGY OTOLARYNGOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome	130	Hypoglossal nerve stimulation for obstructive sleep apnea (OSA) **is being retired** from policy 130. Effective September 11, 2022, we will be using AIM's Clinical Appropriateness Guidelines for Sleep Disorder Management. Providers may access and download a copy of AIM's current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com	September 11, 2022	Commercial Medicare	Prior authorization **required** through AIM Specialty Health.

GENETIC TESTING FOR SINGLE GENE AND MULTIFACTORIAL CONDITIONS

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Genetic Testing. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED

Thrombophilia Testing	Testing for common variants in factor V (*F5*) and prothrombin (*F2*) is medically necessary for any of the following indications (*for additional genes related to thrombophilia see germline genetic testing criteria above*):
	• Pregnant woman who has a personal history of a venous
	• thromboembolism (VTE)
	• Individual who has a first-degree relative with *F5* or *F2* thrombophilia and one of the following:
	  ○ Surgery is planned
	  ○ Patient is pregnant
	  ○ Females considering estrogen contraception or hormone replacement therapy if results would influence decision to use estrogen
	
	Explanation of Change
	The criterion for an individual with an unprovoked VTE was removed. The revision is considered a restriction in coverage. There are no validated or widely accepted consensus guidelines to support use of thrombophilia molecular testing in this scenario (Freites and Naymagon 2021). Our current criteria are more of an amalgamation of several mostly older papers than direct guideline recommendations (barring ACOG recommendations for pregnancy and family history indications). The 2020 American Society of Hematology recommendations, which are notably silent on the use of molecular testing to guide treatment decision-making, suggest indefinite antithrombotic therapy over stopping
		September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	anticoagulation for patients with unprovoked DVT and/or PE following primary treatment (Ortel et al. 2020). Thrombophilia molecular testing would therefore no longer alter the treatment plan in this scenario.			
Multifactorial (Non-Mendelian) Genetic Testing	Genetic testing such as gene expression classifiers or polygenic risk scores are considered medically necessary if all of the following are met: **Explanation of Change** • Revision is a clarification and does not represent any change in coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

GENETIC TESTING FOR HEREDITARY CANCER SUSCEPTIBILITY

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Appropriate Use Criteria	Genetic testing for hereditary cancer susceptibility, when the condition is not listed below, is medically necessary when all of the following criteria are met: • Results are expected to lead to a change in medical management • National Comprehensive Cancer Network® (NCCN®) Clinical Practice Guidelines in Oncology (NCCN Guidelines®) include category 1 or 2A, and/or other published management recommendations for an individual who tests positive for the condition/syndrome-specific genes for which testing is being requested • The individual is the most appropriate person to test, or the most appropriate family member is unavailable for testing • An individual's personal and/or family history meets specific testing criteria suggestive of a hereditary cancer syndrome based on best practice guidelines • Testing method is as targeted	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	as possible (e.g., single gene, known familial pathogenic or likely pathogenic (P/LP) variant, etc.) • Testing methodology* has been clinically validated and is the most accurate method unless technical limitations (e.g., poor sample quality) necessitate the need for alternate testing strategies **Explanation of Change** Revisions include clarifications to streamline text and align with additional changes made to the guideline (see below) with no impact on coverage stance.			
Germline Testing Following Identification of a Somatic Variant	After a somatic variant is identified in a solid tumor or hematologic malignancy, follow-up germline testing for that variant is medically necessary when the following criteria are met **Explanation of Change** The revision is a clarification with no impact on coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.
National Compre-hensive Cancer Network ® (NCCN® Criteria)	Delete reference to the Neuroendocrine and Adrenal Tumors *and* Gastric Cancer NCCNⓇ guidelines. This section now only lists the NCCNⓇ Genetic/Familial High-Risk Colorectal Cancer v1.2021 *and* the NCCNⓇ Genetic/Familial High-Risk Breast, Ovarian and Pancreatic guidelines v2.2022. **Explanation of Change** • The NCCNⓇ Neuroendocrine and Adrenal Tumors guidelines and Gastric Cancer guidelines have evolved and become much broader in scope. Claims for genetic testing for Hereditary Paraganglioma-Pheochromocytoma syndromes, von Hippel-Lindau and hereditary diffuse gastric cancer can be adjudicated using our appropriate use criteria. This revision does not	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	impact coverage stance. • The NCCN® Genetic/Familial High-Risk Breast, Ovarian and Pancreatic guidelines were updated on March 9, 2022 to v2.2022. Revisions were only made to the discussion section which do not impact current coverage criteria.			
Hereditary Paragan-Glioma Pheochromo-cytoma Syndromes and von Hippel-Lindau	**Hereditary Paraganglioma-Pheochromocytoma Syndromes** *Entire section is deleted.* **von Hippel-Lindau** *Entire section is deleted.* **Explanation of Change** Claims for genetic testing for Hereditary Paraganglioma-Pheochromocytoma syndromes and von Hippel-Lindau can be adjudicated using the appropriate use criteria. Therefore, these hereditary syndromes do not differ from any others and do not need to be called out in this guideline. This revision does not impact coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

GENETIC TESTING FOR REPRODUCTIVE CARRIER SCREENING AND PRENATAL DIAGNOSIS

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Spinal Muscular Atrophy	**Spinal Muscular Atrophy** Spinal muscular atrophy (SMA) carrier screening by SMN1 dosage/deletion analysis (81329) is medically necessary when testing has not been previously performed. **Explanation of Change** The family history bullet is being deleted; it is a recommendation and not an enforceable coverage criterion.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

MOLECULAR TESTING OF SOLID AND HEMATOLOGIC TUMORS AND MALIGNANCIES

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Scope	This document addresses	September	Commercial	Prior

	molecular testing and gene expression profiling of solid and hematologic tumors and malignancies (including cell free tumor DNA/circulating tumor cells/liquid biopsy testing) for the purpose of screening/surveillance, diagnosis, selecting therapeutic agents and predicting risk, prognosis, monitoring, or recurrence of cancer… **Explanation of Change** Revision is a clarification with no impact on current coverage stance.	4, 2022		authorization **still required** through AIM Specialty Health.
General Coverage Criteria	Somatic tumor testing is medically necessary when all of the following criteria are met: (Please see below for conditions with separate specific criteria) • The clinical benefit of testing outweighs the potential risk of psychological or medical harm to the individual being tested. • The test is as targeted as possible for the clinical situation (e.g., common variants, genes related to phenotype) **Explanation of Change** The revision creates more consistency in General Coverage Criteria across the GTUM guidelines and does not represent a change in coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.
Conditions for Which Testing May be Medically Necessary	Table 1. Molecular studies are medically necessary for the indications listed below when the above General Coverage Criteria or FDA Companion Diagnostics Coverage Criteria are met (list is not all inclusive) (*see criteria below for chromosomal microarray, cell-free, and minimal residual disease testing*). **Molecular Studies** **Hematologic/Oncologic Testing** **Targeted Genomic Sequencing Panels or Single Gene Tests** • Acute Lymphoblastic	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	Leukemia • Acute Myelogenous Leukemia • B-Cell Lymphoma • Chronic Lymphocytic Leukemia • Chronic Myeloid Leukemia • Myelodysplastic Syndrome • Essential Thrombocythemia or Thrombocytosis* • Polycythemia Vera* • Primary Myelofibrosis, Pre-PMF, suspicion for PMF* • T-Cell Lymphoma, Peripheral **Solid Organ Tumor Testing (for biomarker detection to aid in therapeutic decision-making only)** **Targeted Genomic Sequencing Panels** • Cholangiocarcinoma o FDA CDx tests: FoundationOne® CDx or Oncomine Dx Target Test • Colorectal Cancer, Metastatic/Stage IV • Endometrial Cancer • Gastrointestinal Stromal Tumors o Prostate Cancer, Metastatic Castration-Resistant o FDA CDx tests: FoundationOne® CDx • Non-Small Cell Lung Cancer, (Stage IIIB and above) o FDA CDx tests: FoundationOne® CDx or Oncomine Dx Target Test • Tumor Agnostic/All Applicable Solid Tumors o FDA CDx tests: FoundationOne® CDx for tumor mutational burden (TMB) only **Targeted Single Gene Testing** • Breast Cancer (PIK3CA) • Cutaneous Melanoma (BRAF, KIT) • Non-Small Cell Lung Cancer, Resected Stage IB-IIIA (EGFR) • Ovarian, Fallopian Tube, or Primary Peritoneal Cancer			

	(BRCA1, BRCA2) • Thyroid Cancer (BRAF, RET fusions) • Tumor Agnostic (MSI, NTRK) *2016 WHO Criteria must be met The entire table is new - for readability **Explanation of Change** Revisions to this table are primarily formatting for clarity/transparency and do not impact current coverage stance. FoundationOne® is considered medically necessary for Non-Small Cell Lung Cancer (Stage IIIB and above) and targeted multigene panels are now considered medically necessary for endometrial cancer.			
The following tests are not medically necessary	• Whole exome tumor sequencing for any indication (including other genome-wide interrogation strategies, e.g. transcriptome) • Whole genome tumor sequencing for any indication (including other genome-wide interrogation strategies, e.g. transcriptome) **Explanation of Change** This revision is a clarification for transparency in order to address an evolving clinical space and does not represent a change in coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.
Breast Cancer Gene Expression Classifiers	AND all of the following criteria are met: • Patient has undergone surgery and full pathological staging prior to Testing MammaPrint® (81521) is medically necessary to assess the risk for recurrence in an individual when all of the following criteria are met: **Explanation of Change** "Prior to testing" was added to this criterion for all breast cancer GECs listed in the guideline as a point of	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	clarification and does not represent a change in current coverage stance. The CPT code for the microarray platform of MammaPrint® was added in order to convey that we intend to only cover this version and not the next generation sequencing platform now available (*See the CPT Code section of this guideline below for additional detail.*)			

Cell-Free Testing	• Locally Advanced or Metastatic Non-Small Cell Lung Cancer (NSCLC)
	  ○ Initial Biomarker Determination
	  ▪ FDA approved companion diagnostic tests (i.e., cobas EGFR Mutation Test v2, FoundationOne® Liquid CDx, or Guardant360® CDx) or a targeted multi-gene panel (i.e., ctDx Lung™ or Target Selector™ NGS Lung Panel) are medically necessary when tissue-based testing cannot be performed, e.g., insufficient tissue
	
	Explanation of Change
	ctDx Lung™ and Target Selector™ NGS Lung Panel are listed as the only approvable *targeted* multi-gene panels for initial biomarker determination in locally advanced or metastatic NSCLC. The Target Selector™ NGS Lung Panel has a similar composition/utility to ctDx Lung™, and the "i.e." is now being used to provide clarification and increased transparency regarding the tests we currently consider medically necessary.
		September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

Chromo-somal Microarray Analysis	Chromosomal microarray analysis is medically necessary in any of the following clinical scenarios when general coverage criteria above are met: • To aid diagnosis when part of the initial work-up involves cytogenetic (karyotype) and/or	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	FISH analyses and testing was uninformative or could not be performed • For methylation analysis (e.g., Brain/Central Nervous System cancers) **Explanation of Change** This section is necessary following revisions to Table 1 and does not represent a change in current coverage stance.			
Minimal Residual Disease (MRD) Monitoring	**For hematological cancers:** NGS immunosequencing for MRD clone identification is covered when the following criteria is met: • There is a confirmed diagnosis of B-cell acute lymphoblastic leukemia which is Philadelphia chromosome (BCR-ABL) negative • Testing is performed on bone marrow NGS minimal residual disease (MRD) testing for Philadelphia chromosome (BCR-ABL) negative B-cell ALL is covered when all of the following criteria are met: • Immunosequencing at the time of diagnosis identified at least one clone for MRD tracking • Complete cytologic remission is achieved • Testing is performed on bone marrow Targeted testing with prospective evidence of clinical utility for the tumor type and disease characteristics is medically necessary. **For solid tumors:** Molecular testing for MRD and/or disease monitoring is not medically necessary. **Explanation of Change** Revisions are clarifications and do not impact current coverage stance	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.
Cancer Screening	**Prostate Cancer (symptomatic cancer screening)** PCA3 (81313) or ConfirmMDx (81551) is medically necessary for	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty

	men ≥50 years with prior negative biopsy when repeat biopsy is being considered after PSA testing (within 6 months of this test request) reveals a persistently elevated PSA of 3.1-10.0 ng/mL. **Indeterminate Thyroid Nodules** Targeted multi-gene panels, Afirma® Genomic Sequence Classifier, ThyGeNEXT®/ThyraMIR™, or ThyroSeq® v3.0 are medically necessary for Bethesda Category III (AUS/FLUS) indeterminate thyroid nodules.* Targeted multi-gene panels,ThyGeNEXT®/ThyraMIR™, or ThyroSeq® v3.0 are medically necessary for Bethesda Category IV (FN/SFN) indeterminate thyroid nodules.* *FNA samples with Hurthle cell predominance are excluded from coverage. **Explanation of Change** • Timing of PSA testing in relation to the PCA3 or ConfirmMDx test was added for clarification. • Criteria for gene expression classifier testing for ITNs was moved from Table 1 to this section for clarity/improved organization.			Health.

GENETIC TESTING FOR HEREDITARY CARDIAC DISEASE

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED

Appropriate Use Criteria	Genetic testing is medically necessary when all of the following criteria are met:
	• The test is clinically reasonable:
	  ○ Symptoms and presentation are consistent with the suspected condition
	  ○ Results are expected to lead to a change in medical management
		September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	○ If testing guidelines* exist, the clinical scenario falls within those recommendations ○ The test is customarily recognized as clinically and technically appropriate in the diagnosis and/or treatment of the suspected condition • The clinical benefit of testing outweighs the potential risk of psychological or medical harm to the individual being tested • The test is as targeted as possible for the clinical situation (e.g., familial pathogenic or likely pathogenic (P/LP) variant testing, common variants, genes related to phenotype) • The clinical presentation warrants testing of multiple genes when a multi-gene panel is requested • The testing methodology has been clinically validated and is the most accurate method unless technical limitations (e.g., poor sample quality) necessitate the need for alternate testing strategies **See the Professional Society Guidelines section.* **Genetic Testing of Affected Individuals** In addition to the above appropriate use criteria, confirmatory or diagnostic genetic testing for hereditary arrhythmias (i.e., Brugada syndrome (BrS), catecholaminergic polymorphic ventricular tachycardia (CPVT), Long QT syndrome (LQTS)) and cardiomyopathies (i.e., arrhythmogenic right ventricular cardiomyopathy (ARVC), dilated cardiomyopathy (DCM), hypertrophic cardiomyopathy (HCM), left ventricular non-compaction cardiomyopathy (LVNC), restrictive cardiomyopathy (RCM)) is medically necessary when all of the following criteria are met: • The individual has a clinical			

	diagnosis of a hereditary cardiomyopathy or arrhythmia **OR** the individual has a suspected syndromic, metabolic or neuromuscular form of a hereditary cardiomyopathy or arrhythmia • The requested testing is as targeted as possible to a specific subset of genes with a demonstrated gene/disease association with the individual's diagnosed or suspected condition Single-site genetic testing of asymptomatic individuals for a known familial deleterious or suspected deleterious pathogenic or likely pathogenic (P/LP) variant is medically necessary. **Genetic Testing in the Evaluation of Unexplained Sudden Cardiac Arrest** Cardiac genetic testing of an individual with an unexplained sudden cardiac arrest is medically necessary in the following circumstances: • Comprehensive clinical cardiac evaluation (heart rhythm monitoring, cardiac imaging, provocative testing, etc.) has not confirmed a diagnosis of a specific underlying heritable cardiac condition (e.g., ARVC, HCM, LQTS, etc.) • Non-genetic causes of sudden cardiac arrest have been ruled out (toxicology, ischemic coronary artery disease, etc.) **Post-Mortem Genetic Testing** Post-mortem cardiac genetic testing of an individual with sudden unexplained death, whose first degree family member is a covered member, is medically necessary in the following circumstances: • When the autopsy reveals evidence for a *specific* underlying heritable cardiac condition (e.g., ARVC, HCM, DCM, RCM) AND all of the following criteria are met: a. The corresponding targeted			

	testing is ordered (e.g., HCM panel testing in cases where autopsy revealed evidence for HCM) • In 'autopsy negative' cases when cause of death remains unknown after completion of autopsy and toxicology testing and one of the following criteria are met: a. documented arrhythmic death is suggestive of an arrhythmia syndrome b. deceased individual is less than 40 years old at time of death c. sudden cardiac death event is preceded by specific triggers associated with familial arrhythmia syndromes **Tests Not Clinically Appropriate** • Broad "multi-condition" panel testing (e.g., pan-cardio panel, arrhythmia panel) is not medically necessary for routine cardiac genetic testing • Genetic testing for short QT syndrome and atrial fibrillation is not medically necessary • Genetic testing for isolated left ventricular noncompaction cardiomyopathy (LVNC) is not medically necessary **Explanation of Change** This GTUM is undergoing significant global revisions and will now include general criteria for genetic testing of affected individuals, genetic testing in the evaluation of sudden cardiac arrest and genetic testing in the post-mortem setting. The National Institute of Health Clinical Genomic Resources (ClinGen) recently completed an evidence-based appraisal of genes associated with hereditary cardiac disease, and the resulting curated lists of genes associated with these conditions are much more restrictive than gene content found on most current commercially available genetic testing panels. The GTUM will not include granular detail on panel size in the criteria, but case adjudication using this new GTUM will take into account ClinGen curation (*which will be described in*			

	the GTUM Background) as well as considering commercial availability.			

PHARMACOGENOMIC TESTING

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED

Scope	Pharmacogenomic testing broadly describes how one's genome, or multiple genes, can influence drug response while more targeted pharmacogenetic testing describes genotyping a specific gene to predict response to certain medications. This document addresses pharmacogenomic testing for the purpose of informing medication selection, dosage, and risk of adverse side effects. This guideline does not address tumor testing (see GTUM Guideline: Molecular Testing of Solid and Hematologic Tumors and Malignancies), germline testing (see GTUM Guideline: Genetic Testing for Hereditary Cancer Susceptibility) or gene expression classifiers as well as genetic testing to generate polygenic risk scores (see GTUM Guideline: Single-Gene and Pharmacogenetic testing of common variants associated with drug metabolism is medically necessary when all of the following criteria are met:
	• All of the following:
	  ○ The individual is a candidate for a targeted drug therapy associated with a specific genotype
	  ○ The results of the pharmacogenetic test will directly impact clinical decision-making and clinical outcome for the individual
	  ○ Published, peer-reviewed studies have proven that identifying the specific genetic variant improves clinical outcomes
	• Identification of the genetic variant is required or recommended in a specific
		September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

	population prior to initiating therapy with the target drug as noted by the U.S. Food and Drug Administration (FDA)-approved prescribing label • The clinical benefit of testing outweighs the potential risk of psychological or medical harm to the individual being tested • The test is as targeted as possible for the clinical situation (e.g., genes related to phenotype) Multi-gene pharmacogenomic genotyping assays in which each included target does not meet the above criteria are not medically necessary. **Explanation of Change** The revision is a clarification for consistency across GTUMs and does not change current coverage stance.			

