February 1, 2019

RE: Medical Policy and Clinical UM Guidelines notification letter

Dear Provider:

Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Nevada (Anthem) are pleased to provide you with our updated and new medical policies. Anthem will also be implementing changes to our Clinical Utilization Management (UM) Guidelines that are adopted for Nevada. The Clinical UM guidelines published on our website represent the clinical UM guidelines currently available to all Plans for adoption throughout our organization. Because local practice patterns, claims systems and benefit designs vary, a local Plan may choose whether or not to implement a particular clinical UM guideline. The link below can be used to confirm whether or not the local Plan has adopted the clinical UM guideline(s) in question. Adoption lists are created and maintained solely by each local Plan.

The major new policies and changes are summarized below. Please refer to the specific policy for coding, language, and rationale updates and changes that are not summarized below.

New Medical Policies effective for service dates on and after May 1, 2020:

- **GENE.00052 Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling:** This document addresses whole genome sequencing, whole exome sequencing, gene panels and molecular profiling.
    - Outlines the Medically Necessary and Investigational & Not Medically Necessary criteria for whole genome sequencing, whole exome sequencing, gene panels, and molecular profiling.
    - Incorporated whole genome sequencing, whole exome sequencing, gene panel testing, and molecular profiling into single document.
    - Contains content from all other documents regarding whole genome/whole exome/mitochondrial DNA testing, all panel tests (defined as 5 or more genes, or gene mutation variants, same day, same member, same rendering provider) and molecular profiling:
        - GENE.00001 Genetic Testing for Cancer Susceptibility
        - GENE.00012 Preconception or Prenatal Genetic Testing of a Parent or Prospective Parent
        - GENE.00025 Molecular Profiling and Proteogenomic Testing for the Evaluation of Malignancies
        - GENE.00028 Genetic Testing for Colorectal Cancer Susceptibility
        - GENE.00029 Genetic Testing for Breast and/or Ovarian Cancer Syndrome
        - GENE.00030 Genetic Testing for Endocrine Gland Cancer Susceptibility
        - GENE.00035 Genetic Testing for TP53 Mutations
        - GENE.00043 Genetic Testing of an Individual's Genome for Inherited Diseases

Revised Medical Policies and Adopted Clinical UM Guidelines effective May 1, 2020:

- **SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH):** This document addresses various surgical and minimally invasive procedures used in the treatment of benign prostatic hyperplasia, and the use of these procedures for other genitourinary conditions.
    - Revised title. Previous title: Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia. (BPH) and Other Genitourinary Conditions.

- Revised scope of document to only address benign prostatic hyperplasia (BPH).
- Combined surgical and minimally invasive treatments into one Medically Necessary section.
- Revised Medically Necessary criteria for transurethral incision of the prostate by adding "prostate volume less the 30 mL.
- Added transurethral convective water vapor thermal ablation in individuals with prostate volume less than 80 mL as Medically Necessary indication.
- Added waterjet tissue ablation as Medically Necessary indication.
- Moved transurethral radiofrequency needle ablation from Medically Necessary to Not Medically Necessary section.
- Changed Investigational & Not Medically Necessary indications to Not Medically Necessary.
- Moved placement of prostatic stents from standalone statement to combined Not Medically Necessary statement.

- **SURG.00037 Treatment of Varicose Veins (Lower Extremities):** This document addresses various modalities for the treatment of valvular incompetence (reflux) of the great saphenous vein (GSV), anterior accessory great saphenous vein (AAGSV), or small saphenous vein (SSV) (also known as greater saphenous vein or lesser saphenous vein, respectively) and associated varicose tributaries as well as telangiectatic dermal veins.
  - Added the anterior accessory great saphenous vein (AAGSV) as Medically Necessary for ablation techniques when criteria are met.
  - Added language to the Medically Necessary criteria for ablation techniques addressing variant anatomy.
  - Added limits to retreatment to the Medically Necessary criteria for all procedures

- **SURG.00047 Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia and Gastroparesis:** This document addresses selected transendoscopic therapies for the treatment of gastroesophageal reflux disease (GERD), dysphagia and gastroparesis.
  - Revised title. Previous title: Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia.
  - Expanded scope to include gastroparesis.
  - Added gastric peroral endoscopic myotomy or peroral pyloromyotomy as Investigational & Not Medically Necessary.

- **SURG.00097 Vertebral Body Stapling and Tethering for the Treatment of Scoliosis in Children and Adolescents:** This document addresses vertebral body stapling and vertebral body tethering as surgical treatments of scoliosis.
  - Revised title. Previous title: Previous title: Vertebral Body Stapling for the Treatment of Scoliosis in Children and Adolescents.
  - Expanded scope of document to include vertebral body tethering.
  - Added vertebral body tethering as Investigational & Not Medically Necessary.

