

December 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 March 1, 2020:**

- **MED.00130 Surface Electromyography Devices for Seizure Monitoring:** This document addresses devices that use surface electromyography (sEMG) to monitor seizures.
  - The use of surface electromyography (sEMG) devices for seizure monitoring is considered Investigational and Not Medically Necessary.

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

- **GENE.00023 Gene Expression Profiling of Melanomas:** This document addresses gene expression profiling to assist in determining the diagnosis, risk stratification and clinical management of cutaneous and uveal (ocular) melanoma.
  - Expanded Scope to include testing for the diagnosis of melanoma.
  - Updated Investigational and Not Medically Necessary statement to include suspicion of melanoma.
- **GENE.00046 Prothrombin (Factor II) Genetic Testing:** This document addresses prothrombin (factor II) genetic testing for the screening, diagnosis and management of prothrombin-related thrombophilia.
  - Revised title. Previous Title: Prothrombin G20210A (Factor II) Mutation Testing.
  - Expanded scope and position statement to include all prothrombin (factor II) variations.
- **MED.00110 Growth Factors, Silver-based Products and Autologous Tissues for Wound Treatment, Soft Tissue Grafting, and Regenerative Therapy:** This document addresses the use of the following: Recombinant human platelet-derived growth factor, antimicrobial silver wound dressings, autologous blood-derived wound products, platelet rich plasma (PRP), bone marrow aspirate concentrate, bioengineered autologous skin-derived products, autologous adipose-derived regenerative cell therapy, autologous protein solution.
  - Revised title. Previous title: Growth Factors, Silver-based Products and Autologous Tissues for Wound Treatment and Soft Tissue Grafting.

- Added new Investigational and Not Medically Necessary statements addressing Autologous adipose-derived regenerative cell therapy and use of autologous protein solution.
- **SURG.00052 Percutaneous Vertebral Disc and Vertebral Endplate Procedures:** This document addresses several minimally invasive surgical procedures designed to destroy nociceptive nerve fibers with or without structural changes to the intervertebral discs.
  - Revised title. Previous title: Intradiscal Annuloplasty Procedures (Percutaneous Intradiscal Electrothermal Therapy [IDET], Percutaneous Intradiscal Radiofrequency Thermocoagulation [PIRFT] and Intradiscal Biacuplasty [IDB]).
  - Combined the three Investigational and Not Medically Necessary statements into a single statement.
  - Added Intraosseous basivertebral nerve ablation to the Investigational and Not Medically Necessary statement.
- **TRANS.00035 on-Hematopoietic Adult Stem Cell Therapy:** This document addresses the use of non-hematopoietic adult stem cell therapy for the prevention and treatment of health conditions, including but not limited to, orthopedic, autoimmune, inflammatory, and degenerative conditions. Stem cell therapy involves the use of stem cells (usually in the form of an injection or infusion) to repair damaged cells and body tissues.
  - Revised title. Previous title: Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament Disorders, Autoimmune, Inflammatory and Degenerative Diseases.
  - Expanded Position Statement to include non-hematopoietic adult stem cell therapy.
- **CG-DME-46 Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Extremities:** This document addresses the use of pneumatic compression devices (PCDs) for the prevention of deep vein thrombosis (DVT) of the extremities.
  - Revised title. Previous title: Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Lower Limbs.
  - Expanded Scope.
  - Revised Medically Necessary statement to include upper extremities.