CHROMOSOMAL MICROARRAY ANALYSIS, WHOLE EXOME AND WHOLE GENOME SEQUENCING

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Whole Exome Sequencing	**Phenotype Suspicious for a Genetic Diagnosis** • Individual with confirmed congenital bilateral sensorineural hearing loss of unknown etiology **Explanation of Change** Revision is a clarification that reflects how claims are currently being adjudicated and does not represent a change in coverage stance.	September 4, 2022	Commercial	Prior authorization **still required** through AIM Specialty Health.

RADIOLOGY - EXTREMITY IMAGING

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Radiology. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED

General Information/ Overview	**General prerequisites for extremity imaging: Conservative management** ○ Exception to specified duration of conservative management may be made in unusual circumstances (for example, worsening of symptoms during a course of conservative management) when clearly documented in the medical record, or when the duration period is substantiated by documentation of serial evaluation **Explanation of change** Allow exception to specified durations of conservative management in rare cases	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Inflammatory Conditions	**Plantar fasciitis and fibromatosis** Advanced imaging is considered medically necessary in EITHER of the following scenarios: ○ Evaluation for plantar fasciitis following a failure of at least 6 months of treatment, including at least two of the following: mechanical de-weighting, foot orthosis, night splints, taping, or manual therapy **Explanation of change** Removed phrase “conservative management” because the full definition of “conservative management” in this document does not apply here	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Trauma	**Fracture** Advanced imaging is considered medically necessary in ANY of the following scenarios: • Evaluation of supracondylar, intra-articular, or Salter-Harris (growth plate) fractures when radiographs are insufficient for management • To assess fracture healing for delayed union or nonunion when radiographs are nondiagnostic	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	IMAGING STUDY • MRI upper extremity (joint or non-joint); MRI lower extremity • CT upper or lower extremity for preoperative planning • CT upper or lower extremity for detection of occult fracture when MRI cannot be performed • CT upper extremity (joint or non-joint) for delayed union or nonunion of the scaphoid as an alternative to MRI • CT lower extremity as an alternative to MRI for evaluation of tibial plateau fracture **Explanation of change** Added indication for evaluation of supracondylar fracture Added CT as an alternative to MRI for tibial plateau fracture			

Ligament and Tendon Derangement of the Upper Extremity	**Rotator cuff tear**
	Advanced imaging is considered medically necessary for diagnosis and management when **ALL** of the following apply:
	• Radiographs or ultrasound are nondiagnostic
	• At least one positive sign to support the diagnosis of rotator cuff tear has been demonstrated
	• **EITHER** of the following:
	  ○ At least one positive sign of a complete rotator cuff tear
	  ○ Failure of at least 6 weeks of conservative management
	
	Explanation of change
	Combined acute and chronic rotator cuff tear due to overlap in prerequisites
	Standardized conservative management to 6 weeks (previously 4 weeks for acute rotator cuff tear)
		September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

Miscella-neous Conditions	**Chronic anterior knee pain (including chondromalacia patella and patellofemoral pain**	September 11, 2022	Commercial Medicare	Prior authorization **still required** through

	syndrome) Advanced imaging is considered medically necessary following nondiagnostic radiographs when **BOTH** of the following criteria are met: • Chronic anterior knee pain not attributable to a specific injury • Failure of at least 6 weeks of conservative management **Explanation of change** Modified language around prior injury for clarity			AIM Specialty Health.
Perioperative Imaging, unspecified	**Shoulder arthroplasty, presurgical planning** *Advanced imaging is not indicated for robotic-assisted shoulder arthroplasty.* Advanced imaging is considered medically necessary for evaluation in **ANY** of the following scenarios: • For preoperative assessment of bone stock and bone version prior to shoulder arthroplasty • For assessment of rotator cuff status to determine the surgical approach • For planned reverse shoulder arthroplasty in **ANY** of the following scenarios: ○ Reconstruction after a tumor resection ○ Glenohumeral osteoarthritis with irreparable rotator cuff tear ○ Failed hemiarthroplasty ○ Failed total shoulder arthroplasty with non-repairable rotator cuff ○ Shoulder fracture that is not repairable or cannot be reconstructed with other techniques ○ Advanced joint disease of the shoulder with severe osteoarthritis, pain and loss of function for at least 6 months duration and not responsive to at least 6 weeks of conservative management **IMAGING STUDY** • MRI upper extremity (joint) • CT upper extremity (joint)	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	for preoperative assessment of bone stock and bone version, or for planned reverse shoulder arthroplasty **Explanation of change** Modified language to clarify intent – total shoulder arthroplasty should not require advanced imaging			
Perioperative Imaging (including delayed hardware failure), not otherwise specified	**Perioperative Imaging (including delayed hardware failure), not otherwise specified** Includes conditions not otherwise referenced in the Extremity Imaging guidelines. *Advanced imaging is not indicated for robotic-assisted hip arthroplasty.* **Explanation of change** Excluded robotic-assisted hip arthroplasty as robotic-assisted surgery in general does not provide net benefit over conventional arthroplasty	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

RADIOLOGY - SPINE IMAGING

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Radiology. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
General Information/ Overview	**General prerequisites for spine imaging:** **Conservative management** ○ Exception to specified duration of conservative management may be made in unusual circumstances (for example, worsening of symptoms during a course of conservative management) when clearly documented in the medical record, or when the duration period is substantiated by documentation of serial evaluation **Explanation of change** Allow exception to specified durations of conservative management in rare cases	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Trauma	**Cervical injury**	September	Commercial	Prior

	Advanced imaging is considered medically necessary in the following scenarios: *ADULT* • Initial diagnosis of trauma with **ANY** of the following: • Management of trauma in **ANY** of the following scenarios: ○ Post-traumatic neurologic deficit on exam ○ Soft tissue injury suggested by CT or radiography ○ Progressively worsening pain unexplained by CT ○ Follow up of known fracture ○ Presurgical planning **IMAGING STUDY** • CT cervical spine • MRI cervical spine for management of trauma, except follow up of known fracture ***PEDIATRIC*** • Diagnosis or management of trauma in **ANY** of the following scenarios: ○ Post-traumatic neurologic deficit on exam **Explanation of change** ○ Modified "diagnosis" and "management" language to mirror thoracic/lumbar section ○ Clarified that post-traumatic neurologic deficit refers specifically to a finding on exam ○ Added "imaging study" section for adults for greater clarity	11, 2022	Medicare	authorization **still required** through AIM Specialty Health.
Thoracic or lumbar injury	**Thoracic or lumbar injury** Advanced imaging is considered medically necessary in the following scenarios: • Initial diagnosis of trauma in **EITHER** of the following scenarios: • Management of trauma in **ANY** of the following scenarios: ○ Post-traumatic neurologic deficit on exam **Explanation of change** Clarified that "neurologic deficit" refers to an exam finding rather	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	than a subjectively reported symptom			
Miscella-neous Conditions of the Spine	**Osteoporosis and osteopenia Management indications** • Testing at 2- to 3-year intervals in persons being treated for osteoporosis or osteopenia • Testing at 3- to 5-year intervals in untreated individuals who met the criteria for initial evaluation, without interval development of risk factors for accelerated bone loss *Note: For patients with interval development of a risk factor for accelerated bone loss, please refer to Screening and Diagnostic Indications.* **IMAGING STUDY** CT bone density **Explanation of change** Removed statement in management section about testing at 3-5 year intervals in patients "without significant osteopenia on prior study" for clarity (this follow up interval is for patients who are not being treated so coverage position is intended to be unchanged).	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Perioperative and Periproce-dural Imaging	**Perioperative and periprocedural Imaging, including delayed hardware failure or healing related to prior surgery, not otherwise specified** *Includes conditions not otherwise referenced in the Spine guidelines. For pain after spine surgery beyond the perioperative time frame, please refer to the Pain indications.* Advanced imaging is considered medically necessary for diagnosis and management following nondiagnostic radiographs. **Explanation of change** Added requirement for initial evaluation with radiographs	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

RADIOLOGY - VASCULAR IMAGING

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Radiology. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Brain, Head and Neck	**Pulsatile tinnitus** **IMAGING STUDY** • CTA or MRA head • CTA or MRA neck **Explanation of change** Allow optional CTA/MRA Neck evaluation	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Stroke or transient ischemic attack (TIA), intracranial evaluation	**Stroke or transient ischemic attack (TIA), intracranial evaluation** *Also see Brain Imaging guidelines.* Vascular imaging is considered medically necessary in **ANY** of the following scenarios: • Acute (7 days or less) stroke/TIA in **ANY** of the following scenarios: ○ Acute stroke in an interventional candidate ○ Evidence of acute ischemia or infarct on brain imaging ○ Evaluation following acute TIA • Subacute (within 30 days) stroke/TIA in **EITHER** of the following scenarios: ○ Signs or symptoms attributable to the anterior circulation, when the presence of intracranial stenosis will lead to use of dual antiplatelet therapy ○ Signs or symptoms other than syncope attributable to the posterior circulation **Explanation of change** Recategorization into dedicated Stroke/TIA section (no content change)	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Chest	**Acute aortic syndrome** **IMAGING STUDY** • CTA chest	September 11, 2022	Commercial Medicare	Prior authorization **still required** through

	• MRA chest **Explanation of change** Allow either CTA or MRA chest for thoracic dissection (surveillance sometimes done w/ MR)			AIM Specialty Health.
Abdomen and Pelvis	**Acute aortic syndrome** **IMAGING STUDY** • CTA abdomen or CTA Abdomen/Pelvis • MRA abdomen with or without MRA pelvis • CT or MRI; alternatives to CTA or MRA above **Explanation of change** Addition of optional pelvic imaging for possible iliac vessel involvement – prior content gap	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Aneurysm of the abdominal aorta or iliac arteries	**Aneurysm of the abdominal aorta or iliac arteries** Vascular imaging is considered medically necessary in **ANY** of the following scenarios: **Screening** One time evaluation in: • Previously diagnosed aneurysm of the thoracic aorta, iliac, femoral or popliteal arteries **Management** • Baseline and initial 12-month evaluation following endograft repair **Surveillance** • Stable aneurysms treated with endografts: Duplex arterial ultrasound annually; CT every 5 years • Stable aneurysms treated with open surgical repair: every 5 years **IMAGING STUDY** • Duplex arterial ultrasound; all indications • CT abdomen and/or pelvis for management, surveillance with endografts or surgical repair, or when duplex arterial ultrasound cannot be performed or is nondiagnostic • CTA abdomen and/or pelvis for management, surveillance with surgical repair, or when	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	duplex arterial ultrasound cannot be performed or is nondiagnostic • MRI abdomen and/or pelvis for management, surveillance with surgical repair, or when duplex arterial ultrasound cannot be performed or is nondiagnostic • MRA abdomen and/or pelvis for management, surveillance with surgical repair, or when duplex arterial ultrasound cannot be performed or is nondiagnostic **Explanation of change** • Screening: addition of femoral aneurysm to listed lower extremity sites predisposing to AAA (content gap) • Management: alignment with SVS guidelines for post-endovascular repair only, repeat imaging in 12 months after baseline • Surveillance: alignment with SVS guidelines for annual surveillance post endovascular repair			
Venous thrombosis or occlusion	**Venous thrombosis or occlusion** Advanced imaging is considered medically necessary for diagnosis and management of thrombosis or occlusion of major abdominal vessels in **EITHER** of the following scenarios: • Evaluation of the hepatic or portal veins when duplex venous ultrasound cannot be performed or is nondiagnostic • Evaluation of all other abdominal venous structures **IMAGING STUDY** • CTA abdomen or CTA abdomen/pelvis • MRA abdomen with or without MRA pelvis **Explanation of change** • Restructure for clarification of intent, no content change for indications. • Duplex venous US removed from "Imaging Study" options (not managed by AIM) – no content change.	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	• Imaging study corrected to include optional added pelvic imaging (not only pelvic vein imaging)			
Upper Extremity	**Peripheral arterial disease (PAD)** Vascular imaging is considered medically necessary for diagnosis, management, and surveillance in **ANY** of the following scenarios: **Diagnosis** of suspected PAD: • Any sign or symptom with inconclusive physiologic testing (including exercise testing) **Management** of known PAD in **ANY** of the following scenarios: • Resting ischemic pain or signs of atheroembolic disease of the upper extremities (such as ischemic or discolored fingers, livedo reticularis etc.) • Atypical symptoms with inconclusive physiological testing • Persistent claudication despite a trial of conservative therapy in initial revascularization candidates • Baseline study following percutaneous or surgical revascularization • Post-revascularization, with any new or worsening upper extremity signs or symptoms • Post revascularization when surveillance physiological testing is inconclusive **Explanation of change** ○ Diagnosis: suspected PAD without physiologic testing (including exercise testing) not indicated ○ Management: adding items from 2016 guideline currently still operationalized (no operational content change)	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Lower Extremity	**Peripheral arterial disease (PAD)** Vascular imaging is considered medically necessary in **ANY** of the following scenarios: **Screening** • Not indicated **Diagnosis** of suspected PAD: • Any sign or symptom with inconclusive physiologic testing (including exercise testing)	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	Management of known PAD in **ANY** of the following scenarios: • Prior diagnosis of PAD with **ANY** of the following new or worsening signs or symptoms: ○ Resting ischemic pain, non-healing wounds, and gangrene ○ Ischemic or discolored toes, and livedo reticularis ○ Sudden onset of pain associated with pulselessness, pallor, loss of motor or sensory function • Post revascularization with any new or worsening lower extremity non-joint pain not addressed above, following nondiagnostic physiologic testing (physiologic testing not required if venous graft was used) **Surveillance** • Annual follow up after surgical revascularization when a venous graft has been used **Explanation of change** • Diagnosis: suspected PAD without physiologic testing (including exercise testing) not indicated (added scenarios aligned with PAD upper extremity) • Management post-revascularization: clarification of symptoms not addressed in section above (redundant) and physiologic testing requirement			
Popliteal artery aneurysm	**Popliteal artery aneurysm** Advanced imaging is considered medically necessary surveillance of popliteal artery aneurysm following open or endovascular repair at 3, 6, and 12 months following repair, then annually. **IMAGING STUDY** Duplex arterial ultrasound **Explanation of change** New indication for Arterial US surveillance for repaired popliteal artery aneurysm (in alignment with 2021 SVS guidelines)	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

SLEEP DISORDER MANAGEMENT

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Sleep Disorder Management. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

POLICY TITLE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Polysomnography and Home Sleep Testing				
In-Lab (Attended) Sleep Studies in Adult Patients (Age ≥ 19 yrs)	**Established sleep disorder (OSA or other) – follow-up laboratory studies** A patient with established diagnosis of OSA should have a follow-up in-lab sleep study if **ANY** of the following (1-3) apply: 1. To assess efficacy of surgery (including adenotonsillectomy or upper airway) or oral appliances/devices in a patient who has a contraindication to a home sleep study (as outlined in Table 1* above) 2. To re-evaluate the diagnosis of OSA and need for continued CPAP if there is significant weight loss (defined as 10% of body weight) since the most recent sleep study in a patient who has a contraindication to a home sleep study (as outlined in Table 1* above) 3. To optimize device settings on one occasion following insertion of a hypoglossal nerve stimulator A patient with established diagnosis of OSA or other sleeping disorders should have a follow-up in-lab study if ANY of the following (1-3) apply: 1. To titrate CPAP/BPAP in a patient who has a contraindication* to the use of APAP or for whom an attempt at APAP titration has been unsuccessful 2. To titrate CPAP/BPAP in a patient with a contraindication** to the use of APAP (or has failed APAP retitration) whose attempted	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	split-night study did not adequately establish appropriate CPAP/BPAP treatment parameters 3. To retitrate CPAP/BPAP in a patient who has a contraindication** to APAP (or has failed APAP retitration) and has recurrence of symptoms or worsening of symptoms despite PAP adherence as defined by CMS criteria (use of PAP greater than or equal to 4 hours per night on 70% of nights during a consecutive 30-day period) *Table outlines contraindications to home sleep study but is not shown here. **Contraindications to APAP are not shown here. **Explanation of change** • Clarification specifies patient having contraindication for home sleep study. • One follow-up in-lab sleep study as appropriate following insertion of a hypoglossal nerve stimulator. • Revised definition of PAP therapy adherence per CMS criteria.			
In-Lab (Attended) Sleep Studies in non-Adult Patients (Age ≤ 18)	**Established sleep disorder (OSA or other) – follow-up studies** A follow-up in-lab sleep study is appropriate in ANY of the following (1–5) situations: 1. A patient with established OSA continues to exhibit persistent snoring or other symptoms of sleep disordered breathing despite PAP adherence as defined by CMS criteria (use of PAP greater than or equal to 4 hours per night on 70% of nights during a consecutive 30-day period) 2. The patient has undergone adenotonsillectomy more than 8 weeks previously for management of established OSA 3. To re-evaluate the diagnosis of OSA and need for continued PAP if there is significant weight loss (defined as 10% of	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	body weight) since the most recent sleep study 4. To titrate CPAP or BPAP in a patient whose diagnostic study confirms that the patient is a candidate for positive airway pressure therapy and split-night study has not been performed or was inadequate 5. The initial sleep study has led to a diagnosis other than OSA and the repeat study is requested because of a change in clinical status or to assess efficacy after a change in therapy **Explanation of change** Revised definition of PAP therapy adherence per CMS criteria			
Multiple Sleep Latency Testing (MSLT) and/or Maintenance of Wakefulness Testing (MWT)				
In-Lab (Attended) Sleep Studies in Adult Patients (Age ≥ 19 yrs)	**Repeat MWT is appropriate for occupational safety evaluation when BOTH of the following conditions are met** 1. The patient has an established diagnosis of a sleep breathing disorder or narcolepsy 2. The test is performed while on the current treatment to determine adequacy of therapy **Explanation of change** New indication for MWT in occupational safety evaluation	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.
Management of OSA using Oral Appliances (OA)				
Custom Fabricated Oral Appliances (CPT E0486)	**Treatment with OA is appropriate for patients 16 years of age or older with severe OSA (apnea/hypopnea index [AHI] greater than 30) meeting BOTH of the following criteria (A-B)** A. The appliance is a TRD or a MRA which complies with CMS criteria B. **ONE** of the following (a-c) applies: a. The patient is not a candidate for positive airway pressure therapy b. Positive airway pressure therapy has not been effective despite a 45-day trial and participation in a positive airway pressure compliance program	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	c. The patient has tried continuous positive airway pressure (CPAP) but has not been compliant despite a 45-day trial and participation in a positive airway pressure compliance program. **Explanation of change** Limit oral appliance use to patients 16 years and older			
Custom Fabricated Oral Appliances (CPT E0486)	**Treatment with OA is appropriate for patients 16 years of age or older with mild or moderate OSA meeting ALL of the following criteria (A-C)** A. At least **ONE** of the following (a-b): a. AHI greater than or equal to 15 and less than or equal to 30 b. AHI 5–14 with any of the following: excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, treatment-resistant hypertension (persistent hypertension in a patient taking three or more antihypertensive medications), ischemic heart disease, history of stroke B. At least **ONE** of the following (a-d): a. The patient is not a candidate for positive airway pressure therapy b. Positive airway pressure therapy has not been effective despite a 45-day trial and participation in a positive airway pressure compliance program c. The patient has tried CPAP but has not been compliant despite a 45-day trial and participation in a positive airway pressure compliance program d. The patient prefers to use an OA rather than PAP as the initial therapy C. The appliance is a TRD or a MRA which complies with	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

	CMS criteria **Explanation of change** Limit oral appliance use to patients 16 years and older			
Management of OSA using Implanted Hypoglossal Nerve Stimulators				
Implanted Hypoglossal Nerve Stimulators	**Treatment with HNS is appropriate for adult patients with OSA meeting ALL of the following criteria (A-E)** A. Age 18 years or older B. AHI or RDI > 15 and < 65 with less than 25% central events C. BMI < 32 D. Have failed or are intolerant of PAP therapy E. Non-concentric retropalatal obstruction on drug-induced sleep endoscopy **Treatment with HNS is appropriate for adolescent and young adult patients with Down syndrome and OSA meeting ALL of the following criteria (A-E)** A. Age 10-21 years B. AHI or RDI >10 and <50 with less than 25% central apneas after prior adenotonsillectomy C. BMI < 95th percentile for age D. Have either had tracheotomy or been ineffectively treated with CPAP due to noncompliance, discomfort, undesirable side effects, persistent symptoms despite compliance use, or refusal to use the device E. Non-concentric retropalatal obstruction on drug-induced sleep endoscopy **Explanation of change** New criteria for use of hypoglossal nerve stimulators (HNS) in the management of OSA in adults in addition to young adults and adolescents with Down syndrome.	September 11, 2022	Commercial Medicare	Prior authorization **still required** through AIM Specialty Health.