- **CG-MED-68 Therapeutic Apheresis:** This document addresses therapeutic apheresis, a procedure by which blood is removed from the body, separated into components, manipulated and returned to the individual.
  - Added diagnostic criteria to the condition "chronic inflammatory demyelinating polyradiculoneuropathy" (CIDP) when it is treated by plasmapheresis or immunoadsorption.

Anthem Medical Policies and Clinical UM Guidelines are developed by our national Medical Policy and Technology Assessment Committee. The Committee, which includes Anthem medical directors and representatives from practicing physician groups, meets quarterly to review current scientific data and clinical developments.

All coverage written or administered by Anthem excludes from coverage, services or supplies that are investigational and/or not medically necessary. A member's claim may not be eligible for payment if it was determined not to meet medical necessity criteria set in Anthem's medical policies. Review procedures have been refined to facilitate claim investigation.

Anthem's Medical Policies and Clinical UM Guidelines are available online:

The complete list of our Medical Policies and Clinical UM Guidelines may be accessed on Anthem's Web site at **anthem.com**, and select **Providers.** Under the *Provider Resources* heading, select **Policies and Guidelines**. Select **Nevada** as Your State. Select **View Medical Policies & UM Guidelines**. Select the link titled "**Medical Policies and Clinical UM Guidelines (for Local Plan Members)**". Choose **Continue**, then select the either the **Medical Policies** or the **UM Guidelines** tab.

To view the list of specific clinical UM guidelines adopted by Nevada, navigate to the Disclaimer page by following the instructions above; scroll to the bottom of the page. Above the "Continue" button, choose the link titled "**Specific Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield of Nevada**."

Sincerely,

Allen Marino, M.D.
Medical Director
Anthem Blue Cross and Blue Shield

Attachment A – Revised Medical Policies and Clinical Guidelines

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
ADMIN.00001	Medical Policy Formation	• Updated text in Description/Scope regarding services addressed and subspecialty committees
ANC.00009	Cosmetic and Reconstructive Services of the Trunk and Groin	• Added MN indications for liposuction and lipectomy for the treatment of lymphedema and lipedema when there is a significant physical functional impairment and other criteria are met. • Expanded the REC indications for liposuction and lipectomy for lymphedema and lipedema beyond breast cancer when there is a significant variation from normal. • Clarified Cosmetic & Not Medically Necessary statement for liposuction and lipectomy. • Made minor spelling and grammar edits throughout Position Statement section.
BEH.00002	Transcranial Magnetic Stimulation	• Simplified Medically Necessary criteria addressing the use of psychopharmacologic agents and reduced the number of required trials of antidepressant medications from 4 to 2.
GENE.00001	Genetic Testing for Cancer Susceptibility	• Medical policy archived 02/05/2020. Converted to CG-GENE-14.
GENE.00006	Epidermal Growth Factor Receptor (EGFR) Testing	• Medical policy archived 02/05/2020. Converted to CG-GENE-20.
GENE.00012	Preconception or Prenatal Genetic Testing of a Parent or Prospective Parent	• Medical policy archived 02/05/2020. Converted to CG-GENE-13.
GENE.00025	Proteogenomic Testing for the Evaluation of Malignancies	• Revised title. Previous title: Molecular Profiling and Proteogenomic Testing for the Evaluation of Malignancies. • Removed molecular profiling and gene panel testing language. • Molecular profiling and gene panel testing moved to GENE.00052.
GENE.00028	Genetic Testing for Colorectal Cancer Susceptibility	• Medical policy archived 02/05/2020. Converted to CG-GENE-15.
GENE.00029	Genetic Testing for Breast and/or Ovarian Cancer Syndrome	• Medical policy archived 02/05/2020. Converted to CG-GENE-16.
GENE.00030	Genetic Testing for Endocrine Gland Cancer Susceptibility	• Medical policy archived 02/05/2020. Converted to CG-GENE-17.
GENE.00035	Genetic Testing for TP53 Mutations	• Medical policy archived 02/05/2020. Converted to CG-GENE-18.
GENE.00043	Genetic Testing of an Individual's Genome for Inherited Diseases	• Medical policy archived 02/05/2020. Converted to CG-GENE-13.
GENE.00045	Detection and Quantification of Tumor DNA Using Next Generation Sequencing in Lymphoid Cancers	• Medical policy archived 02/05/2020. Converted to CG-GENE-19.

