MEDICAL POLICY UPDATE

FOR PROFESSIONAL AND FACILITY PROVIDERS

HIGHMARK.

April 2018

In This Issue

Policy

Coverage Guidelines Revised for Ipilimumab (Yervoy)

NEWS FOR ALL PROVIDER TYPES

Highmark Blue Cross Blue Shield has revised the coverage guidelines for ipilimumab (Yervoy®). Highmark may consider ipilimumab (Yervoy) medically necessary for patients age 12 years or older, in combination with nivolumab (Opdivo®) for:

- Limited (one to three) and multiple (greater than 3) central nervous system metastatic lesions
- The treatment of uveal melanoma as a single agent or in combination with nivolumab (Opdivo)
- As subsequent systemic therapy in combination with nivolumab (Opdivo) for the treatment of malignant pleural mesothelioma

This medical policy will apply to both professional provider and facility claims. The effective date is July 2, 2018.

Please refer to Medical Policy I-34, Ipilimumab (Yervoy), and I-120, Programmed Death Receptor (PD-1)/ Programmed Death-Ligand (PD-L1) Blocking Antibodies, for additional information.

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.
Note: This publication may contain certain administrative requirements, policies, procedures, or other similar requirements of Highmark Inc. (or changes thereto) which are binding upon Highmark Inc. and its contracted providers. Pursuant to their contract, Highmark Inc. and such providers must comply with any requirements included herein unless and until such item(s) are subsequently modified in whole or in part.

Clinical Guidelines Revised for Bortezomib (Velcade)

Highmark Blue Cross Blue Shield has revised the coverage guidelines for Velcade® (bortezomib) to include coverage for mycosis fungoides/sezary syndrome and primary cutaneous CD30+ T-cell lymphoproliferative disorders per updated National Comprehensive Cancer Network guidelines. This revised coverage will apply to both professional provider and facility claims. The effective date is July 2, 2018.

Please refer to Medical Policy I-83, bortezomib (Velcade), for additional information.

Place of Service: Outpatient

Coverage Guidelines Revised for Ado-trastuzumab emtansine (Kadcyla)

Highmark Blue Cross Blue Shield has revised the coverage guidelines for Ado-trastuzumab emtansine (Kadcyla®) to include coverage for HER-2 positive non-small cell lung cancer per the National Comprehensive Cancer Network approved indications. This revised coverage will apply to both professional provider and facility claims.
The effective date is April 2, 2018.

Please refer to Medical Policy I-113, Ado-trastuzumab emtansine (Kadcyla), for additional information.

Coverage Criteria Revised for Pneumatic Compression Devices

Highmark Blue Cross Blue Shield has revised the coverage criteria for Pneumatic Compression Devices. The revised policy will apply to professional provider claims. The effective date is July 2, 2018.

Coverage Criteria Added:
The use of pneumatic compression devices for the treatment of lymphedema of the head and neck is considered experimental/investigational.

Coverage Criteria Revised:
The following paragraphs have been revised to include “in-home use”:

- Pneumatic compression devices/lymphedema pumps and appliances for in-home use may be covered as durable medical equipment (DME) when all of the following are met:
- In-home use of limb compression devices for the following indications may be considered medically necessary for any one of the following:
- Segmented pneumatic compression therapy devices with calibrated gradient pressure may be considered medically necessary for in-home use when the following medical necessity criteria are met:
- In-home use of limb compression devices for VTE prophylaxis for periods longer than 30 days post-surgery is not medically necessary.

Please refer to Medical Policy E-7, Pneumatic Compression Devices, for additional information.

Coverage Criteria Established for Extracorporeal Membrane Oxygenation (ECMO) for Adult Conditions

Highmark Blue Cross Blue Shield has established new clinical criteria for ECMO for adult conditions. This new policy will apply to professional provider claims.
The effective date is July 2, 2018.

The use of ECMO in adults may be considered medically necessary for the management of acute respiratory failure when ALL of the following criteria are met:

- Respiratory failure is due to a potentially reversible etiology; and
- Respiratory failure is severe, as determined by either of the following:
  - o A standardized severity instrument such as the Murray score; or
  - o One of the following criteria for respiratory failure severity:
    - Uncompensated hypercapnia with a pH less than 7.2; or
    - PaO_2/FIO_2 of less than 100 mm Hg on fraction of inspired oxygen (FIO_2) greater than 90%; or
    - Inability to maintain airway plateau pressure (Pplat) less than 30 cm H_20 despite a tidal volume of four (4) to six (6) mL/kg ideal body weight; or
    - Oxygenation Index* greater than 30: or
    - CO_2 retention despite high Pplat (greater than 30 cm H_2O).