May 2022

BEHAVIORAL HEALTH

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED

Electrical Stimulation Devices for Psychiatric and Neurological Conditions	157	**Policy clarified** to include new references.	May 1, 2022	Commercial Medicare	No action required. Still not a covered service.

DERMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Treatment of Varicose Veins/Venous Insufficiency	238	**Policy clarified.** Last criteria clarified under saphenous veins and accessory saphenous veins to state: A failure after the use of medical grade compression stockings (medical grade at least 20-30mmHg pressure).	May 1, 2022	Commercial	Prior authorization still required.

DURABLE MEDICAL EQUIPMENT (DME)

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Manual and Power Operated Wheelchairs	365	On February 1, 2022, we clarified that prior authorization requirements for power operated wheelchairs were being delayed until further notice. **Effective June 1, 2022,** prior authorization for power operated wheelchairs **will be required.** Prior authorization **will not be required** for manual wheelchairs.	June 1, 2022	Commercial Medicare	Prior authorization required for all Commercial PPO and EPO; HMO and POS products effective June 1, 2022.
Myoelectric Prosthetic and Components for the Upper Limb	227	**Policy clarified.** Not medically necessary policy statement updated to Investigational for policy standardization purposes.	May 1, 2022	Commercial Medicare	Prior authorization still required.

		Clarification added that the second policy statement pertains to advanced prosthetic components with both sensor and myoelectric control (e.g., LUKE Arm). Policy intent unchanged.			

ENDOCRINOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Insulin Delivery Devices	332	**Policy clarified** to include a note that Omnipod® DASH and Omnipod® 5 can only be obtained through the pharmacy benefit.	April 11, 2022	Commercial	No action required.

GASTROENTEROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Serological Diagnosis of Celiac Disease	138	**Policy revised.** Medically necessary indications described for serologic measurement of deamidated gliadin peptide (DGP) antibodies.	August 1, 2022	Commercial Medicare	No action required.

HEMATOLOGY ONCOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Flow Cytometry for Cell Analysis	342	**Policy clarified** to include multiple myeloma and myelodysplastic syndromes.	May 1, 2022	Commercial Medicare	No action required.
Medical Technology Assessment Investigational (Non-Covered)	400	**Policy clarified.** Code 83521 removed from noncovered list. This is a covered service.	May 1, 2022	Commercial Medicare	No action required.

Services List		Code 83521 Immunoglobulin light chains free			

MULTISPECIALTY - PRIOR AUTHORIZATION INFORMATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Outpatient Prior Authorization Code List for Commercial	072	**Prior authorization implementation.** On February 1, 2022, we clarified that outpatient prior authorization requirements for Commercial PPO and EPO were being delayed until further notice. **Effective June 1, 2022,** outpatient prior authorization requirements will be implemented for Commercial PPO and EPO.	June 1, 2022	Commercial	Prior authorization required for Commercial PPO and EPO products effective June 1, 2022.

OPHTHALMOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Intravitreal and Punctum Corticosteroid Implants	272	**Policy clarified.** Editorial refinement to policy statement. Policy intent unchanged.	May 1, 2022	Commercial Medicare	No action required.
Orthoptic Training for the Treatment of Vision or Learning Disabilities	611	**Policy clarified.** Not medically necessary policy statement changed to Investigational for policy standardization purposes. Policy intent unchanged.	May 1, 2022	Commercial Medicare	No action required.
Viscocana-lostomy and Canaloplasty	372	**Policy clarified.** Not medically necessary policy statement changed to Investigational for policy standardization purposes. Policy intent	May 1, 2022	Commercial Medicare	No action required.

		unchanged.			

ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Ultrasound Accelerated Fracture Healing Device	497	**Policy clarified.** Not medically necessary policy statements updated to investigational for policy standardization purposes. Policy intent unchanged.	May 1, 2022	Commercial	No action required.

PLASTIC SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Surgical and Non-surgical Treatment of Gynecomastia	661	**Policy clarified.** Prior authorization is no longer required.	June 1, 2022	Commercial Medicare	Prior authorization for Commercial HMO/POS and Medicare HMO and Medicare PPO is no longer required.

PULMONOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Hyperbaric Oxygen Therapy	653	**Policy clarified.** Prior authorization is no longer required.	June 1, 2022	Commercial Medicare	Prior authorization for Commercial HMO/POS and Medicare HMO and Medicare PPO is no longer required.

April 2022

BEHAVIORAL HEALTH

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED

Applied Behavior Analysis (ABA)	091	**Policy revised.** Policy notes for ABA updated to include additional information for standard treatment protocols for behavior identification assessment, behavior identification supporting assessment and adaptive behavior treatment protocols for focused ABA and comprehensive ABA treatment. Added note for group adaptive behavior treatment regarding standard treatment protocols.	July 1, 2022	Commercial	PA still required.
Medical Technology Assessment Noncovered Services	400	**Policy clarified.** Prescription Digital Therapeutics for Substance Abuse (HCPCS A9291) **added to non-covered list**.	April 1, 2022	Commercial Medicare	No action required.

CLINICAL LABORATORY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical Technology Assessment Noncovered Services	400	**Policy clarified.** Wound panel added to non-covered list.	March 17, 2022	Commercial Medicare	No action required.

GASTROENTEROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Endoscopic retrograde cholangio-Pancreato-graphy (ERCP) with Laser or Electro-hydraulic Lithotripsy	209	**Policy is retired**. This is a covered service.	April 1, 2022	Commercial Medicare	No action required.

MULTISPECIALTY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Amniotic Membrane and Amniotic Fluid	643	**Policy revised.** New investigational statement added for repair following Mohs microsurgery.	July 1, 2022	Commercial Medicare	No action required.

OBSTETRICS GYNECOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Maternal Serum Biomarkers for Prediction of Adverse Obstetric Outcomes	163	**New policy** describing ongoing investigational indications. Noncovered CPT codes moved from MP 400 Medical Technology Assessment Noncovered Services.	April 1, 2022	Commercial Medicare	No action required.
Laparoscopic and Transcervical Techniques for the Myolysis of Uterine Fibroids	244	**Policy clarified.** Policy intent remains unchanged. Title changed to Laparascopic, percutaneous, and transcervical techniques for uterine fibroid myolysis.	April 1, 2022	Commercial Medicare	No action required.

ORTHOPEDIC SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical Technology Assessment Noncovered Services	400	**Policy clarified.** Regenerative Peripheral Nerve Interface (RPNI) during amputation added to list of non-covered services.	April 1, 2022	Commercial Medicare	No action required.

OTOLARYNGOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Cryoablation for Chronic Rhinitis	843	**Policy revised.** New investigational indications described for radiofrequency ablation and laser ablation for chronic rhinitis. Title changed to Cryoablation, Radiofrequency Ablation, and Laser Ablation for Treatment of Chronic Rhinitis.	July 1, 2022	Commercial Medicare	No action required.
Temporoman-dibular Joint Disorder	035	**Policy revised.** Investigational policy statement modified to include dextrose prolotherapy.	July 1, 2022	Commercial Medicare	No action required.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medicare Advantage Part B Step Therapy	020	**Riabni moving to Step 1 medication** (which means it will no longer require prior authorization). **Truxima moving to Step 2 medication** (prior authorization will be required for members new to therapy; existing users within the past 365 days will be grandfathered).	July 1, 2022	Medicare	Providers will be required to use Riabni or Ruxience prior to use of Rituxan or Truxima.

RADIOLOGY - VASCULAR IMAGING

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AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Stenosis or occlusion,	**Stenosis or occlusion, extracranial carotid arteries**	June 12, 2022	Commercial Medicare	Prior authorization still

extracranial carotid arteries	*See separate indication for acute stroke or transient ischemic attack.*
	Vascular imaging is considered medically necessary in patients who are candidates for carotid revascularization in **ANY** of the following scenarios:
	• Screening
	  ○ Starting 5 years post-neck irradiation and every 3 years thereafter
	  ○ Initial evaluation of carotid calcification incidentally detected on nonvascular imaging
	• Surveillance of established carotid disease
	  ○ Stenosis or occlusion in asymptomatic persons with no prior revascularization
	  ○ Moderate (50%-69%) stenosis: every 12 months
	  ○ Severe (70% or greater) stenosis: every 6 months
	  ○ Post-revascularization after the first year: every 12 months
	Note: Revascularization refers to carotid endarterectomy or carotid artery stenting. Standard field of view for advanced imaging of the neck includes the aortic arch.
	
	Explanation of change
	• Screening: New indications post neck irradiation, for incidental carotid calcification
	• Surveillance: alignment with SVS guideline for annual imaging post-revascularization after first year (reduced frequency for residual severe stenosis by prior GL; no change for mild-moderate residual stenosis; expansive when no residual stenosis).
				required via AIM.

Stroke or transient ischemic attack (TIA),	**Stroke or transient ischemic attack (TIA), extracranial evaluation** Vascular imaging is considered	June 12, 2022	Commercial Medicare	Prior authorization still required via AIM.

extracranial evaluation	medically necessary in **ANY** of the following scenarios: • Acute (7 days or less) stroke/TIA in **ANY** of the following scenarios: ○ Acute stroke in an interventional candidate ○ Evidence of acute ischemia or infarct on brain imaging ○ Evaluation following acute TIA • Subacute (within 30 days) stroke/TIA in **EITHER** of the following scenarios: ○ Signs or symptoms attributable to the anterior (carotid) circulation, in patients who are candidates for carotid revascularization ○ Signs or symptoms other than syncope attributable to the posterior circulation • Chronic (30 days or more) stroke/TIA when no carotid evaluation since the stroke/TIA event in **EITHER** of the following scenarios: ○ Signs or symptoms attributable to the anterior (carotid) circulation, in patients who are candidates for carotid revascularization ○ Signs or symptoms other than syncope attributable to the posterior circulation **IMAGING STUDY** - Duplex arterial ultrasound (any indication) - CTA or MRA neck for acute stroke/TIA, subacute stroke/TIA, and chronic posterior circulation stroke/TIA - CTA or MRA neck for chronic anterior circulation stroke/TIA when duplex arterial ultrasound cannot be performed or is nondiagnostic **Explanation of change** • Recategorization into dedicated Stroke/TIA section (no content change for Acute			

	Stroke/TIA) • Subacute stroke/TIA: allow CTA/MRA Neck without previously prerequisite US in alignment with 2021 AHA/ASA guidelines • Chronic stroke/TIA: New Carotid US indication given potential for intervention; CTA/MRA Neck allowed for chronic posterior circulation stroke/TIA			

Pulmonary embolism	**Pulmonary embolism**
	Also see Cardiac Imaging guidelines.
	ADULT
	Advanced imaging is considered medically necessary in **ANY** of the following scenarios:
	• **Pulmonary embolism likely** based on modified Wells criteria45 (> 4 points)
	• **Pulmonary embolism unlikely** based on modified Wells criteria45 (≤ 4 points) with a positive D-dimer
	• Suspected pulmonary embolism in pregnancy when PE cannot be excluded by YEARS algorithm (**EITHER** of the following scenarios):
	  ○ D-dimer ≥ 1000 ng/mL
	  ○ D-dimer ≥ 500 ng/mL and **ANY** of the following:
	  ▪ Clinical signs of deep-vein thrombosis, after normal compression ultrasonography
	  ▪ Hemoptysis
	  ▪ Pulmonary embolism as the most likely diagnosis
	PEDIATRIC
	Advanced imaging is considered medically necessary in **EITHER** of the following scenarios:
	• Moderate or high clinical suspicion of pulmonary embolism
	• Concern for recurrent embolism in patients on adequate medical therapy
		June 12, 2022	Commercial Medicare	Prior authorization still required via AIM.

	Explanation of change Removal of CXR requirement added last cycle given lower threshold for elevated D-dimer scenarios, thrombosis related to COVID infection, etc			

March 2022

BEHAVIORAL HEALTH

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Esketamine Nasal Spray (Spravato™) and Intravenous Ketamine for Mental Health Conditions	087	Annual policy review. References, description and summary reviewed. No changes to policy statements made.	March 1, 2022	Commercial Medicare	Prior authorization still required.

CARDIOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Lipid Apheresis	465	**Prior authorization update.** Prior authorization **will no longer be required** for Commercial HMO/POS and Medicare HMO and Medicare PPO.	April 1, 2022	Commercial Medicare	Prior authorization no longer required.

DURABLE MEDICAL EQUIPMENT

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Continuous Passive Motion in the Home Setting	407	**Enforcement update.** Diagnoses codes list added. New diagnoses-to-CPT codes edit implemented. Policy criteria unchanged.	April 1, 2022	Commercial	No action required.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Dificid fidaxomicin	700	**Policy retired**.	March 1, 2022	Commercial	Prior authorization no longer required.
Medicare Advantage Part B Step Therapy	020	Avsola moved to Step 1 medication, which means it will **no longer require prior authorization**.	April 1, 2022	Medicare	Providers will be required to use Avsola or Inflectra prior to use of Remicade or Renflexis.

February 2022

BEHAVIORAL HEALTH

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Applied Behavior Analysis (ABA)	091	**New policy** describing medically necessary indications and prior authorization information. Transferred from InterQual criteria.	March 1, 2022	Commercial Medicare	Providers should continue to request prior authorization.

DURABLE MEDICAL EQUIPMENT

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Manual and Power Operated Wheelchairs	365	Prior authorization requirements for power operated wheelchairs are **delayed until further notice**.	Delayed until further notice	Commercial	No action required.

GASTROENTEROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Wireless Capsule Endoscopy to Diagnose Disorders of the Small Bowel, Esophagus,	185	**Policy revised.** Magnetic capsule endoscopy (NaviCam) added to policy with new indication and investigational policy statement. Title changed to "Wireless	May 1, 2022	Commercial Medicare	No action required.

and Colon		Capsule Endoscopy for Gastrointestinal (GI) Disorders.”			

INFERTILITY /OBSTETRICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Assisted Reproductive Services	086	**Policy clarified.** Clarification made to additional ICSI criteria section. ICSI is a covered service when done to fertilize cryopreserved eggs.	February 1, 2022	Commercial Medicare	No action required.

MULTISPECIALTY - PRIOR AUTHORIZATION IMPLEMENTATION DELAYED

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Outpatient Prior Authorization Code List for Commercial	072	Outpatient prior authorization requirements for Commercial PPO and EPO are **delayed until further notice.**	Delayed until further notice	Commercial	No action required.

NEUROLOGY NEUROSURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Laser Interstitial Thermal Therapy for Neurological Conditions	948	**New policy** describing investigational indications.	May 1, 2022	Commercial Medicare	No action required.

NEUROLOGY NEUROSURGERY ORTHOPEDICS REHABILITATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Trans-cutaneous Electrical Nerve Stimulation	003	**Policy revised.** New investigational indications described for TENS devices for essential tremor and	May 1, 2022	Commercial	No action required.

		attention deficit hyperactivity disorder.			

ONCOLOGY CLINICAL LABORATORY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical Technology Assessment Investigational (Non-Covered) Services List	400	**Policy clarified.** NavDx DNA Blood Test for Detection of HPV-driven Cancer added.	February 1, 2022	Commercial Medicare	No action required.

OTOLARYNGOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical Technology Assessment Noncovered Services	400	**Policy clarified.** Code 42975 removed from Medical Technology Assessment Noncovered Services List. 42975 Diagnostic sleep endoscopy with evaluation of velum, pharynx, tongue base, and larynx	January 1, 2022	Commercial Medicare	No action required.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Immune Modulating Drugs	004	**Policy revised.** In accordance with the FDA change, JAK inhibitors Xeljanz and Rinvoq will transition to the non-preferred in the respective disease states.	March 1, 2022	Commercial	Prior authorization will continue in the same process in line with the FDA change.

PLASTIC SURGERY AND DERMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Bioengineered Skin and Soft Tissue Substitutes	663	**Policy clarified** to include a list of allogeneic acellular dermal matrix products for breast reconstructive surgery.	February 1, 2022	Commercial Medicare	No action required.

TRANSPLANTATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Immune Cell Function Assay	182	**Policy clarified.** Statements reworded for clarity but intent of statements unchanged.	May 1, 2022	Commercial Medicare	No action required.

January 2022

DURABLE MEDICAL EQUIPMENT

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Manual and Power Operated Wheelchairs	365	Prior authorization requirements for power operated wheelchairs **delayed until further notice**.	Delayed until further notice	Commercial Medicare	No action required.

HEMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma	066	**Policy revised.** New medically necessary indications described for B-cell acute lymphoblastic leukemia. Brexucabtagene autoleucel is considered medically necessary for adult patients with relapsed/refractory B-cell acute lymphoblastic	January 1, 2022	Commercial	Prior authorization still required.

		leukemia. See CAR T-Cell Therapy Services for B-cell Acute Lymphoblastic Leukemia (Brexucabtagene Autoleucel) Prior Authorization Request Form #945.			