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
MED.00109	Corneal Collagen Cross-Linking	• Medical policy archived 02/05/2020. Converted to CG-SURG-105.
MED.00110	Growth Factors, Silver-based Products and Autologous Tissues for Wound Treatment and Soft Tissue Grafting	• Removed Medically Necessary and Investigational & Not Medically Necessary statements addressing recombinant human platelet-derived growth factor [becaplermin (Regranex)].
MED.00117	Autologous Cell Therapy for the Treatment of Damaged Myocardium	• Removed all language addressing infusion of growth factors (for example, granulocyte colony stimulating factor) from document including Position Statement. • Transitioning granulocyte colony stimulating factor criteria (filgrastim [G-CSF]) to IngenioRx.
MED.00124	Tisagenlecleucel (Kymriah®)	• Clarified Investigational & Not Medically Necessary criteria addressing history of allogeneic stem cell transplant by adding "for individuals with large B-cell lymphoma only".
RAD.00023	Single Photon Emission Computed Tomography Scans for Noncardiovascular Indications	• Medical policy archived 02/05/2020. Converted to CG-MED-87.
RAD.00054	MRI of the Bone Marrow	• Medical policy archived 12/14/2019.
SURG.00011	Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting	• Added AmbioDisk and Artacent Ocular as Medically Necessary allogeneic amniotic membrane-derived grafts or wound coverings for ocular indications. • Added AmbioDisk and Artacent Ocular as Investigational & Not Medically Necessary when the Medically Necessary criteria are not met and for all other indications. • Added new products to the Investigational & Not Medically Necessary section.
SURG.00023	Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures	• Added *elective removal* of an implant for individuals with an increased risk of breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) due to the use of Allergan BIOCELL textured breast implants and tissue expanders as Medically Necessary.
SURG.00032	Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention	• Clarified age and size of interatrial shunting in Medically Necessary criteria addressing Patent Foramen Ovale closure.
SURG.00122	Venous Angioplasty with or without Stent Placement or Venous Stenting Alone	• Medical policy archived 02/05/2020. Converted to CG-SURG-106.
SURG.00127	Sacroiliac Joint Fusion	• Clarified Medically Necessary statement for open sacroiliac joint fusion procedures (SIJF) (excluding minimally invasive or percutaneous sacroiliac joint fusion procedures) when criteria met.

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
		• Added Medically Necessary statement minimally invasive and percutaneous sacroiliac joint fusion procedures for the treatment of chronic SI joint pain or functional impairment subsequent to pelvic girdle trauma when criteria met. • Revised Investigational & Not Medically Necessary statement for SIJF procedures, including but not limited to "poorly defined low back pain". • Revised Investigational & Not Medically Necessary statement for minimally invasive SIJF and percutaneous SIJF procedures to include conditions not listed above.
SURG.00145	Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)	• Added FDA-approved percutaneous ventricular assist devices (pVADs) for the treatment of individuals with cardiogenic shock as Medically Necessary when criteria are met. • Revised Investigational & Not Medically Necessary statement for pVAD.
TRANS.00033	Heart Transplantation	• Added the use a mechanical circulatory support device as Medically Necessary indication.
CG-ANC-04	Ambulance Services: Air and Water	• Added a note to the Clinical Indications section regarding timeframe difference for ground and air transport: "Air transportation may be appropriate if the time between identification of the need for transportation until arrival at the intended destination for ground ambulance would be 30 minutes or longer than air transport".
CG-BEH-01	Assessment of Autism Spectrum Disorders and Rett Syndrome	• Revised title. Previous title: Screening and Assessment for Autism Spectrum Disorders and Rett Syndrome. • Removed genetic testing language. • Genetic testing addressed in CG-GENE-13.
CG-GENE-12	PIK3CA Mutation Testing for Malignant Conditions	• Revised title. Previous title: PIK3CA Mutation Testing. • Clarified that document only addresses malignant conditions. • Clarified Medically Necessary criteria for use of circulating tumor DNA (ctDNA) testing. • Clarified Not Medically Necessary statement.
CG-GENE-13	Genetic Testing for Inherited Diseases	• Content moved from GENE.00012 & GENE.00043. • Investigational & Not Medically Necessary changed to Not Medically Necessary as a result of Medical Policy to Clinical UM Guideline transition. • Title revised. • Removed whole genome, whole exome, and gene panel testing from document. • No other change to clinical indications. • Whole genome, whole exome & gene panel testing moved to GENE.00052.
CG-GENE-14	Gene Mutation Testing for Solid Tumor Cancer Susceptibility and Management	• Content moved from GENE.00001. • Investigational & Not Medically Necessary changed to Not Medically Necessary as a result of Medical Policy to Clinical UM Guideline transition. • Revised title.