*Oxygenation Index = FIO2 x 100 x MAP/PaO2 mm Hg (where FIO2 x 100 = FIO2 as percentage; MAP = mean airway pressure in cm H2O; PaO2 = partial pressure of oxygen in arterial blood).

AND

NONE of the following contraindications is present:

- High ventilator pressure (peak inspiratory pressure greater than 30 cm H_2O) or high fraction of inspired oxygen (greater than 80%) ventilation for more than 168 hours; or
- Signs of intracranial bleeding; or
- Multisystem organ failure; or
- Prior (i.e., before onset of need for ECMO) diagnosis of a terminal condition with expected survival less than six (6) months; or
- A do-not-resuscitate directive; or
- Cardiac decompensation in an individual who has already been declined for ventricular assist device or transplant; or
- Known neurologic devastation without potential to recover meaningful function; or
- Determination of care futility**:

**Assessment of ECMO futility:
Patients undergoing ECMO treatment should be periodically reassessed for clinical improvement. ECMO should not be continued indefinitely if the any of the following criteria are met:

- Neurologic devastation as defined by the following:
  - o Consensus from two (2) attending physicians that there is no likelihood of an outcome better than “persistent vegetative state” at six (6) months; and

  - At least one of the attending physicians is an expert in neurologic disease and/or intensive care medicine; and
  - Determination made following studies including computed tomography, electroencephalography, and exam; or
- Inability to provide aerobic metabolism, defined by the following:
  - Refractory hypotension and/or hypoxemia; or
  - Evidence of profound tissue ischemia based on creatine phosphokinase or lactate levels, lactate-to-pyruvate ratio, or near-infrared spectroscopy; or
- Presumed end-stage cardiac or lung failure without "exit" plan (i.e., declined for assist device and/or transplantation).

The use of ECMO in adults may be considered medically necessary as a bridge to heart, lung, or combined heart-lung transplantation for the management of respiratory, cardiac, or combined cardiorespiratory failure refractory to optimal conventional therapy.

Place of Service: Inpatient

Please refer to Medical Policy G-44, Extracorporeal Membrane Oxygenation (ECMO) for Adult Conditions, for additional information.

New Policy: Radiation Treatment with Lutathera

Highmark Blue Cross Blue Shield has established coverage criteria for the radiopharmaceutical, Lutathera (Lutetium; Lu 177 dotatate).

Lutetium 177 dotatate is indicated:

- In the treatment of inoperable somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETS) of the foregut, midgut and hindgut in adults; **or**
- In the treatment of metastatic somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETS) of the foregut, midgut and hindgut in adults; **or**
- In the treatment of inoperable somatostatin receptor positive tumors of the pancreas; **or**
- In the treatment of metastatic somatostatin receptor positive tumors of the pancreas.

Lutetium 177 dotatate is considered experimental/investigational, and therefore, non-covered in the treatment of all other neuroendocrine tumors, because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

This will apply to both professional provider and facility claims. The place of service is outpatient or inpatient. The effective date is July 2, 2018.

Please refer to Medical Policy R-94, Radiation Treatment with Lutathera, for additional information.

Physical Medicine Publication Cancelled

In February 2018, Highmark Blue Cross Blue Shield announced revised and established coverage guidelines for physical medicine effective April 30, 2018.

Highmark Blue Cross Blue Shield is cancelling the publication of physical medicine. The revised policy publication will be announced at a later date.

Please refer to medical policy Y-1, Physical Medicine, for additional information.

Occupational Therapy Publication Cancelled

In February 2018, Highmark Blue Cross Blue Shield announced revised and established coverage guidelines for occupational therapy effective April 30, 2018.

Highmark Blue Cross Blue Shield is cancelling the publication of occupational therapy. The revised policy publication will be announced at a later date.

Please refer to medical policy Y-2, Occupational Therapy, for additional information.

Manipulation Services Publication Cancelled

In February 2018, Highmark Blue Cross Blue Shield announced revised and established coverage guidelines for manipulation services effective April 30, 2018.