NEUROLOGY NEUROSURGERY AND ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Diagnosis and Treatment of Sacroiliac Joint Pain	320	**Policy clarified.** "Transiliac placement" and "eg, iFuse" added to the medically necessary statement on sacroiliac joint fusion. See Diagnosis and Treatment of Sacroiliac Joint Pain Prior Authorization Request Form #927.	January 1, 2022		Prior authorization still required.

December 2021

CARDIOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting	287	**Policy clarified** to include that placement of implantable cardiac hemodynamic devices in the **inpatient setting is considered investigational.**	December 1, 2021	Commercial	No action required.

CLINICAL LABORATORY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Identification of Micro-	555	**Policy clarified** to include that urinary tract	November 1, 2021	Commercial Medicare	No action required.

organisms Using Nucleic Acid Probes		infection panel is considered investigational.			

DURABLE MEDICAL EQUIPMENT

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Manual and Power Operated Wheelchairs	365	Prior authorization requirements for power operated wheelchairs delayed until further notice.	Delayed until further notice	Commercial	Prior authorization required effective April 1, 2022.

GASTROENTEROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Percutaneous Electrical Nerve Field Stimulation (PENFS) for Irritable Bowel Syndrome	922	**New policy** describing medically necessary indications.	March 1, 2022	Commercial Medicare	No action required.

GENETIC TESTING

The following updates will apply to the AIM Clinical Appropriateness Guidelines for Genetic Testing. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com

AIM GUIDELINE	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Single Gene and Multifactorial Conditions Genetic Testing Guideline	**Thrombophilia Testing** **Medically necessary criteria for F5/F2 listed** in this section are not changing. The following sentence will be deleted: The following test, including but not limited to, is not medically necessary. • MTHFR Chromosomal Microarray Analysis	March 6, 2022	Commercial	Prior authorization still required via AIM.

	Criteria Deleted from this Guideline in its entirety. **Explanation of Change** • Thrombophilia criteria are being incorporated into this guideline. No changes in coverage/stance are suggested. MTHFR is listed in the NMN CPT code table. This sentence is deleted for clarity and to avoid redundancy. • Chromosomal microarray analysis (CMA) criteria and content are being moved from this guideline to the Whole Exome and Whole Genome Sequencing guideline.			
Hereditary Cancer Susceptibility Genetic Testing Guideline	**Appropriate Use Criteria** At least one of the following: • Individual's personal or family history meets specific testing criteria for at least one of the syndromes listed below • Personal and/or family history is consistent with the hereditary cancer syndrome being tested for when that syndrome is not specifically addressed in these guidelines. **Explanation of Change** Text updates and clarification with no impact on coverage. **Germline Testing Following Identification of a Somatic Pathogenic or Likely Pathogenic (P/LP) Variant** **Section Title:** Germline Testing Following Identification of a Somatic Variant After a somatic variant is identified in a solid or hematologic malignancy, follow-up germline testing for that variant is medically necessary when the following criteria are met: • There are NCCN Guidelines® category 1 or 2A and/or other published management recommendations specific to germline pathogenic/likely pathogenic (P/LP) variants in the requested gene • There is high clinical suspicion for the variant to be germline based on patient and/or family history OR characteristics of the variant	March 6, 2022	Commercial	Prior authorization still required via AIM.

	itself (e.g., high allele frequency in tumor sample, well-described founder P/LP variants, concordance between gene and associated tumor type)
	Explanation of Change
	• Section title revision better encompasses the type of medically necessary somatic variants that prompt high clinical suspicion for the possibility of germline origin. This clarification does not represent a change in coverage stance.
	• Suggested revisions to criteria streamline similar/redundant text with no impact on coverage stance.
	
	National Comprehensive Cancer Network® (NCCN®) Criteria
	Genetic testing for the following syndromes is medically necessary when an individual meets the testing criteria outlined in the relevant NCCN® Clinical Practice Guidelines in Oncology:
	• Hereditary Colorectal Cancer Syndromes
	  ○ Hereditary Colorectal Cancer syndromes include: Lynch syndrome, Familial adenomatous polyposis (FAP)/Attenuated familial adenomatous polyposis (AFAP), MYH associated polyposis, Juvenile polyposis syndrome, Peutz-Jeghers syndrome, Serrated Polyposis Syndrome
	  ▪ For the purpose of evaluating criteria, Lynch syndrome related cancers include: colorectal, endometrial, keratoacanthoma, stomach, ovarian, small bowel, urothelial, sebaceous adenoma or carcinoma, hepatobiliary, pancreas, and			

	brain cancer ○ Testing is targeted to the genes listed in NCCN® **Genetic/Familial High-Risk Colorectal Cancer, v1.2021** • Hereditary Breast and Ovarian Cancer Syndromes ○ Hereditary Breast and Ovarian Cancer syndromes include: Hereditary Breast and Ovarian Cancer syndrome, Cowden syndrome/PTEN Hamartoma tumor syndrome, Li Fraumeni syndrome, and other breast/ovarian cancer susceptibility syndromes ▪ For the purpose of evaluating criteria, Hereditary Breast and Ovarian Cancer syndromes related cancers include: breast, ovarian, pancreatic and prostate cancer. ○ Testing is targeted to the susceptibility genes (*high and moderate penetrant genes*) listed in NCCN® Genetic/Familial High-Risk Breast, Ovarian and Pancreatic, v1.2022 • Multiple Endocrine Neoplasia (type 1 and type 2) ○ Testing is targeted to the genes listed in NCCN® Neuroendocrine and Adrenal Tumors, v3.2021 ○ Diffuse Gastric Cancer ○ Testing is targeted to the genes listed in NCCN® Gastric Cancer, v3.2021 **Explanation of Change:** Suggested revisions clarify/streamline text with no impact on coverage stance. Applicable NCCN Guideline® versions were updated (criteria in new versions do not impact coverage stance). The asterisk was also removed from the title of this section for clarification (an additional asterisk			

	is found in the NCCN® section of the Professional Society Guidelines which better directs the reader to the asterisked text). **Hereditary Paraganglioma-Pheochromocytoma Syndrome** Section Title: Hereditary Paraganglioma-Pheochromocytoma Syndromes Single gene testing or a targeted gene panel is medically necessary for hereditary paraganglioma-pheochromocytoma (PGL/PCC) syndromes when all of the following criteria are met: • Individual meets general criteria for hereditary cancer genetic testing (above) • Individual* with pheochromocytoma or paraganglioma • Other syndromes and causes of PGL/PCC have been ruled out (e.g.,multiple endocrine neoplasia) *Testing can be extended to first- or second- degree relatives if the affected proband is unavailable for testing. Single-site testing is medically necessary for those at risk for a known familial P/LP variant. **Explanation of Change** Suggested revisions are clarification/streamlining redundancy with no impact on coverage criteria.			
Reproductive Carrier Screening and Prenatal Diagnosis Genetic Testing Guideline	**Carrier Screening** Familial Disease Fragile X Cystic Fibrosis Spinal Muscular Atrophy Hemoglobinopathies Ashkenazi Jewish Carrier Screening Other Ethnicities **Carrier Screening Not Clinically Appropriate** **Explanation of Change** Suggested revisions are clarification/streamlining with no impact on coverage criteria. **Appropriate Use Criteria (Hemoglobinopathies section** Hemoglobinopathy genetic carrier screening is medically necessary when any of the following criteria are	March 6, 2022	Commercial	Prior authorization still required via AIM.

	met: • Clinical or laboratory features (e.g., CBC, hemoglobin electrophoresis) are suggestive of a hemoglobinopathy • Results of testing by conventional studies (e.g., electrophoresis, liquid chromatography, isoelectric focusing) yield equivocal results and a definitive diagnosis remains uncertain • A definitive diagnosis is known but specific P/LP variant identification is necessary for reproductive options/interventions, e.g., preimplantation genetic testing or prenatal diagnosis **Explanation of Change** Suggested revisions are clarification/streamlining redundancy with no impact on coverage criteria. **Appropriate Use Criteria (Other Ethnicities and Carrier Screening Not Clinically Appropriate sections)** **Other Ethnicities** Carrier screening for additional conditions may be considered medically necessary if the patient is at increased risk to be a carrier based on their ethnicity, including but not limited to: • Tay-Sachs carrier screening for individuals with French Canadian ancestry • Maple syrup urine disease (MSUD) screening for individuals with Mennonite ancestry Multi-gene panel testing is medically necessary when the individual's personal and/or family history meets one or more criteria above for all of the genes on the panel. **Carrier Screening Not Clinically Appropriate** The following tests are not medically necessary for carrier screening in the general population: • Thrombophilia screening • Whole exome sequencing **Explanation of Change** Multi-gene panel testing (historically referred to as expanded carrier screening panels) will now be			

	addressed in the “Other Ethnicities” section. This suggested revision does not reflect a change in coverage stance. We are currently evaluating the ACMG Practice Resource (Gregg et al. 2021) that calls for universal pan-ethnic carrier screening using a panel of 113 genes. At this time, we feel the data rising to the rigor of our evidentiary standards is lacking. We look forward to further conversations with our clients, other professional society responses, and additional evidence to substantiate ACMG recommendations. Other programmatic ways to address 81443 should also be part of ongoing discussions. **<u>Preimplantation Genetic Testing of Embryos and Preimplantation Genetic Testing for Aneuploidy</u>** **Preimplantation Genetic Testing of Embryos** Preimplantation genetic testing is not medically necessary for any other indication, including but not limited to the following: • human leukocyte antigen (HLA) typing of an embryo to identify a future suitable stem-cell tissue or organ transplantation donor • testing solely to determine if an embryo is a carrier of an autosomal recessively-inherited disorder • testing for a multifactorial condition testing for variants of unknown significance • nonmedical gender selection • nonmedical traits • Preimplantation genetic testing for aneuploidy (PGT-A) by any testing methodology for any indication DELETE Preimplantation Genetic Testing for Aneuploidy section **Explanation of Change** Suggested revisions are clarifications/streamlining of text with no impact on coverage stance. **<u>Prenatal Cell-Free DNA Screening</u>** Prenatal cell-free DNA screening is not medically necessary for the following indications:			

	• high-order multiple gestations (i.e., triplets or higher) • multiple gestation pregnancies with fetal demise, vanishing twin, one or more anomalies detected in one fetus • miscarriage (including recurrent pregnancy loss) or fetal demise SensiGene® (81479 or 81403) testing is medically necessary in a single gestation pregnancy when all of the following criteria are met: • a maternal anti-D antibody has been identified • the paternal Rh genotype is determined to be heterozygous or is unknown • the results will impact antenatal care **Explanation of Change** • Criteria update: the criteria for SensiGene® testing was deleted in the prior guideline iteration (effective September 6, 2021) because the test was no longer commercially available. The test has returned, so original criteria (with the same coverage stance) are being added back to this guideline. • Other suggested revisions are clarifications with no impact on coverage stance. **Prenatal Molecular Genetic Testing of a Fetus and Reproductive Genetic Testing for Recurrent Pregnancy Loss** **Prenatal Molecular Genetic Testing of a Fetus** *Note: The criteria below do not apply to cytogenetic testing (e.g., karyotype, chromosome analysis).* Single gene, multi-gene, or chromosomal microarray prenatal genetic testing is medically necessary when the results of the genetic test will impact clinical decision-making and the requested method is scientifically valid for the suspected condition. Prenatal molecular genetic testing in a			

	fetus for familial variants of unknown significance is not medically necessary. **Reproductive Genetic Testing for Pregnancy Loss** *Note: The criteria below do not apply to cytogenetic testing (e.g., karyotype, chromosome analysis).* Chromosome microarray (CMA) testing on products of conception is medically necessary for: • evaluation of recurrent pregnancy loss* • evaluation of intrauterine fetal demise (IUFD) or stillbirth after 20 weeks of gestational age • evaluation of a pregnancy loss with one or more major structural anomalies **Recurrent pregnancy loss is defined by two or more unexplained pregnancy losses.* Genetic testing (using single gene or multi-gene panel assays) for genes associated with thrombophilia, e.g., F2, F5, MTHFR, is not medically necessary. **Explanation of Change** Suggested revisions are clarifications, streamlining and re-organizing of text with no impact on coverage stance.			
Somatic and Hematologic Tumors Genetic Testing Guideline	**Cell-free testing (e.g., cfDNA, ctDNA, liquid biopsy)** in the following scenarios is medically necessary when General Coverage Criteria or FDA Companion Diagnostic Coverage Criteria above are met: • Metastatic Castrate-Resistant Prostate Cancer (mCRPC) ○ FoundationOne® Liquid CDx is medically necessary in men with metastatic castrate resistant prostate cancer (mCRPC) when the patient meets criteria per the FDA label for treatments for which this test has been approved as a companion	March 6, 2022	Commercial	Prior authorization still required via AIM.

	diagnostic
	• Ovarian, Fallopian Tube, or Primary Peritoneal Cancer
	  ○ FoundationOne® Liquid CDx is medically necessary if tumor is unavailable in women with ovarian, fallopian tube, or primary peritoneal cancer when the patient meets criteria per the FDA label for treatment(s) for which this test has been approved as a companion diagnostic
	• Advanced or Metastatic Breast Cancer
	  ○ therascreen® PIK3CA testing is medically necessary using liquid biopsy if tumor is unavailable for advanced or metastatic breast cancer when the patient meets criteria per the FDA label for treatments for which this test has been approved as a companion diagnostic
	• Locally Advanced or Metastatic Non-Small Cell Lung Cancer (NSCLC)
	  ○ Initial Biomarker Determination
	  ▪ FDA approved companion diagnostic tests (i.e., cobas EGFR Mutation Test v2, FoundationOne® Liquid CDx, or Guardant360® CDx) or a targeted multi-gene panel, e.g., ctDxLung™, are medically necessary when tissue-based testing cannot be performed, e.g., insufficient tissue
	  ○ At time of progression on an EGFR tyrosine kinase inhibitor (TKI) therapy
	  ▪ Targeted cell-free			

	testing (i.e., cobas EGFR Mutation Test v2) is medically necessary • Targeted cell-free testing is not medically necessary when progression is on Osimertinib Cell-free testing is not medically necessary when the patient already meets criteria for treatment without the need for additional testing (e.g., patient meets criteria based on known genetic results or biomarker status is not required). **Explanation of Change** • Revisions to the first sentence reference new formatting for headings in the guideline and do not reflect any changes to the current coverage stance. • Revisions to mCRPC; ovarian, fallopian tube or peritoneal cancer; and advanced or metastatic breast cancer are clarifications to streamline text that do not impact current coverage stance. • The FDA issued a CDx approval in July 2021 for MET exon 14 skipping mutations to treat with capmatinib. FoundationOne® Liquid • CDx now has FDA CDx approval for EGFR, ALK fusions, and MET exon skipping mutations. Other revisions to this criteria reflect clarifications and no changes in coverage stance. **Minimal Residual Disease (MRD) Testing** Targeted testing with prospective evidence of clinical utility for the tumor type and disease characteristics is medically necessary. **Explanation of Change** Clarification of text with no impact on current coverage stance. **Targeted Molecular Testing for NTRK Fusions** Targeted molecular testing for NTRK1/2/3 fusions is medically necessary when general coverage criteria above are met for any of the			

	following indications: **Explanation of Change** Clarification of text with no impact on current coverage stance. **<u>Cancer Screening (historically referred to as Prostate Cancer (symptomatic cancer screening) section)</u>** Formatting changes (addition of heading/subheading), include: **Cancer Screening** *(new heading)* **Population Based Cancer Screening** *(new subheading, see criteria below)* **Prostate Cancer (symptomatic cancer screening)** *(current subheading)* Text/criteria changes, include: **Population Based Cancer Screening** Multi-Cancer Early Detection (MCED) testing is not medically necessary. **Prostate Cancer (symptomatic cancer screening)** *(current subheading)* Text/criteria changes, include: **Population Based Cancer Screening** Multi-Cancer Early Detection (MCED) testing is not medically necessary. **Prostate Cancer (symptomatic cancer screening)** *(current subheading)* (*additional text not listed here*) Assays not listed above are considered not medically necessary. Serial testing and/or concurrent testing with multiple assays is not medically necessary. **Explanation of Change** • Formatting changes to add a general heading, Cancer Screening, and an additional subheading, Population Based Cancer Screening, are proposed to allow addressing other forms of cancer screening. These revisions do not reflect changes to coverage stance- simply clarifications. • Population Based Cancer Screening: As a clinical space, multi-cancer early detection tests are receiving increasing levels of			

	attention. Published data is insufficient to support population-based screening. It was pertinent to add a NMN statement. This is a clarification, not a change in coverage stance. • Prostate Cancer (symptomatic cancer screening): the suggested revision is clarification of our stance to support denials preventing abuse of testing beyond validated scenarios			
Pharmacogenomic and Thrombophilia Genetic Testing Guideline	**Scope** **Guideline Title:** Pharmacogenomic Testing **Scope:** Pharmacogenomic testing broadly describes how one's genome, or multiple genes, can influence drug response while more targeted pharmacogenetic testing describes genotyping a specific gene to predict response to certain medications. This document addresses pharmacogenomic testing for the purpose of informing medication selection, dosage, and risk of adverse side effects. This guideline does not address tumor testing (see Molecular Testing of Solid and Hematologic Tumors and Malignancies) or germline testing (see Genetic Testing for Hereditary Cancer Susceptibility) performed to direct treatment decisions or genetic testing to generate polygenic risk scores (see Genetic Testing for Single-Gene and Multifactorial Conditions). All tests listed in these guidelines may not require prior authorization; please refer to the health plan. **Explanation of Change** Suggested revisions are formatting changes or clarifications and do not impact current coverage stance. **Appropriate Use Criteria (Thrombophilia Testing)** **Thrombophilia Testing:** criteria deleted and moved to Genetic Testing for Single-Gene and Multifactorial Conditions. **Explanation of Change** Thrombophilia criteria and content are being moved to the Genetic Testing for Single-Gene and Multifactorial Conditions guideline for clarity. The	March 6, 2022	Commercial	Prior authorization still required via AIM.

	field of Pharmacogenomics is separate and distinct from genetic testing for thrombophilia and as ordering patterns and the testing landscape have changed, the criteria for thrombophilia testing should be housed in the guideline that encompasses general testing for genetic disease and not pharmacogenomics.			
Chromosomal Microarray Analysis, Whole Exome and Whole Genome Sequencing Guideline	**Scope** This document addresses the diagnostic use of chromosomal microarray analysis (CMA) and whole exome sequencing (WES) in the evaluation of rare disease. It does not address the use of WES as a technology for tumor profiling (see Molecular Testing of Solid and Hematologic Tumors and Malignancies). This document also addresses whole genome sequencing (WGS) as well as other broad scale profiling, e.g. whole transcriptome analysis and genome mapping. All tests listed in these guidelines may not require prior authorization or may have separate coverage criteria; please refer to the health plan. **Genetic Counseling Requirement** **Genetic testing, i.e., whole exome sequencing, included in these Guidelines is covered when:** **Explanation of Change** The genetic counseling requirement does not apply to genetic testing using chromosomal microarray analysis, now included in this guideline. Whole exome sequencing is the medically necessary genetic testing for which this requirement is applicable. This was clarified with the revision. **Whole Exome Sequencing (Phenotype Suspicious of a Genetic Disorder, Epilepsy and Hearing Loss sections)** **Whole Exome Sequencing** Whole exome sequencing (WES) (81415 with or without 81416) is medically necessary for any of the following clinical scenarios when all of the general criteria for WES testing (below) are also met.	March 6, 2022	Commercial	Prior authorization still required via AIM.