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
		• Limited scope to gene mutation testing for solid tumor cancer susceptibility and management. • Added criteria for gene mutation testing to guide targeted cancer therapy in individuals with solid tumors. • Removed genetic panel testing from document. • Whole genome, whole exome & gene panel testing moved to GENE.00052.
CG-GENE-15	Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP), Attenuated FAP and MYH-associated Polyposis	• Content moved from GENE.00028. • Investigational & Not Medically Necessary changed to Not Medically Necessary as a result of Medical Policy to Clinical UM Guideline transition. • Revised title. • Removed genetic panel testing from document. • Gene panel testing moved to GENE.00052.
CG-GENE-16	BRCA Testing for Breast and/or Ovarian Cancer Syndrome	• Content moved from GENE.00029. • Investigational & Not Medically Necessary changed to Not Medically Necessary as a result of Medical Policy to Clinical UM Guideline transition. • Revised title. • Revised Clinical Indications to include recommendations from the USPSTF. • Added Note to refer to the NCCN testing criteria and BRCA1 or BRCA2 mutation assessment tools listed in the Discussion/General Information section. • Removed gene panel testing from document. • Gene panel testing moved to GENE.00052.
CG-GENE-17	RET Proto-oncogene Testing for Endocrine Gland Cancer Susceptibility	• Content moved from GENE.00030. • Investigational & Not Medically Necessary changed to Not Medically Necessary as a result of Medical Policy to Clinical UM Guideline transition. • Revised title. • Removed gene panel testing from document. • Gene panel testing moved to GENE.00052.
CG-GENE-18	Genetic Testing for TP53 Mutations	• Content moved from GENE.00035. • Investigational & Not Medically Necessary changed to Not Medically Necessary as a result of Medical Policy to Clinical UM Guideline transition. • Removed gene panel testing from document. • Gene panel testing moved to GENE.00052.
CG-GENE-19	Detection and Quantification of Tumor DNA Using Next Generation Sequencing in Lymphoid Cancers	• Content moved from GENE.00045. • Investigational & Not Medically Necessary changed to Not Medically Necessary as a result of Medical Policy to Clinical UM Guideline transition. • Clarified that “minimal residual disease” is also referred to as “measurable residual disease” in Medically Necessary criteria.

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
CG-GENE-20	Epidermal Growth Factor Receptor (EGFR) Testing	• Content moved from GENE.00006. • Investigational & Not Medically Necessary changed to Not Medically Necessary as a result of Medical Policy to Clinical UM Guideline transition. • Removed acronym and made minor wording change in Clinical Indications section.
CG-MED-87	Single Photon Emission Computed Tomography Scans for Noncardiovascular Indications	• Content moved from RAD.00023. • Investigational & Not Medically Necessary changed to Not Medically Necessary as a result of Medical Policy to Clinical UM Guideline transition. • No other change to clinical indications.
CG-SURG-27	Gender Reassignment Surgery	• Revised title. Previous title: Sex Reassignment Surgery. • Updated title and document contents to replace “sex reassignment” with “gender reassignment” and “his or her” with “their”. • Clarified Medically Necessary statement regarding hair removal procedures. • Made minor language revisions to Clinical Indications section. • Added text to the Background section regarding WPATH recommendations for the content of referral letters.
CG-SURG-61	Cryosurgical or Radiofrequency Ablation to Treat Solid Tumors Outside the Liver	• Combined content of CG-SURG-61 Cryosurgical Ablation of Solid Tumors Outside the Liver and CG-SURG-62 Radiofrequency Ablation to Treat Tumors Outside the Liver with no change to criteria. • Revised title. Previous title: Cryosurgical Ablation of Solid Tumors Outside the Liver.
CG-SURG-62	Radiofrequency Ablation to Treat Tumors Outside the Liver	• Medical policy archived 12/18/20019. Content merged into CG-SURG-61.
CG-SURG-105	Corneal Collagen Cross-Linking	• Content moved from MED.00109. • Investigational & Not Medically Necessary changed to Not Medically Necessary as a result of Medical Policy to Clinical UM Guideline transition. • Clarified Medically Necessary criteria addressing the time of diagnosis of progressive keratoconus ("over 24 consecutive months" changed to "within 24 months").
CG-SURG-106	Venous Angioplasty with or without Stent Placement or Venous Stenting Alone	• Content moved from SURG.00122. • Investigational & Not Medically Necessary changed to Not Medically Necessary as a result of Medical Policy to Clinical UM Guideline transition. • No other change to clinical indications.