Highmark Blue Cross Blue Shield is cancelling the publication of manipulation services. The revised policy publication will be announced at a later date.

Please refer to medical policy Y-9, Manipulation Services, for additional information.

Medicare Advantage Policy

Coverage Guidelines Revised for Ipilimumab (Yervoy)

Highmark's Medicare Advantage products have revised the coverage guidelines for ipilimumab (Yervoy®). Effective July 2, 2018, Highmark may consider ipilimumab (Yervoy) medically necessary for patients age 12 years or older, in combination with nivolumab (Opdivo®) for:

- Limited (one to three) and multiple (greater than 3) central nervous system metastatic lesions
- The treatment of uveal melanoma as a single agent or in combination with nivolumab (Opdivo)
- As subsequent systemic therapy in combination with nivolumab (Opdivo) for the treatment of malignant pleural mesothelioma

This Medicare Advantage medical policy will apply to both professional provider and facility claims.

Please refer to Medical Policy I-59, Ipilimumab (Yervoy®), and Medical Policy I-120, Programmed Death Receptor (PD-1)/ Programmed Death-Ligand (PD-L1) Blocking Antibodies, for additional information.

Clinical Guidelines Revised for Bortezomib (Velcade)

Highmark's Medicare Advantage products have established new coverage guidelines for Velcade® (bortezomib) according to updated guidelines from the National Comprehensive Cancer Network. Highmark will cover Velcade (bortezomib) when it's used to treat mycosis fungoides/sezary syndrome and primary cutaneous CD30+ T-cell lymphoproliferative disorders. The new coverage guidelines will apply to professional provider and facility claims. The effective date is July 2, 2018.

Please refer to Medical Policy I-83, bortezomib (Velcade), for additional information.

Place of Service: Outpatient

Criteria Established for Injectable Collagenase Clostridium Histolyticum

Highmark's Medicare Advantage products have established new coverage guidelines for injectable collagenase clostridium histolyticum based on the Food and Drug Administration approved indications. This medical policy will apply to both professional provider and facility claims. The effective date is July 2, 2018.

Please refer to Medical Policy I-107, Injectable Collagenase Clostridium Histolyticum, for additional information.

Coverage Guidelines Revised for Ado-trastuzumab emtansine (Kadcyla)

Highmark's Medicare Advantage products have revised the coverage guidelines for ado-trastuzumab emtansine (Kadcyla®) to include coverage for HER-2 positive non-small cell lung cancer per the National Comprehensive Cancer Network approved indications. This revised coverage will apply to both professional provider and facility claims. The effective date is April 2, 2018.

Please refer to Medical Policy I-113, Ado-trastuzumab emtansine (Kadcyla), for additional information.

Comments on these new medical policies?

We want to know what you think about our new medical policy changes. Send us an email with any questions or comments that you may have on the new medical policies in this edition of *Medical Policy Update*.

Write to us at **medicalpolicy@highmark.com**.

Contents

Save yourself valuable time with e-Subscribe! Sign up today and you'll begin receiving email notifications with a direct link to the latest issue of *Medical Policy Update*.

About this newsletter

Medical Policy Update is the monthly newsletter for most health care professionals (and office staff) and facilities who participate in our networks and submit claims to Highmark using the 837P HIPAA transaction or the CMS 1500 form, or the 837I HIPAA transaction.

Medical Policy Update focuses only on medical policy and claims administration updates, including coding guidelines and procedure code revisions, and is the sole source for this information. For all other news, information and updates, be sure to read *Provider News*, available on the Provider Resource Center at **www.highmarkbcbs.com**.

Inquiries about Eligibility, Benefits, Claims Status or Authorizations
For inquiries about eligibility, benefits, claim status or authorizations, Highmark Blue Cross Blue Shield encourages providers to use the electronic resources available to them - Navinet® and the applicable HIPAA transactions – prior to placing a telephone call to the Provider Service Center at 1-800-242-0514.

Acknowledgement

The five-digit numeric codes that appear in *Medical Policy Update* were obtained from the *Current Procedural Terminology (CPT)*, as contained in CPT-2018, Copyright 2016, by the American Medical Association. *Medical Policy Update* includes *CPT* descriptive terms and numeric procedure codes and modifiers that are copyrighted by the American Medical Association. These procedure codes and modifiers are used for reporting medical services and procedures.