	Phenotype Suspicious for a Genetic Diagnosis Testing is ordered after an individual has been evaluated by a board-certified medical geneticist or other board-certified specialist physician with specific expertise in the conditions being tested for and relevant genes, AND any of the following: • Individual with multiple major structural or functional congenital anomalies affecting unrelated organ systems (including major metabolic disorders), **OR** • Individual with one major structural or functional congenital anomaly and two or more minor structural anomalies, **OR** • Individual with one major structural congenital anomaly and a family history strongly implicating a genetic etiology **OR** • Individual with known or suspected developmental and epileptic encephalopathy (onset before three years of age) for which likely non-genetic causes of epilepsy (e.g., environmental exposures; brain injury secondary to complications of extreme prematurity, infection, trauma) have been excluded, **OR** • Individual diagnosed with global developmental delay* following formal assessment by a developmental pediatrician or neurologist, **OR** • Individual diagnosed with a moderate/severe/profound intellectual disability** following formal assessment by a developmental pediatrician or neurologist, **OR** • Individual with confirmed bilateral sensorineural hearing loss of unknown etiology *Global developmental delay is defined as significant delay in younger children, <5 years of age, in at least two of the major developmental domains: gross or fine motor; speech and language; cognition; social and personal development; and activities of daily living. **Moderate/severe/profound			

	intellectual disability as defined by DSM-5 diagnosed by 18 years of age. **Explanation of Change** • There is now sufficient evidence that the diagnostic yield and clinical utility has been proven for WES as a first-tier test in individuals with global developmental delay (gDD) or intellectual disability (ID) (as defined above). The revised WES criteria streamlines current criteria with an expansion for testing applicable only to those with ID/gDD. **<u>Whole Exome Sequencing (General Criteria for WES Testing)</u>** WES is not medically necessary in the following scenarios: • Testing using cell-free DNA • Preimplantation testing of an embryo • Genetic carrier screening • Asymptomatic screening • Oncology indications • Isolated mild intellectual disability • Isolated autism spectrum disorder **Explanation of Change** • The addition of "asymptomatic screening" is a clarification- no change in stance. "Executive health screens" outside the realm of reproductive testing are gaining popularity, thus a criterion addressing this testing was added. • The addition of "isolated mild intellectual disability and autism spectrum disorder" are clarifications and do not represent a change in coverage stance. **<u>Chromosomal Microarray Analysis</u>** *Current coverage criteria for CMA from the Genetic Testing for Single-Gene and Multifactorial Conditions guideline were inserted with the following changes:* Chromosomal microarray analysis (CMA) is medically necessary for any of the following indications: • Non-syndromic autism spectrum disorder • Non-syndromic global developmental delay or			

	intellectual disability* • Individual with multiple major structural or functional congenital anomalies affecting unrelated organ systems (including major metabolic disorders)* • Known or suspected developmental and epileptic encephalopathy (onset before three years of age) for which likely non-genetic causes of epilepsy (e.g., environmental exposures; brain injury secondary to complications of extreme prematurity, infection, trauma) have been excluded* *CMA is intended for use in the detection of chromosomal duplications and deletions only and is therefore indicated when the possibility of microdeletion or microduplication syndromes/conditions are suspected. It cannot detect other common variant types (e.g., sequence variants). If sequence variants are high on the differential diagnosis, please see whole exome sequencing criteria above. **Explanation of Change** The asterisk was added to the non-syndromic global developmental delay or intellectual disability criterion to reflect the gDD/ID criterion added to WES criteria (the asterisk also now directs one to the whole exome sequencing criteria "below" since CMA is now part of the same guideline). **Whole Genome Sequencing** Whole genome sequencing (WGS) is not medically necessary*. Whole genome sequencing of the transcriptome (RNA sequencing) and genome mapping are not medically necessary. **Explanation of Change** The addition of "genome mapping" is a clarification and does not represent a change in coverage stance.			

MULTISPECIALTY - PRIOR AUTHORIZATION INFORMATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED

Medicare Advantage Management	132	**Policy clarified.** Outpatient prior authorization requirements for **Medicare Advantage PPO** effective date is January 1, 2022.	January 1, 2022	Medicare	Prior authorization required for certain procedures for Medicare Advantage PPO products.
Outpatient Prior Authorization Code List for Commercial	072	Outpatient prior authorization requirements for Commercial PPO and EPO is **delayed until further notice**.	Delayed until further notice	Commercial	No action required.

NEUROLOGY NEUROSURGERY AND ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Epidural Steroid Injections for Neck and Back Pain	690	**Enforcement update.** Diagnoses codes list added. New diagnoses-to-CPT codes edit implemented. Policy criteria unchanged.	January 7, 2022	Commercial	No action required.
Evaluation of Biomarkers for Alzheimer Disease (AD)	581	**Policy clarified.** Additional evidence review added for use of cerebrospinal fluid biomarkers in the management of mild cognitive impairment or mild dementia due to who are being evaluated for the initiation or continuation of amyloid beta targeting therapy. These indications are considered investigational.	December 1, 2022	Commercial Medicare	No action required.
Medical Technology Assessment Noncovered Services	400	**Ongoing investigational statement transferred to MP #482** Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, Biacuplasty and Intraosseous Basivertebral Nerve	December 1, 2022	Commercial	No action required.

		Ablation.			
Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, Biacuplasty and Intraosseous Basivertebral Nerve Ablation	482	**Policy clarified.** Policy statements updated to include ongoing investigational statement on intraosseous radiofrequency ablation of the basivertebral nerve (e.g., Intracept® system) for the treatment of vertebrogenic back pain.	December 1, 2022	Commercial	No action required.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medicare Advantage Part B Step Therapy	020	Mvasi and Zirabev removed as Step 1 requirement prior to use of Beovu, Eylea, Lucentis, Macugen based on updated CMS guidance.	December 1, 2021	Medicare	Providers will be required to use Avastin prior to use of Beovu, Eylea, Lucentis, Macugen based on updated CMS guidance.

PLASTIC SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Reduction Mammaplasty for Breast-Related Symptoms	703	**Policy clarified.** New medically necessary indications described for repeat reduction mammoplasty.	December 1, 2021	Commercial	Outpatient prior authorization still required.
Gender Affirming Services (Transgender Services)	189	**Policy clarified.** Policy statement on surgical procedures revised to clarify that surgical procedures may be done in stages as needed. Policy statement on facial feminization or	December 1, 2021	Commercial Medicare	Outpatient prior authorization still required for surgical procedures.

		masculinization clarified to include scalp advancement (only as needed in conjunction with forehead contouring). Policy statement revised to clarify that hormone therapy is not required for transmasculine or gender diverse members requesting surgical chest procedures.			

PSYCHIATRY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders	297	**Policy clarified** to specify using an FDA-cleared device and modality. Policy statements unchanged.	December 1, 2021	Commercial	Outpatient prior authorization still required.

UROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence	471	**Policy revised.** Medically necessary policy statement in men and women with stress urinary incontinence who have failed appropriate conservative therapy expanded to include polyacrylamide hydrogel, which is now FDA approved.	March 1, 2022	Commercial	No action required.

November 2021

ALLERGY IMMUNOLOGY AND OTOLARYNGOLOGY

POLICY TITLE	POLICY	POLICY CHANGE SUMMARY	EFFECTIVE	PRODUCTS	PROVIDER

	NO.		DATE	AFFECTED	ACTIONS REQUIRED
Cryoablation for Chronic Rhinitis	843	**New medical policy** describing ongoing investigational indications. Ongoing investigational policy statement transferred from MP 400 to new policy **#843** Cryoablation of Chronic Rhinitis. HCPCS code: C9771 remains investigational.	November 1, 2021	Commercial Medicare	No action required.
Intraoperative Neurophysiologic Monitoring Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring	211	**Policy clarified** to indicate that IONM of the facial nerve may be indicated during cochlear implantation, middle ear, and mastoid surgery and other neurotologic/otologic surgical procedures).	November 1, 2021	Commercial	Outpatient prior authorization still required.
Medical Technology Assessment Investigational (Non-Covered) Services List	400	**Ongoing investigational policy** statement on cryoablation for chronic rhinitis removed and transferred to new policy **#843** Cryoablation of Chronic Rhinitis.	November 1, 2021	Commercial Medicare	No action required.

ALTERNATIVE MEDICINE

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Complementary Medicine	178	**Policy clarified** to add bioelectromagnetic therapy as an investigational service. **Policy clarified** to include description, summary and references from literature search through October 2021. Ongoing investigational policy	November 1, 2021	Commercial Medicare	No action required

		statement unchanged.			

DURABLE MEDICAL EQUIPMENT AND REHABILITATION MEDICINE

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Durable Medical Equipment (DME)	842	**New medical policy** listing DME medical policies.	February 1, 2022	Commercial	No action required.
Manual and Power Operated Wheelchairs	365	Prior authorization requirements for power operated wheelchairs **delayed until further notice**.	Delayed until further notice	Commercial	Outpatient prior authorization required.

ONCOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Surgical and Debulking Treatments for Lymphedema	037	**Policy clarified:** Criteria pertaining to Bioimpedance (L-Dex) differential of at least 10 units was removed. Policy intent is unchanged.	November 1, 2021	Commercial Medicare	No action required.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Site of Care	137	**New pharmacy policy implementation cancelled:** Policy #137 Site of Care is not being implemented as previously announced in May 2021.	N/A	N/A	No action required.

October 2021

NEW MEDICAL POLICIES					
New Medical Policy Title	Policy Number	Policy Summary	Effective Date	Products Affected	Policy Type
Aducanumab for Alzheimer	946	New medical policy describing investigational	October 8, 2021	Commercial Medicare	Neurology

Disease		indications.			
Adjunctive Techniques for Screening and Surveillance of Barrett Esophagus and Esophageal Dysplasia	841	New medical policy describing investigational indications.	January 1, 2022	Commercial Medicare	Gastro-enterology

REVISED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Gender Affirming Services (Transgender Services)	189	Policy revised to include new medically necessary statements for vocal cord surgery for transfeminine members. Clarified to indicate chest procedures may be done with or without body contouring. Policy reformatted for clarity.	October 1, 2021	Commercial Medicare	Plastic Surgery
Intravitreal and Punctum Corticosteroid Implants	272	New medically necessary indications described for fluocinolone acetonide intravitreal implant (Yutiq®) for the treatment of chronic noninfectious posterior uveitis affecting the posterior segment of the eye.	January 1, 2022	Commercial Medicare	Ophthal-mology
Plastic Surgery	068	Policy updated to include medically necessary language for adolescent and adult intersex members whose anatomy does not conform to typical binary notions of male or female and/or is not congruent with their gender identity.	September 1, 2021	Commercial	Plastic and Reconstruc-tion Surgery
Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers	354	New investigational indications described for use of lymphedema pumps applied to the head and neck to treat lymphedema.	January 1, 2022	Commercial	Oncology

Advanced Imaging Radiology

Effective for dates of service on and after November 7, 2021 and March 13, 2022, the following updates will apply to the AIM Advanced Imaging Clinical Appropriateness Guidelines. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. **Note:** *Updates highlighted in green are effective November 7, 2021. Updates in black are effective March 13, 2022.*

AIM Guideline	Contains the following updates	Effective Date	Products Affected	Policy Type
Abdomen and Pelvis Imaging	**Female Reproductive System and Obstetric Indications** Uterine leiomyomata (fibroids) Advanced imaging is considered medically necessary following nondiagnostic ultrasound for management prior to a fertility-sparing procedure, with the exception of MR-guided focused ultrasound **Explanation of change** • Expanded to include other fertility sparing procedures • New requirement for nondiagnostic US prior to MRI **Gastrointestinal Indications** **Explanation of change** • Removed as a standalone indication because advanced imaging is not routinely recommended for imaging suspected intussusception **Hepatobiliary Indications** Diffuse liver disease For hepatocellular cancer screening in high-risk patients, see the Oncologic Imaging guidelines. **IMAGING STUDY** CT abdomen for EITHER of the following: • Suspected liver disease • Iron overload in hemochromatosis when MRI cannot be performed or is nondiagnostic • MRI abdomen for evaluation of hemochromatosis • MR elastography for diagnosis and management of advanced hepatic fibrosis/cirrhosis • Multiparametric MRI (LiverMultiScan) in EITHER of the following scenarios: o As an alternative to MR elastography for diagnosis and management of advanced hepatic fibrosis/cirrhosis o As an alternative to MRI abdomen for evaluation of hemochromatosis **Explanation of change** o Moved screening for HCC in cirrhosis to Oncologic Imaging guidelines; defined patients in whom advanced imaging is indicated o New indication for LiverMultiScan in patient population for whom MR elastography is appropriate, and for evaluation of	Updates highlighted in green are effective November 7, 2021 Updates in black are effective March 13, 2022	Commercial Medicare	Radiology Imaging

	hemochromatosis. **<u>Jaundice</u>** **ADULT** Advanced imaging is considered medically necessary for the diagnosis of jaundice when unexplained by liver and biliary function tests. **PEDIATRIC** Advanced imaging is considered medically necessary following nondiagnostic ultrasound, for the diagnosis of jaundice when unexplained by liver and biliary function tests. **Explanation of change** o Requirement for initial evaluation with US in pediatric patients **<u>Osseous Indications</u>** Sacroiliitis, not otherwise specified Advanced imaging is considered medically necessary for diagnosis and management following pelvic or sacral radiographs in EITHER of the following scenarios: o Condition predisposing to sacroiliitis, such as inflammatory bowel disease, psoriasis, or infection, when radiographs are negative or equivocal for sacroiliitis o Radiographs equivocal for sacroiliitis **Explanation of change** Defined patient population in whom advanced imaging is indicated **<u>Pancreatic Indications</u>** Pancreatic mass, indeterminate solid Advanced imaging is considered medically necessary for diagnosis, management, and surveillance. **IMAGING STUDY** • CT abdomen or CT abdomen and pelvis, with pancreatic protocol • MRI abdomen **Explanation of change** • Included CT pelvis as this is sometimes included in pancreatic protocol CT **<u>Pancreatic mass, indeterminate cystic (IPMN/IPMT)</u>** **ADULT** Advanced imaging is considered medically necessary for diagnosis, management, and surveillance in surgical candidates when EUS/FNA has not been performed or is nondiagnostic in ANY of the following scenarios: • Initial evaluation of an indeterminate mass identified on ultrasound • Age 80 or greater at the time of diagnosis: every other year for up to 4 years or every other year if enlarging • Cysts less than 1.5 cm			

	○ Age less than 65 at diagnosis: every 12 months for up to 9 years from the time of initial diagnosis ○ Age 65 to 79 at diagnosis: every 24 months for up to 10 years from the time of initial diagnosis • Cysts 1.5 cm or greater ○ Every 6-12 months for 2 years then yearly for up to 10 years **PEDIATRIC** Advanced imaging is considered medically necessary for diagnosis, management, and surveillance. **IMAGING STUDY** • CT abdomen or CT abdomen and pelvis • MRI/MRCP abdomen **Explanation of change** • Clarified age criteria and follow up intervals • Added CT pelvis to address pancreatic protocol variations **<u>Pancreatitis</u>** Advanced imaging is considered medically necessary in EITHER of the following scenarios: • Evaluation of suspected complications due to acute pancreatitis (see pancreatic pseudocyst) • Recurrent acute pancreatitis of uncertain etiology, defined as more than 2 attacks of acute pancreatitis without established end-stage chronic pancreatitis Note: Patients with mild acute or uncomplicated pancreatitis usually do not require cross-sectional imaging, aside from ultrasound for identification of gallstones and/or biliary ductal calculi. **IMAGING STUDY** • CT abdomen or CT abdomen and pelvis **Explanation of change** • Added CT pelvis to allow for venous phase pelvic imaging and/or evaluation of paracolic gutters • Clarified definition of recurrent acute pancreatitis so that it only excludes end-stage chronic pancreatitis, not all chronic pancreatitis **<u>Renal, Adrenal, and Urinary Tract Indications</u>** **Explanation of change** • Removed as CT is generally not indicated unless there is concern for underlying pathology such as mass or hydronephrosis, which are addressed separately within the guidelines. **<u>Hematuria</u>** **ADULT** Advanced imaging is considered medically necessary for diagnosis and management in ANY of the following scenarios:			

	• Traumatic hematuria
	• Macroscopic hematuria
	• Microscopic hematuria in EITHER of the following scenarios:
	  ○ Symptomatic
	  ○ Asymptomatic in EITHER of the following scenarios:
	  ▪ High-risk patients (defined as ANY of the following):
	  • Age greater than 59 years
	  • More than 30 pack year smoking history
	  • More than 25 red blood cells per high powered field (RBC/HPF)
	  • History of gross hematuria
	  ▪ Low or intermediate risk patients (those not meeting the high-risk criteria above) when ALL of the following criteria are met:
	  • Persistent and unexplained following repeat urinalysis
	  • Negative renal ultrasound
	  • Nondiagnostic cystoscopy
	Explanation of change
	Modified criteria for asymptomatic microhematuria based on AUA guideline
	
	<u>Polycystic kidney disease</u>
	Advanced imaging is considered medically necessary for diagnosis and management following nondiagnostic ultrasound, to evaluate total kidney volume AND to assist in decisions on medical therapy.
	Explanation of change
	Added language clarifying that advanced imaging should be used to guide treatment changes, given that not all patients undergo medical therapy
	
	<u>Renal masses (includes renal cysts)</u>
	For patients with a known primary malignancy, or for renal cancer screening in patients with a genetic predisposition, see the Oncologic imaging guidelines.
	See separate indication for Polycystic kidney disease.
	ADULT
	Advanced imaging is considered medically necessary in patients with a known renal mass and a genetic or medical predisposition to renal cancer			

	or in ANY of the following scenarios:
	• Diagnosis and management of an indeterminate renal mass in ANY of the following scenarios:
	  ○ Initial evaluation of an indeterminate mass identified on ultrasound
	  ○ Growth (more than 3 mm per year) over a 5-year period
	  ○ Mass with at least one suspicious feature (ANY of the following):
	  ▪ Thick or irregular cyst wall
	  ▪ Mural nodule
	  ▪ Calcification
	  ▪ Greater than 20 HU on a contrast enhanced CT or between 21 and 69 HU on a noncontrast CT
	  ▪ Infiltrative or ill defined
	• Management of a solid benign renal mass with new or worsening symptoms
	• Surveillance
	  ○ Bosniak IIF: 6 months and 12 months after initial diagnosis, then annually until 5 years from the time of initial diagnosis
	  ○ Solid renal mass suspicious for renal cancer or Bosniak III or IV complex cyst: initial at 6-12 months after initial diagnosis, then annually when part of an active surveillance management strategy
	Note: Classification is based on the Bosniak criteria prior to the 2019 update.
	Explanation of change
	• Clarified that this indication includes both cystic and solid masses
	• Clarified follow up endpoint for Bosniak IIF
	• Removed endpoint for active surveillance
	
	<u>Urinary tract calculi</u>
	*Recurrence applies when the patient has a prior history of stones but the prior episode has resolved (either the stone is known to have passed based on clinical follow-up, or prior imaging has shown resolution).
	Explanation of change
	• Defined difference between management and recurrence – no intended change in coverage
	• For post-lithotripsy or ureteroscopic stone removal, deleted requirement that calculi be radiolucent as this requirement is not in AUA guideline
	
	Transplant-related imaging
	Advanced imaging is considered medically necessary in the following scenarios:
	• For living donors, a single pre-transplant evaluation			

	• For patients on the transplant waiting list for liver transplantation, annual surveillance • Evaluation of suspected post-transplant complications Note: For patients on the transplant list but who have not undergone transplantation and who have a change in clinical condition, please refer to the applicable sign- or symptom-based indication. **IMAGING STUDY** • CT abdomen or CT abdomen/pelvis • MRI abdomen as an alternative to CT abdomen for surveillance in patients on the waiting list for liver transplantation **Explanation of change** New indication for transplant-related imaging			
Brain Imaging	**<u>Congenital and Developmental Conditions</u>** Sickle cell disease (pediatric only) Advanced imaging is considered medically necessary for periodic screening and surveillance for silent cerebral infarcts in patients with sickle cell disease. **IMAGING STUDY** • MRI brain **Explanation of change** New indication for infarct evaluation in sickle cell based on AHS guideline **<u>Acoustic neuroma</u>** Also see indication for hearing loss. Also see Head and Neck Imaging guidelines. Advanced imaging is considered medically necessary for management of known acoustic neuroma in patients with neurofibromatosis type 2 or in ANY of the following scenarios: Management • Signs, symptoms or imaging findings suggestive of recurrence or progression Surveillance • Following conservative treatment (“watch and wait”) or incomplete resection (including proton beam therapy or stereotactic radiosurgery) annually for 5 years • Single follow up study following gross total resection within the first year after surgery **IMAGING STUDY** • MRI brain **Explanation of change** • Removed indication for CT brain; CT temporal bone is preferable to CT brain for this indication and has been added to the Head and Neck guidelines • Clarified that the follow up within 12 months of surgery is intended to be a single follow up study **<u>Meningioma</u>**	March 13, 2022		

	Advanced imaging is considered medically necessary in EITHER of the following scenarios:
	Management
	• For a patient with known meningioma and new or worsening symptoms
	Surveillance in EITHER of the following scenarios:
	• Every 6 months if ANY of the following are present:
	  ○ Vasogenic edema on prior MRI
	  ○ Interval growth on prior imaging
	  ○ Lesion is located in the sphenoid wing, venous sinus, or skull base regions
	• Every 12 months if none of the above features are present
	IMAGING STUDY
	• MRI brain
	• CT brain when MRI cannot be performed
	Explanation of change
	New guideline delineating follow up interval for meningioma (previously included in "Brain tumor, NOS"
	
	<u>Pituitary adenoma</u>
	For management and surveillance, this indication applies to pituitary lesions that have been previously characterized by a dedicated pituitary protocol MRI with one or more findings suggestive of an adenoma.
	• Advanced imaging is considered medically necessary in ANY of the following scenarios:
	• Diagnosis of suspected pituitary adenoma when supported by signs or symptoms as well as laboratory findings
	• Management (including perioperative evaluation) of known adenoma
	• Surveillance of clinically stable adenoma in EITHER of the following:
	  ○ Unresected
	  ▪ Macroadenoma (size greater than 10 mm)
	  ▪ Microadenoma (size 10 mm or less): Annual surveillance imaging
	  ○ Resected
	  ▪ At least 3 months following resection
	Note: Surveillance imaging applies to patients who are clinically stable and in whom there is no anticipated change in management. Management applies to patients with new or worsening signs or symptoms, or in whom resection or other change in treatment is planned.
	IMAGING STUDY
	• MRI brain
	• CT brain for management or surveillance of microadenoma when MRI cannot be performed or as an alternative to MRI brain for macroadenoma			

	Explanation of change • Added detail to distinguish this from incidentaloma • Removed indication for CT when MRI is nondiagnostic in macroadenoma **<u>Pituitary incidentaloma</u>** *Applies to pituitary lesions incidentally discovered on advanced imaging that have not been fully characterized with a dedicated pituitary protocol MRI.* Advanced imaging is considered medically necessary for the diagnosis of an incidentaloma greater than or equal to 5 mm that is not a simple cyst. **IMAGING STUDY** • MRI brain **Explanation of change** • New indication for incidentaloma **<u>Tumor – not otherwise specified</u>** See Oncologic Imaging guidelines for management of an established malignancy Advanced imaging is considered medically necessary for diagnosis, management, and surveillance of tumor when suggested by prior imaging. **IMAGING STUDY** • CT brain • MRI brain Exclusions: In the absence of suspicious features (hemorrhage, contrast enhancement, calcifications), routine surveillance of the following lesions is not indicated: • Arachnoid cyst • Pineal cyst • Lipoma • Epidermoid **Explanation of change** • Added indication for management to address new or worsening signs or symptoms • Excluded specific lesions for which routine surveillance is not indicated **<u>Headache</u>** **Explanation of change** Removed for greater clarity as “associated with the headache” is difficult to operationalize			
Cardiac Imaging	Indications where FFR-CT may be appropriate but is not a required capability of the performing imaging facility **<u>Preoperative evaluation for patients undergoing noncoronary cardiac surgery</u>** • Patients undergoing evaluation for transcatheter aortic valve implantation/replacement (TAVI or TAVR) at	Updates highlighted in green are effective November 7, 2021 Updates in black are		

	low or intermediate ["or intermediate" removed 3-13-22] risk for CAD (using ASCVD Pooled Cohort Equations) to avoid invasive angiography, where all the necessary preoperative information can be obtained using cardiac CT • Patients undergoing evaluation for valve surgery (not including TAVR) at low or intermediate risk for CAD (using ASCVD Pooled Cohort Equations) **Explanation of change** Revise criteria for preoperative evaluation of patients undergoing TAVI/TAVR or other cardiac valve surgery to include those at low risk for CAD and exclude those at intermediate risk for patients undergoing TAVI/TAVR **Literature support:** Otto CM, Nishimura RA, Bonow RO, et al. 2020 ACC/AHA Guideline for the management of patients with valvular heart disease: A report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Journal of the American College of Cardiology. 2021;77(4):e25-e197 **Evaluation of Left Ventricular Function** • Post-cardiac transplant evaluation when EITHER of the following applies: ○ Evaluation of new or worsening cardiac signs, symptoms or new EKG abnormalities ○ Surveillance of a stable patient (no new or worsening cardiac signs or symptoms) at ANY of the following times: ▪ Within the first 6 months post-transplant ▪ 3-month intervals between 6- and 24-months post-transplant ▪ 6-month intervals more than 24 months post-transplant **Explanation of change** Frequency of surveillance echo increased to allow every 6 months in stable patients more than two years post-cardiac transplant based on expert opinion. (Cleveland Clinic)	effective March 13, 2022		
Chest Imaging	**Pneumonia** Advanced imaging is considered medically necessary in ANY of the following scenarios: • Radiographs show no improvement following at least 4 weeks of medical treatment • Recurrence of pneumonia in the same location within 6 months • Evaluation of known or suspected complications of pneumonia following nondiagnostic radiographs	Updates highlighted in green are effective November 7, 2021 Updates in		

	• Immunosuppressed patients with signs or symptoms of pneumonia **Explanation of change** • Removed indication for diagnosis of COVID-19 due to availability and accuracy of lab testing • Complications of COVID should be addressed via the remaining indications within Pneumonia **<u>Pulmonary nodule or mass</u>** Advanced imaging is considered medically necessary in the following scenarios: Pulmonary nodules detected on lung cancer screening CT • Follow up according to the most current version of Lung-RADS **Calcified nodules detected on a diagnostic chest CT** • Follow up of calcified nodules other than those with benign calcification patterns* is at the discretion of the ordering provider *Benign calcification patterns include granulomas and popcorn calcifications, for which routine follow up is not medically necessary **Noncalcified nodules detected on a diagnostic chest CT** • Younger than age 35 o Nodules ≥ 1 cm or with suspicious morphology (includes nodules with irregular or spiculated margins) • Age 35 or older o Solid nodules: see Table 1 o Subsolid nodules: see Table 2 **Nodules identified on incomplete thoracic CT** • Less than 6 mm: see table 1 or 2 “less than 6 mm” • 6 mm to 8 mm: 3 to 12 month follow up with complete chest CT; subsequent follow up based on characterization of nodule • Greater than 8 mm or suspicious morphology*: complete chest CT with subsequent follow up based on characterization of nodule *Suspicious morphology includes nodules with irregular or spiculated margins **IMAGING STUDY** • CT chest (all indications) • PET, PET-CT when BOTH of the following are criteria are met: o Nodule is well-demarcated, solid or part solid, and lacks a benign calcification pattern. o Size is greater than 8 mm in greatest diameter **Explanation of change** • Clarified language around 18-24 month follow	black are effective March 13, 2022		

	up CT • Removed some constraints around PET/CT for pulmonary nodule follow up (no intended change in coverage; change made for clarity or for difficult to operationalize points) • Separated follow up for nodules detected on lung cancer screening CT to align those with Lung-RADS (minimal change in coverage position) **Interstitial lung disease (ILD), non occupational including idiopathic pulmonary fibrosis (IPF)** In a patient with persistent cough but without other signs or symptoms, please see the Chronic cough indication. Advanced imaging is considered medically necessary in ANY of the following scenarios: Diagnosis when ANY of the following are present: • Persistent breathlessness on exertion • Bilateral inspiratory crackles on physical exam • Clubbing of the fingers • Suggestive of ILD/IPF on other diagnostic tests (chest radiography, pulmonary function) • Additional risk factors (ANY of the following): o Connective tissue disease o Predisposing drugs o Known telomerase mutation o Familial ILD/IPF with at least two affected first-degree relatives **Explanation of change** • Removed "persistent cough" here as it is addressed in the "chronic cough" indication. **Transplant-related imaging** Advanced imaging is considered medically necessary in the following scenarios: • Single evaluation prior to lung, liver, kidney, or hematopoietic stem cell transplantation • Evaluation for complications following lung, liver, kidney, or hematopoietic stem cell transplantation Note: For patients on the transplant list but who have not undergone transplantation and who have a change in clinical condition, please refer to the applicable sign- or symptom-based indication. **IMAGING STUDY** • CT chest **Explanation of change** • New indication for imaging related to transplant			
Head and Neck Imaging	**Sinusitis/rhinosinusitis** Screening • A single study is considered medically necessary for evaluation of immunosuppressed patients prior to	Updates highlighted in green are effective November 7,		

	chemotherapy or bone marrow or stem cell transplant
	Diagnosis
	• Complications of sinusitis
	  o Orbital
	  o Intracranial
	  o Vascular
	  o Related to invasive fungal sinusitis
	• Initial evaluation of acute recurrent rhinosinusitis, chronic rhinosinusitis, or barosinusitis not responsive to at least 3 weeks of acceptable medical therapy including EITHER of the following:
	  o trial of nasal saline irrigation and intranasal steroids
	  o trial of nasal saline irrigation OR intranasal steroids and at least two other forms of sinonasal medical therapy
	Explanation of change
	• New screening indication for immunosuppressed patients prior to chemo or transplant (based on Operational input and to comply with NCCN 2A recommendation)
	
	<u>Acoustic neuroma</u>
	Also see indication for hearing loss.
	Also see Brain Imaging guidelines.
	Advanced imaging is considered medically necessary for management of known acoustic neuroma in patients with neurofibromatosis type 2 or in ANY of the following scenarios:
	Management
	• Symptoms or imaging findings suggestive of recurrence or progression
	Surveillance
	• Following conservative treatment ("watch and wait") or incomplete resection (including proton beam therapy or stereotactic radiosurgery) annually for 5 years
	• Single follow up study following gross total resection within the first year after surgery
	IMAGING STUDY
	• CT orbit, sella, or posterior fossa and outer, middle, or inner ear when MRI cannot be performed
	
	Explanation of change
	• Added indication for CT temporal bone rather than CT brain in patients who cannot have MRI
	
	<u>Parathyroid adenoma</u>
	Advanced imaging is considered medically necessary in EITHER of the following scenarios:
	• To identify an adenoma for surgical planning in patients with ANY of the following:
	  o Symptomatic hyperparathyroidism
		2021
		
		Updates in black are effective March 13, 2022		

	○ Serum calcium > 1 mg/dL above the normal range ○ Primary hyperparathyroidism and imaging showing osteoporosis, fragility fracture, or vertebral compression fracture ○ Hyperparathyroidism diagnosed at age 50 years or younger ○ Clinical or biochemical evidence consistent with parathyroid cancer ○ Patient unwilling or unable to comply with observation protocols ○ Neurocognitive/neuropsychiatric symptoms due to hyperparathyroidism • Localization of residual parathyroid tissue in patients with recurrent or persistent disease following parathyroidectomy **IMAGING STUDY** ○ CT soft tissue neck when ultrasound and parathyroid scintigraphy are nondiagnostic or normal in patients with high clinical suspicion of a parathyroid adenoma ○ CT soft tissue neck as an alternative to parathyroid SPECT or SPECT-CT when requested by providers experienced in the treatment of parathyroid adenomas **Explanation of change** • Specified scenarios where surgery is recommended based on American Association of Endocrine Surgeons guidelines **<u>Temporomandibular joint dysfunction</u>** Advanced imaging is considered medically necessary for diagnosis or management when BOTH of the following requirements are met: • Mechanical symptoms (such as locking, popping, or clicking) which have not improved with a six-week course of conservative treatment, including nonsteroidal anti-inflammatory drugs or acetaminophen, a short-term trial of soft diet and proper chewing techniques, and an oral appliance (such as a bite block) • Surgical intervention is being considered **Explanation of change** • Specified duration of conservative treatment **<u>Perioperative imaging, not otherwise specified</u>** Includes only indications not listed elsewhere in this guideline document Advanced imaging is considered medically necessary in the following scenario: • For preoperative planning related to orthognathic surgery **IMAGING STUDY** • CT paranasal sinus and maxillofacial area • CT soft tissue neck			

	Explanation of change • New preoperative indication to address Operational concerns			

Oncologic Imaging	The following sections include indications for which advanced imaging is considered medically necessary, along with prerequisite information and supporting evidence where available. Indications, diagnoses, or imaging modalities not specifically addressed are considered not medically necessary.
	Indications are presented in the following sections by tumor type.
	Explanation of change
	• Addition of standard preamble language present in all AIM guidelines
	
	<u>Colorectal cancer screening</u>
	CT colonography (CTC) is indicated in ANY of the following scenarios:
	• Screening CT colonography is indicated for average risk individuals* as an alternative to conventional colonoscopy at 5-year intervals, beginning at age 45
	*Average risk:
	• No personal history of colonic adenoma, serrated sessile polyp (SSP), or colorectal cancer (CRC)
	• No personal history of inflammatory bowel disease
	• Negative first-degree family history for CRC, confirmed advanced adenoma (i.e., high-grade dysplasia, ≥ 1 cm, villous or tubulovillous histology or an advanced SSP)
	Explanation of change
	Alignment with updated USPSTF recommendation
	
	<u>Pancreatic cancer screening</u>
	Annual CT or MRI (preferred) Abdomen is indicated as an alternative to endoscopic ultrasound in ANY of the following scenarios:
	• Peutz-Jeghers syndrome (LKB1/STK11 mutations), starting at age 40
	• Familial Atypical Multiple Melanoma and Mole syndrome (FAMMM; CDKN2A, p16 mutation), starting at age 40
	• BRCA1, PALB2, ATM, or MLH1/MSH2/MSH6 (Lynch syndrome) gene mutation and at least one first degree relative (FDR) with pancreatic cancer, starting at age 45 or 10 years earlier than the youngest affected relative
	• BRCA2 gene mutation with EITHER of the following, starting at age 45 or 10 years earlier than the youngest affected relative:
	  ○ At least one FDR with pancreatic cancer
	  ○ At least two blood relatives with
		Updates highlighted in green are effective November 7, 2021
		
		Updates in black are effective March 13, 2022		

	pancreatic cancer • FDR and at least one other blood relative with pancreatic cancer, starting at age 50 or 10 years earlier than the youngest affected relative **Explanation of change** • Addition of age threshold specification by scenario from CAPS Consortium • Restructure of indicated scenarios for operational clarification **<u>Hepatocellular carcinoma (HCC) screening</u>** CT or MRI Abdomen is indicated as an alternative to abdominal ultrasound in patients with Hepatitis B or cirrhosis (any etiology) when ultrasound cannot be performed or is nondiagnostic. **Explanation of change** New HCC screening MRI allowance as alternative to AASLD recommended ultrasound screening; CT is restrictive change compared to current Abdominal Imaging indication **<u>Cancer screening, not otherwise specified</u>** CT or MRI is indicated for cancer screening currently categorized as a 2A recommendation from the National Comprehensive Cancer Network (NCCN) **Explanation of change** New section to allow incorporation of evolving NCCN screening recommendations in accordance with AIM adoption framework **<u>Bladder, Renal Pelvis, and Ureter Cancers: Invasive</u>** **FDG-PET/CT** Diagnostic Workup: Indicated in EITHER of the following scenarios: • Evaluation of stage II or stage III bladder cancer prior to definitive treatment when standard imaging cannot be performed or is nondiagnostic for metastatic disease • When bone metastasis is suspected based on signs and symptoms and standard imaging cannot be performed or is nondiagnostic **Explanation of change** PET/CT - NCCN alignment; updated language inclusive of other treatment (including surgery, radiotherapy) **<u>MRI breast</u>** Suspected Cancer: • Lesion characterization when ultrasound and mammography are inconclusive for the presence of breast cancer, and biopsy cannot be performed • Metastatic cancer of unknown primary and suspected to be of breast origin by histology when no mammographic findings of primary			

	breast carcinoma **Explanation of change** • MRI Breast lesion characterization – now requires both mammogram and ultrasound (standard diagnostic workup) • MRI Breast suspected breast primary - aligned with NCCN Occult Primary guideline requiring nondiagnostic mammogram and histopatholgic evidence of breast cancer **<u>FDG-PET/CT</u>** Management: Indicated in ANY of the following scenarios: • Standard imaging cannot be performed or is nondiagnostic for recurrent or progressive disease • Evaluation of elevated LFTs or rising tumor markers when standard imaging has not clearly identified a site of recurrence or progression • Restaging/treatment response when bone is the only site of measurable disease in the chest, abdomen, and pelvis **Explanation of change** • PET clarification: management after negative standard imaging and objective metrics (i.e., nondiagnostic imaging definition) **<u>CT Chest</u>** Surveillance: Indicated annually for Stage II or III colorectal cancer, and every 6-12 months for Stage IV colorectal cancer **Explanation of change** CT Surveillance - NCCN alignment for frequency for stage IV disease (2A recommendation) **<u>CT abdomen and pelvis</u>** Surveillance: Indicated annually for Stage II or III colorectal cancer, and every 6-12 months for Stage IV colorectal cancer **Explanation of change** • CT Surveillance - NCCN alignment for frequency for stage IV disease (2A recommendation) **<u>MRI pelvis</u>** Surveillance: Indicated for rectal cancer treated with transanal local excision alone only **Explanation of change** • MRI Pelvis - NCCN evidence block alignment for surveillance of rectal cancer (2A recommendation) **<u>Esophageal and Gastroesophageal Junction Cancers</u>** **FDG-PET/CT** Management: Indicated in ANY of the following scenarios:			

	• Radiation planning for preoperative or definitive treatment only • Single assessment of response to chemoradiation (as definitive treatment or prior to surgery) when performed at least 5 weeks after completion of therapy • Standard imaging cannot be performed or is nondiagnostic for recurrent or progressive disease **Explanation of change** • PET clarification: Post chemoradiation imaging limited to single treatment response assessment (not ongoing) **<u>Hepatobiliary Cancer</u>** MRI abdomen with or without MRCP Diagnostic Workup and Diagnosis: Indicated for EITHER of the following scenarios: • Known cirrhosis or hepatitis B, with positive or rising serum alpha fetoprotein (AFP)* • Documented hepatobiliary cancer **Explanation of change** • MRI Abdomen +/- MRCP – NCCN alignment for positive or rising AFP in patients undergoing HCC screening (2A recommendation) **<u>Histiocytic Neoplasms</u>** MRI or CT (any) Diagnostic Workup: Indicated when categorized as 2A recommendation by NCCN Management: Indicated when categorized as 2A recommendation by NCCN Surveillance: Indicated when categorized as 2A recommendation FDG-PET/CT Diagnostic Workup: Indicated in EITHER of the following scenarios: • Patients with LCH and high-risk bone lesions and/or suspected multisystem disease • Patients with ECD or RDD Management: Indicated for ANY of the following scenarios: • Following radiation therapy • Treatment response after 2-3 cycles of systemic therapy and at completion • Treatment response of ECD • After completion of surgical curettage Surveillance: Indicated **Explanation of change** • New NCCN section (2A recommendations) **<u>Lung Cancer – Non-Small Cell</u>** **FDG-PET/CT** Diagnostic Workup: Indicated for evaluation of extent of disease following biopsy confirmation of non-small cell lung cancer if not previously performed			

	Management: Indicated in ANY of the following scenarios: • Radiation planning for preoperative or definitive treatment • Evaluation following induction or neoadjuvant therapy, to determine eligibility for resection • Assessment of response to definitive chemoradiation when performed at least 12 weeks following therapy • Standard imaging cannot be performed or is nondiagnostic for recurrent or progressive disease **Explanation of change** • PET for pulmonary nodule/mass characterization moved to Chest Imaging guideline • PET management: Language standardization for nondiagnostic imaging; combined with redundant scenario below reflecting "nondiagnostic CT" **<u>Lymphoma – Hodgkin</u>** **CT neck, CT chest, CT abdomen and pelvis** Surveillance: Indicated, not to exceed 2 years following completion of treatment **Explanation of change** • CT surveillance - NCCN evidence block alignment (CT neck, chest, abdomen/pelvis w/ contrast no more than q 6 months for the first 2 years following completion of therapy, or as clinically indicated, 2A) **<u>FDG-PET/CT</u>** Management: Indicated in ANY of the following scenarios: • Radiation planning for definitive or consolidative treatment • Evaluation of response following 2-4 cycles of treatment • Baseline post-treatment evaluation at least 3 weeks following completion of all cycles of chemotherapy or 12 weeks following completion of radiation therapy • Single follow up when first post-treatment baseline PET showed Deauville 4 or 5 findings* • Clinical suspicion for recurrence or progression of disease based on standard imaging or objective signs/symptoms **Explanation of change** PET management: Specification of single follow-up after baseline post-treatment PET **<u>Lymphoma – Non-Hodgkin and Leukemia</u>** **Acute Leukemia** **FDG-PET/CT** Management: Indicated in ANY of the following scenarios:			

	• Relapsed or refractory extramedullary disease • Treatment response of ALL with lymphomatous extramedullary disease • When standard imaging cannot be performed or is nondiagnostic **Explanation of change** • Acute leukemia: Addition of new scenario for ALL post-treatment induction, NCCN alignment (category 2A recommendation) **<u>Lymphoma – Non-Hodgkin: Intermediate and high grade non-Hodgkin lymphoma</u>** Includes Castleman Disease, Post-Transplant Lymphoproliferative Disorders **Explanation of change** • Lymphoma – Non-Hodgkin: Intermediate and high-grade non-Hodgkin lymphoma: Addition of included subtypes (NCCN classification) **<u>Melanoma</u>** CT neck, CT chest, CT abdomen and pelvis Surveillance: Indicated for stage IIB or higher **Explanation of change** • CT surveillance - NCCN alignment (stage 0-IIA: routine imaging not recommended to screen for asymptomatic recurrence, category 2A) **<u>Neuroendocrine Tumors</u>** **Well-differentiated neuroendocrine tumor** Somatostatin receptor-based imaging* *Somatostatin receptor-based imaging includes PET with 68Ga dotatate or 64Cu dotatate radiotracers. **Explanation of change** • Updated somatostatin receptor-based imaging notation to include 64Cu dotatate as option. **<u>Poorly-differentiated neuroendocrine tumor</u>** **FDG-PET/CT** Management: Indicated to assess treatment response when PET used for initial staging **Explanation of change** • NCCN does not address PET/CT for management **<u>Prostate Cancer Current Guideline</u>** MRI pelvis including multiparametric technique Diagnostic Workup and Diagnosis: Indicated in ANY of the following scenarios: • Persistent and unexplained elevation in PSA levels* or very suspicious DRE • Initial staging of intermediate or high-risk prostate cancer • Risk-stratification of low-risk cancer for potential active surveillance **Explanation of change** • Language/scenario clarifications (no clinical			

	intent change) **68Ga Prostate-specific membrane antigen (PSMA) PET/CT or 18F-DCFPyL (piflufolastat or Pylarify) PET/CT** Diagnostic Workup and Diagnosis: Not indicated Management: Indicated when ALL of the following criteria are met: • Original clinical stage T1-T3 and NX or N0 treated with prostatectomy and/or radiation therapy, with biochemically recurrent/persistent disease1 • Results of conventional imaging2 performed within the past 60 days are negative for metastasis • Patient is a candidate for curative intent salvage therapy3 • PSA level is > 1 ng/ml or PSA is rising • PET/CT has not been performed within the past 3 months Surveillance: Not indicated **Explanation of change** • Addition of new prostate-specific membrane antigen (PSMA) PET/CT scenarios **Sarcoma of Bone and Soft Tissue** **Soft Tissue Sarcoma** **FDG-PET/CT** Diagnostic Workup: Indicated in ANY of the following scenarios (excluding desmoid tumors): • Standard imaging cannot be performed or is nondiagnostic for metastatic disease • Standard imaging suggests a resectable solitary metastasis • Baseline study prior to neoadjuvant chemotherapy • Initial staging for rhabdomyosarcoma **Explanation of change** • Addition of initial staging for rhabomysarcoma scenario in NCCN alignment: "…May be useful for initial staging because of the possibility of nodal metastases and the appearance of unusual sites of initial metastatic disease in adult patients." (2A rec) • Exclusion for desmoid tumors (not addressed by NCCN) **Gastrointestinal stromal tumors (GIST)** **FDG-PET/CT** Management: Indicated in EITHER of the following scenarios: • Assess treatment response following completion of neoadjuvant chemotherapy • Standard imaging cannot be performed or is nondiagnostic for recurrent or progressive disease **Explanation of change** • Addition of management scenario in alignment			

	with NCCN (use of PET for ambiguous standard imaging findings) **<u>Testicular Cancer</u>** **FDG-PET/CT** Management: Indicated in EITHER of the following scenarios: • Standard imaging cannot be performed or is nondiagnostic for recurrent or progressive disease • Residual mass greater than 3 cm and normal tumor markers after completion of chemotherapy **Explanation of change** • NCCN PET alignment for Residual mass (> 3 cm) and normal serum AFP and beta-hCG specifically post-chemotherapy (2A recommendation) **<u>Thyroid Cancer</u>** Current Guideline MRI chest Diagnostic Workup: Indicated (note: for fixed, bulky, or substernal lesions) Management: Indicated when used in place of CT for initial treatment strategy Screening & Surveillance: Not indicated **Explanation of change** NCCN alignment (not addressed) **<u>Suspected or Known Metastases, not otherwise specified</u>** **MRI appendicular skeleton (pelvis, lower or upper extremity)** Diagnostic Workup: Indicated for ANY of the following: • Evaluation of suspected or known bony pelvic metastases • Evaluation of suspected proximal lower/upper extremity metastasis • Evaluation of suspected distal upper/lower metastasis when radiographs are nondiagnostic Management: Indicated for EITHER of the following: • Evaluation of suspected or known bony pelvic metastases **Explanation of change** • Addition of “proximal” limb scenario (prior content gap) • Removal of “suspected” indications from Management (operationally redundant)			

Radiation Oncology
Effective for dates of service on and after November 7, 2021 and March 13, 2022, the following updates will apply to the AIM Radiation Oncology Clinical Appropriateness Guidelines. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at

aim.guidelines@aimspecialtyhealth.com. **Note:** *Updates highlighted in green are effective November 7, 2021. Updates in black are effective March 13, 2022.*

AIM Guideline	Contains the following updates	Effective Date	Products Affected	Policy Type
Radiation Oncology	**ECOG status** Fractionated radiotherapy, 2 to 10 fractions, is only appropriate in individuals who meet ANY the following criteria: • Pathologic fracture • Soft tissue involvement by tumor • Spinal cord compression • Spine metastasis • Presence of oligometastatic disease (1-5 lesions) when the goal of treatment is long term stabilization of disease **Explanation of change** Removed ECOG performance status from AIM radiation therapy guidelines **Breast cancer – IMRT, SBRT** Intensity Modulated Radiation Therapy (IMRT) is appropriate for breast cancer when ANY one of the following conditions are met: • For individuals with left-sided breast lesions where the risk of cardiac exposure would be excessive with 3D conformal treatment and when ALL of the following are met: ○ 3D planning has been done, with appropriate techniques to limit toxicity ○ Despite the use of all appropriate techniques, the dose-volume constraints would lead to unacceptable risk of cardiac toxicity (EITHER constraint below is exceeded): ▪ More than 10% of the heart would receive 25 Gy or more (V25 > 10%) ▪ More than 10% of the left anterior descending (LAD) artery would receive 15 Gy (V15 > 10%) ○ IMRT plan demonstrates improvement to tissue exposure to within safe ranges • For individuals who will receive internal mammary node irradiation based on ANY one of the following: ○ Pathologically enlarged (as reported based on imaging technique utilized) internal mammary lymph node(s) by CT, MRI, PET/CT, or CXR ○ Pathologically involved internal mammary lymph node(s) (based on aspiration cytology or tissue biopsy pathology) ○ For individuals at high risk of internal mammary lymph node involvement	Updates highlighted in green are effective November 7, 2021 Updates in black are effective March 13, 2022	Commercial Medicare	Oncology

based on ANY one of the following:
    - Four or more positive axillary lymph nodes
    - Medial quadrant tumor with at least one positive axillary lymph node
    - Medial quadrant T3 tumor
- For individuals where the 3D conformal plan results in hot spots (> 2 cm3) receiving more than to 110% of the prescription dose despite the use of forward planned field-in-field blocking and/or mixed beam energy (6 MV and 10 MV/15 MV)
- For individuals being treated with accelerated partial breast irradiation (APBI)
- To treat a previously irradiated field

Note: "Forward planning IMRT" is a term used to describe field-in-field 3D conformal radiation therapy and should not be reviewed under IMRT constraints

Explanation of change

Added CAD V15. Added indication for APBI

Stereotactic Radiosurgery (SRS) or Stereotactic Body Radiation Therapy (SBRT) is appropriate for breast cancer when the following condition is met:

- To treat a previously irradiated field

Note: Five fraction APBI regimens should not be billed as SBRT as this is not an ablative dose and similar dose fractionation schedules can be safely delivered to the whole breast.

Explanation of change

New indication for SRS/SBRT to treat a previously irradiated field. Added Note that 6 Gy x 5 is not SBRT.

Brain metastases – SBRT

Stereotactic Radiosurgery (SRS/SBRT) is appropriate for metastatic brain lesions when EITHER of the following conditions is met:

- There are 5 or fewer brain metastases
- To treat a previously irradiated field

Note: Treatment of multiple lesions with SRS on different days within the same course of therapy should be billed as SBRT with a maximum of 5 units.

Explanation of change

- Added 5 lesions or less since ECOG was removed. Clarification that intent is to include fractionated treatment as well.
- Added Note based on ASTRO coding guidance.

Lung cancer – IMRT

Non-Small Cell Lung Cancer

Intensity Modulated Radiation Therapy (IMRT) is

	appropriate for non-small cell lung cancer when ANY of the following conditions are met:
	• For adjuvant or definitive treatment of stage I and II disease in the curative setting
	  ○ When a 3D plan has been performed and dose-volume constraints would lead to unacceptable risk for normal lung tissue toxicity such that (all must apply)
	  ▪ V20 exceeds 30% with 3D conformal plan (the percent of normal tissues receiving 20 Gy or more accounts for more than 30% of normal lung)
	  ▪ The comparison of the 3D conformal plan and the IMRT plan demonstrates that the IMRT plan will reduce the V20 by 10% as compared to the 3D conformal plan
	  ▪ V5 would be less than 65% (the percent of normal tissues receiving 5 Gy or more accounts for less than 65% of normal lung) with IMRT
	  ▪ Tumor motion has been accounted for during planning
	  ○ When a 3D plan has been performed and dose-volume constraints would lead to unacceptable risk of cardiac toxicity (any constraint below is exceeded)
	  ▪ More than 50% of the heart receives 30 Gy (V30 > 50%)
	  ▪ More than 35% of the heart receives 45 Gy (V45 > 35%)
	  ▪ More than 25% of the heart receives 50 Gy (V50 > 25%)
	  ▪ More than 10% of the left anterior descending artery (LAD) receives 15 Gy (V15 > 10%)
	• For adjuvant or definitive treatment of stage III disease in the curative setting
	• To treat a previously irradiated field
	Explanation of change
	Added CAD V15.
	Reference: Atkins KM, Chaunzwa TL, Lamba N, et al. Association of Left Anterior Descending Coronary Artery Radiation Dose with Major Adverse Cardiac Events and Mortality in Patients with Non-Small Cell Lung Cancer**.** JAMA Oncol. 2021 Feb 1;7(2):206-219. PMID: 33331883; PMCID: PMC7747040.
	
	<u>Small Cell Lung Cancer</u>
	Intensity Modulated Radiation Therapy (IMRT) is appropriate for small cell lung cancer when ANY of			

	the following conditions are met:
	• For definitive treatment in the curative setting
	  ○ When a 3D plan has been performed and dose-volume constraints would lead to unacceptable risk for normal lung tissue toxicity such that (all must apply)
	  ▪ V20 exceeds 30% with 3D conformal plan (the percent of normal tissues receiving 20 Gy or more accounts for more than 30% of normal lung)
	  ▪ The comparison of the 3D conformal plan and the IMRT plan demonstrates that the IMRT plan will reduce the V20 by 10% as compared to the 3D conformal plan
	  ▪ V5 would be less than 65% (the percent of normal tissues receiving 5 Gy or more accounts for less than 65% of normal lung) with IMRT
	  ▪ Tumor motion has been accounted for during planning
	  ○ When a 3D plan has been performed and dose-volume constraints would lead to unacceptable risk of cardiac toxicity (any constraint below is exceeded)
	  ▪ More than 50% of the heart receives 30 Gy (V30 > 50%)
	  ▪ More than 35% of the heart receives 45 Gy (V45 > 35%)
	  ▪ More than 25% of the heart receives 50 Gy (V50 > 25%)
	  ▪ More than 10% of the left anterior descending artery (LAD) receives 15 Gy (V15 > 10%)
	• To treat a previously irradiated field
	Explanation of change
	Added CAD V15.
	Reference: Atkins KM, Chaunzwa TL, Lamba N, et al. Association of Left Anterior Descending Coronary Artery Radiation Dose with Major Adverse Cardiac Events and Mortality in Patients with Non-Small Cell Lung Cancer. JAMA Oncol. 2021 Feb 1;7(2):206-219. PMID: 33331883; PMCID: PMC7747040.
	
	<u>Prostate cancer – IMRT, SBRT, Brachytherapy, Exclusions</u>
	<u>Low risk of recurrence</u>
	Intensity Modulated Radiation Therapy (IMRT) is appropriate for prostate cancer **when EITHER of the following conditions is met:**
	• As primary treatment			

	• To treat a previously irradiated field Stereotactic Body Radiation Therapy (SBRT) is appropriate for prostate cancer **when EITHER of the following conditions is met:** • As primary treatment • To treat a previously irradiated field Brachytherapy is appropriate as monotherapy for low risk prostate cancer. The following is appropriate: • Low dose rate (LDR) brachytherapy Note: Active surveillance is a reasonable alternative to radiation treatment in individuals with low risk prostate cancer. **Explanation of change** No change in intent but this question of anticipated survival is not practical when asking the office staff. **<u>Intermediate risk of recurrence</u>** Intensity Modulated Radiation Therapy (IMRT) is appropriate for prostate cancer **when EITHER of the following conditions is met:** • As primary treatment or in combination with brachytherapy • To treat a previously irradiated field Stereotactic Body Radiation Therapy (SBRT) is appropriate for prostate cancer **when EITHER of the following conditions is met:** • As primary treatment • To treat a previously irradiated field Brachytherapy is appropriate as either monotherapy or as a boost in combination with external beam radiotherapy. **EITHER of the following is appropriate:** • Low dose rate (LDR) brachytherapy used as monotherapy or boost • High dose rate (HDR) brachytherapy used as boost only **Explanation of change** No change in intent but this question of anticipated survival is not practical when asking the office staff. **<u>High risk of recurrence</u>** Intensity Modulated Radiation Therapy (IMRT) is appropriate for prostate cancer **when EITHER of the following conditions is met:** • As primary treatment or in combination with brachytherapy • To treat a previously irradiated field Stereotactic Body Radiation Therapy (SBRT) is appropriate for prostate cancer when the following condition is met: • Only to treat a previously irradiated field Brachytherapy is appropriate for prostate cancer when used in combination with external beam radiotherapy. **EITHER of the following is appropriate:** • Low dose rate (LDR) brachytherapy • High dose rate (HDR) brachytherapy			

	Explanation of change • No change in intent. **Hydrogel spacer** Removed Exclusions: hydrogel spacer Moved to separate document **Explanation of change** Moved hydrogel spacer content (CPT code 55874) from prostate cancer exclusions to a separate guideline document with new criteria and references. **Proton Beam Therapy** Discussion revised for Breast Cancer, CNS Lesions, Head and Neck Cancer, Hepatocellular Cancer, and GI Cancers Clinical Indications: No changes **Explanation of change** • Revised proton beam therapy considerations with discussion of recent clinical studies of treatments for breast cancer, CNS lesions, head and neck cancer, hepatocellular cancer, and other GI cancers. Added references. • No change to clinical indications			

CLARIFICATIONS TO MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Posted Date	Products Affected	Policy Type
Balloon Sinuplasty for Treatment of Chronic Sinusitis	582	Policy criteria clarified to align with the IFAR International Forum of Allergy & Rhinology (IFAR) and European Position (EPOS) guidelines for chronic rhinosinusitis.	October 1, 2021	Commercial Medicare	Oto-laryngology
Expanded Molecular Panel Testing of Cancers to Identify Targeted Therapies	790	Clarification added that requests for liquid biopsy should be made through AIM Specialty Health Genetic Testing Management Program.	October 1, 2021	Commercial Medicare	Oncology Hemato-logy Genetic Testing
Medical Technology Assessment Investigational (Non-Covered) Services List	400	Ongoing investigational CPT codes 81535 and 81536 added. Codes were transferred from retired policy #253 In Vitro Chemoresistance and Chemosensitivity Assays.	October 1, 2021	Commercial Medicare	Oncology Hema-tology Gyne-cology
Medical Technology Assessment Investigational (Non-Covered) Services List		Electrical Stimulation neoGEN-Series® System for chronic pain, long-term (intractable) pain and	September 15, 2021	Commercial Medicare	Rehabilita-tion Medicine

		drug-resistant pain added under the narrative section.			
Total Artificial Hearts and Implantable Ventricular Assist Devices	280	Policy statement revised to remove outdated eligibility criteria, but intent unchanged.	October 1, 2021	Commercial	Cardiology Thoracic Surgery

RETIRED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Cellular Immunotherapy for Prostate Cancer	268	Policy is retired. This drug is managed by AIM Specialty Health. See pharmacy medical policy #099 AIM Oncology Medication Management Program.pdf	October 1, 2021	Commercial Medicare	Oncology
In Vitro Chemoresistance and Chemosensitivity Assays	253	Investigational policy is retired. Ongoing investigational CPT codes 81535 – 81536 added to MP 400 Medical Technology Assessment Investigational (Non-Covered) Services List.	October 1, 2021	Commercial Medicare	Oncology Hema-tology Gyne-cology

NEW PHARMACY MEDICAL POLICIES			
Medical Policy Title	Policy Number	Policy Change Summary	Effective date
Injectable Methotrexate (Otrexup® & Rasuvo®)	840	New pharmacy policy describing medically necessary indications.	January 1, 2022
Multiple Sclerosis Step Therapy	839	New pharmacy policy describing medically necessary indications.	January 1, 2022

REVISED PHARMACY MEDICAL POLICIES			
Medical Policy Title	Policy Number	Policy Change Summary	Effective date
Medicare Advantage Part B Utilization Management	125	The following therapeutic classes or names of drugs will be added to the existing policy: Therapeutic class or name of medication: Immuneglobulins Code: J0840, J0850, J1459, J1460, J1555, J1556, J1557, J1558, J1559,	January 1, 2022

		<table><tr><td></td><td>J1560, J1561, J1562, J1566, J1568, J1569, J1571, J1572, J1573, J1575, J1599, J1670, J2791</td></tr><tr><td>Entyvio</td><td>J3380</td></tr><tr><td>Nplate</td><td>J2796</td></tr><tr><td>Orencia</td><td>J0129</td></tr><tr><td>Simponi</td><td>J1602</td></tr><tr><td>Stelara</td><td>J3357, J3358</td></tr><tr><td>Tyvaso</td><td>J7686</td></tr></table>	
Medicare Advantage Part B Step Therapy	020	▪ Euflexxa will move to Step 1 ▪ Hymovis and Hyalgan will be a Step 2.	January 1, 2022

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NEW MEDICAL POLICIES					
New Medical Policy Title	Policy Number	Policy Summary	Effective Date	Products Affected	Policy Type
Digital Health Therapies for Attention Deficit /Hyperactivity Disorder	947	New policy describing investigational indications for the treatment of attention deficit/hyperactivity disorder.	December 1, 2021	Commercial Medicare	Pediatrics Behavioral Health

REVISED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Magnetic Resonance Imaging-Guided Focused Ultrasound	243	New investigational indications described for the treatment of medication-refractory tremor dominant Parkinson disease.	December 1, 2021	Commercial	Obstetrics Gynecology
Medicare Advantage Management	132	Outpatient prior authorization requirements added for Medicare Advantage PPO.	January 1, 2022	Medicare	Multispecialty
Outpatient Prior Authorization Code List for Commercial	072	Prior authorization requirements for power operated wheelchairs **delayed until further notice.**	Delayed until further notice	Commercial	Multispecialty

CLARIFICATIONS TO MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Posted Date	Products Affected	Policy Type
Cryoablation of Tumors	260	Title changed to "Cryoablation of Tumors Located in the	September 1, 2021	Commercial Medicare	Oncology

Located in the Kidney, Lung, Breast, Pancreas, or Bone		Kidney, Lung, Breast, Pancreas, or Bone." Policy statement revised to align with separation of indications by tumor location - intent unchanged.			
Manual and Power Operated Wheelchairs	365	We announced in July 2021 the following new policies effective October 1, 2021: ▪ MP 365 Manual Wheelchair Bases ▪ MP 366 Power Mobility Devices ▪ MP 367 Wheelchair Options/Accessories ▪ MP 368 Wheelchair Seating. We will be combining these separate medical policies under policy #365 Manual and Power Operated Wheelchairs. Policy #365 is effective October 1, 2021.	September 1, 2021	Commercial	Rehabilita-tion Medicine
Medical Technology Assessment Noncovered Services	400	Cryosurgical Ablation of Posterior Nasal Nerve for Chronic Rhinitis (Clarifix™) added under the narrative section.	September 1, 2021	Commercial Medicare	Oto-laryngology
Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers	354	Diagnoses codes list added. New diagnoses-to-CPT codes edit implemented. Policy criteria unchanged.	October 15, 2021	Commercial	Durable Medical Equipment
Postsurgical Home Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis	541	Diagnoses codes list added. New diagnoses-to-CPT codes edit implemented. Policy criteria unchanged.	October 15, 2021	Commercial	Durable Medical Equipment

RETIRED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
None	N/A	N/A	N/A	N/A	N/A

August 2021

NEW MEDICAL POLICIES					
New Medical Policy Title	Policy Number	Policy Summary	Effective Date	Products Affected	Policy Type
None	N/A	N/A	N/A	N/A	N/A

REVISED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Surgical and Non-CPAP Treatment of Snoring and Obstructive Sleep Apnea Syndrome	130	New investigational indications described for non-CPAP Medical Treatment of OSA: ▪ Daytime Tongue Stimulation ▪ Daytime sleep study (PAP-NAP) ▪ Nasal Expiratory Positive Airway Pressure ▪ eXciteOSA; and ▪ NightBalance Sleep Position Trainer. Title changed.	November 1, 2021	Commercial Medicare	Pulmo-nology Oto-laryngology
Trigger Point and Tender Point Injections	604	Diagnoses codes list added. New diagnoses-to-CPT codes edit implemented. Policy criteria unchanged.	September 1, 2021	Commercial	Ortho-pedics Rehabilita-tion Medicine Rheuma-tology

CLARIFICATIONS TO MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Posted Date	Products Affected	Policy Type
Medical Technology Assessment Noncovered Services	400	The following tests were added to the non-covered services list: ▪ AVISE® Antiphospholipid syndrome (APS) diagnostic test to assess risk for APS and thrombosis ▪ AVISE® Vasculitis-AAV (ANCA-associated vasculitis) diagnostic test for differential diagnosis of AAV ▪ AVISE® Systemic lupus erythematosus (SLE) prognostic panel to assess potential risk for thrombosis, cardiovascular events, lupus nephritis and neuropsychiatric lupus ▪ AVISE® PC4d biomarker	August 1, 2021	Commercial Medicare	Rheuma-tology

		associated with thrombosis in systemic lupus erythematosus ▪ AVISE® Anti-Carbamylated Protein Antibodies (Anti-CarP) prognostic test to identify rheumatoid arthritis patients with increased risk for erosive joint damage ▪ AVISE® Systemic lupus erythematosus (SLE) monitoring for assessment of SLE disease activity			
Transcatheter Pulmonary Valve Implantation	403	Policy statements clarified to specify FDA-approved devices.	August 1, 2021	Commercial Medicare	Cardiology Pulmo-nology

RETIRED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Ultrafiltration in Decompensated Heart Failure	542	Policy is retired.	August 1, 2021	Commercial Medicare	Cardiology

July 2021

NEW MEDICAL POLICIES					
New Medical Policy Title	Policy Number	Policy Summary	Effective Date	Products Affected	Policy Type
Allograft Injection for Degenerative Disc Disease	838	New medical policy describing investigational indications.	October 1, 2021	Commercial Medicare	Neurosurgery Neurology Orthopedics
Manual Wheelchair Bases	365	New medical policy describing medically necessary and not medically necessary manual wheelchair bases.	October 1, 2021	Commercial	DME Rehabilitation
Ostomy Supplies	369	New medical policy describing medically necessary and not medically necessary ostomy supplies.	October 1, 2021	Commercial	DME Gastro-enterology
Power Mobility Devices	366	New medical policy describing medically necessary and not medically necessary power mobility devices (power operated vehicles and power wheelchairs).	October 1, 2021	Commercial	DME Rehabilitation
Urological	370	New medical policy describing	October	Commercial	DME

Supplies		medically necessary and not medically necessary urological supplies.	1, 2021		Urology
Wheelchair Options and Accessories	367	New medical policy describing medically necessary and not medically necessary wheelchair options and accessories.	October 1, 2021	Commercial	DME Rehabilitation
Wheelchair Seati	368	New medical policy describing medically necessary and not medically necessary wheelchair seating.	October 1, 2021	Commercial	DME Rehabilitation

REVISED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma	066	New medically necessary and investigational indications described for Axicabtagene ciloleucel for adult patients with elapsed or refractory follicular lymphoma after 2 or more lines of systemic therapy. See new policy #944 Prior Authorization Request Form for CAR T-Cell Therapy Services for Follicular Lymphoma (Axicabtagene Ciloleucel).	July 1, 2021	Commercial	Hematology
Computer-Assisted Navigation for Orthopedic Procedure	594	Investigational policy statement revised to include spine surgery.	October 1, 2021	Commercial	Neurosurgery Orthopedics

CLARIFICATIONS TO MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Posted Date	Products Affected	Policy Type
Implantable Bone-Conduction and Bone-Anchored Hearing Aids	479	Clarification made to policy statement for FDA approved devices.	July 1, 2021	Commercial Medicare	Otolaryn-gology
Intraoperative Neurophysiologic Monitoring Sensory-Evoked Potentials,	211	Monitoring of laryngeal nerve clarified. Total thyroidectomy clarified to include hemithyroidectomy.	July 1, 2021	Commercial	Neurosurgery Otolaryn-gology

Motor-Evoked Potentials, EEG					
Medical Technology Assessment Investigational (Non-Covered) Services List	400	Avise hydroxychloroquine (HCQ) test added.	July 1, 2021	Commercial Medicare	Multispecialty

RETIRED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
None	N/A	N/A	N/A	N/A	N/A

NEW PHARMACY MEDICAL POLICIES			
Medical Policy Title	Policy Number	Policy Change Summary	Effective date
None	N/A	N/A	N/A

REVISED PHARMACY MEDICAL POLICIES			
Medical Policy Title	Policy Number	Policy Change Summary	Effective date
None	N/A	N/A	N/A

June 2021

NEW MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Chimeric Antigen Receptor Therapy for Multiple Myeloma	942	New medical policy describing medically necessary indications of idecabtagene vicleucel (ABECMA) for individuals with relapsed and/or refractory multiple myeloma and have received four or more prior lines of therapy and when certain conditions are met. See new policy **#943** Prior Authorization Request Form for CAR T-Cell Therapy Services for Multiple Myeloma (Idecabtagene vicleucel)	June 4, 2021	Commercial	Hematology Oncology

REVISED MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Effective Date	Products Affected	Policy Type
Assisted Reproductive	086	Policy updated to add language that intrauterine	September 1, 2021	Commercial Medicare	Obstetrics Gynecology

Services		insemination (IUI) must be done in the office setting and that donor sperm is only covered when used for IUI in the office setting.			Endocrinology
Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Artificial Pancreas Device Systems	107	Artificial Pancreas: Medically necessary policy statement added for use of an FDA-approved hybrid closed loop system in children ages 2 to 6 years.	September 1, 2021	Commercial	Endocrinology
Plastic Surgery	068	New medically necessary indications described. Lipoma removal may be considered medically necessary when the lipoma is painful and causes functional limitations with activities of daily living based on its location.	September 1, 2021	Commercial	Plastic Surgery

Advanced Imaging Radiology
Effective for dates of service on and after September 12, 2021, the following updates will apply to the AIM Advanced Imaging Clinical Appropriateness Guidelines. You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com.

AIM Guideline	Contains updates to the following:	Effective Date	Products Affected	Policy Type
Imaging of the Extremities	Osteomyelitis or septic arthritis; myositis • Removed CT as a follow-up to nondiagnostic MRI due to lower diagnostic accuracy of CT Epicondylitis and Tenosynovitis – long head of biceps • Removed due to lack of evidence supporting imaging for this diagnosis Plantar fasciitis and fibromatosis • Removed CT as a follow-up to nondiagnostic MRI due to lower diagnostic accuracy of CT • Added specific conservative management requirements Brachial plexus mass • Added specific requirement for suspicious findings on clinical exam or prior imaging Morton's neuroma • Added requirements for focused steroid injection, orthoses, plan for	September 12, 2021	Commercial Medicare	Radiology

	surgery Adhesive capsulitis • Added requirement for planned intervention (manipulation under anesthesia or lysis of adhesions) Rotator cuff tear; Labral tear – shoulder; Labral tear - hip • Defined specific exam findings and duration of conservative management • Recurrent labral tear now requires same criteria as an initial tear (shoulder only) Triangular fibrocartilage complex tear • Added requirement for radiographs and conservative management for chronic tear Ligament tear – knee; meniscal tear • Added requirement for radiographs for specific scenarios • Increased duration of conservative management for chronic meniscal tears Ligament and tendon injuries – foot and ankle • Defined required duration of conservative management Chronic anterior knee pain including chondromalacia patella and patellofemoral pain syndrome • Lengthened duration of conservative management and specified requirement for chronic anterior knee pain Intra-articular loose body • Requirement for mechanical symptoms Osteochondral lesion (including osteochondritis dissecans, transient dislocation of patella) • New requirement for radiographs Entrapment neuropathy • Exclude carpal and cubital tunnel Persistent lower extremity pain • Defined duration of conservative management (6 weeks) • Exclude hip joint (addressed in other indications) Upper extremity pain • Exclude shoulder joint (addressed in other indications) • Diagnostic testing strategy limiting use of CT to when MRI cannot be performed or is nondiagnostic Knee arthroplasty, presurgical planning • Limited to MAKO and robotic assist arthroplasty cases			

	Perioperative imaging, not otherwise specified • Require radiographs or ultrasound prior to advanced imaging			
Imaging of the Spine	Congenital vertebral defects • New requirement for additional evaluation with radiographs Scoliosis • Defined criteria for which presurgical planning is indicated • Requirement for radiographs and new or progressive symptoms for postsurgical imaging Spinal dysraphism and tethered cord • Diagnostic imaging strategy limiting the use of CT to cases where MRI cannot be performed • New requirement for US prior to advanced imaging for tethered cord in infants age 5 months or less Multiple sclerosis • New criteria for imaging in initial diagnosis of MS Spinal infection • New criteria for diagnosis and management aligned with IDSA and University of Michigan guidelines Axial spondyloarthropathy • Defined inflammatory back pain • Diagnostic testing strategy outlining radiography requirements Cervical injury • Aligned with ACR position on pediatric cervical trauma Thoracic or lumbar injury • Diagnostic testing strategy emphasizing radiography and limiting the use of MRI for known fracture • Remove indication for follow-up imaging of progressively worsening pain in the absence of fracture or neurologic deficits Syringomyelia • Removed indication for surveillance imaging Non-specific low back pain • Aligned pediatric guidelines with ACR pediatric low back pain guidelines	September 12, 2021	Commercial Medicare	Radiology
Vascular Imaging	• Alternative non-vascular modality imaging approaches, where applicable Hemorrhage, Intracranial • Clinical scenario specification of subarachnoid hemorrhage indication.	September 12, 2021	Commercial Medicare	Radiology

	• Addition of Pediatric intracerebral hemorrhage indication. Horner's syndrome; Pulsatile Tinnitus; Trigeminal neuralgia • Removal of management scenario to limit continued vascular evaluation Stroke/TIA; Stenosis or Occlusion (Intracranial/Extracranial) • Acute and subacute time frame specifications; removal of carotid/cardiac workup requirement for intracranial vascular evaluation; addition of management specifications • Sections separated anatomically into anterior/posterior circulation (Carotid artery and Vertebral or Basilar arteries, respectively) Pulmonary Embolism • Addition of non-diagnostic chest radiograph requirement for all indications • Addition of pregnancy-adjusted YEARS algorithm Peripheral Arterial Disease • Addition of new post-revascularization scenario to both upper and lower extremity PAD evaluation			

CLARIFICATIONS TO MEDICAL POLICIES					
Medical Policy Title	Policy Number	Policy Change Summary	Posted Date	Products Affected	Policy Type
Gender Affirming Services (Transgender Services)	189	Policy statement clarified to include neck lift as a covered procedure only if the excess skin impairs the outcome of the covered facial feminization or masculinization procedures. Prior authorization table updated to clarify that prior authorization is not required for surgically implanted puberty blockers.	June 1, 2021	Commercial Medicare	Plastic Surgery
Medical Technology Assessment Noncovered Services	400	Guidance UTI Test - Pooled Antibiotic Susceptibility Testing (P-AST) added.	June 1, 2021	Commercial Medicare	Urology
Percutaneous Vertebroplasty and Sacroplasty	484	Investigational policy statement edited for clarity. Policy statements otherwise unchanged.	June 1, 2021	Commercial	Orthopedics Neurosurgery
Prescription	127	New policy on hold for further	TBD	Commercial	Behavioral

Digital Therapeutics for Substance Abuse		review.		Medicare	Health

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