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](http://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
DRUG.00046	Ipilimumab (Yervoy®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0119 Yervoy (ipilimumab) on 06/10/2019.</li> </ul>
DRUG.00053	Carfilzomib (Kyprolis®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0120 Kyprolis (carfilzomib) on 06/10/2019.</li> </ul>
DRUG.00062	Obinutuzumab (Gazyva®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0121 Gazyva (obinutuzumab) on 09/01/2019.</li> </ul>
DRUG.00063	Ofatumumab (Arzerra®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0122 Arzerra (ofatumumab) on 06/10/2019.</li> </ul>
DRUG.00067	Ramucirumab (Cyramza®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0123 Cyramza (ramucirumab) on 06/10/2019.</li> </ul>
DRUG.00071	Pembrolizumab (Keytruda®)	<ul style="list-style-type: none"> <li>Added Medically Necessary position for recurrent locally advanced or metastatic esophageal cancer when criteria are met.</li> <li>Revised Medically Necessary criteria for HNSCC to include pembrolizumab as a single agent as a first-line treatment when criteria are met, or a treatment of disease progression on or after platinum-containing chemotherapy.</li> <li>Revised Medically Necessary position for SCLC to include when no response to initial treatment.</li> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0124 Keytruda (pembrolizumab) on 06/10/2019.</li> </ul>
DRUG.00075	Nivolumab (Opdivo®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0125 Opdivo (nivolumab) on 06/10/2019.</li> </ul>
DRUG.00076	Blinatumomab (Blincyto®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0126 Blincyto (blinatumomab) on 09/01/2019.</li> </ul>
DRUG.00082	Daratumumab (DARZALEX®)	<ul style="list-style-type: none"> <li>Revised Medically Necessary criteria to include use of daratumumab in combination with lenalidomide and dexamethasone for newly diagnosed multiple myeloma for those who are ineligible for stem cell transplantation.</li> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0127 Darzalex (daratumumab) on 09/01/2019.</li> </ul>
DRUG.00088	Atezolizumab (Tecentriq®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0128 Tecentriq (atezolizumab) on 09/01/2019.</li> </ul>
DRUG.00107	Avelumab (Bavencio®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0129 Bavencio (avelumab) on 06/10/2019.</li> </ul>
DRUG.00109	Durvalumab (Imfinzi®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0130 Imfinzi (durvalumab) on 09/01/2019.</li> </ul>
DRUG.00112	Gemtuzumab Ozogamicin (Mylotarg®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0132 Mylotarg (gemtuzumab ozogamicin) on 09/01/2019.</li> </ul>
DRUG.00118	Copanlisib (Aliqopa®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0133 Aliqopa (copanlisib) on 09/01/2019.</li> </ul>
GENE.00010	Panel Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status	<ul style="list-style-type: none"> <li>Revised title. Previous title: Genotype Panel Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status.</li> <li>Clarified Position Statement by removing “genotype”.</li> <li>Removed trade names.</li> </ul>

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	<ul style="list-style-type: none"> <li>Clarified Investigational &amp; Not Medically Necessary position statement.</li> </ul>
GENE.00029	Genetic Testing for Breast and/or Ovarian Cancer Syndrome	<ul style="list-style-type: none"> <li>Added Medically Necessary indication for "Individual with a first-, second- or third-degree relative with metastatic prostate cancer".</li> <li>Clarified Medically Necessary indications regarding "at least".</li> </ul>
GENE.00044	Analysis of PIK3CA Status in Tumor Cells	<ul style="list-style-type: none"> <li>Medical policy archived 11/12/2019. Converted to CG-GENE-12.</li> </ul>
MED.00041	Microvolt T-Wave Alternans	<ul style="list-style-type: none"> <li>Medical policy archived 09/25/2019.</li> </ul>
MED.00106	Sipuleucel-T (Provenge®)	<ul style="list-style-type: none"> <li>Medical policy archived 10/01/2019. Transitioned to ING-CC-0134 Provenge (Sipuleucel-T) on 09/01/2019.</li> </ul>
OR-PR.00003	Microprocessor Controlled Lower Limb Prosthesis	<ul style="list-style-type: none"> <li>Clarified Medically Necessary position statement criteria 3 and 4.</li> </ul>
RAD.00023	Single Photon Emission Computed Tomography Scans for Noncardiovascular Indications	<ul style="list-style-type: none"> <li>Added dopamine transporter (DaT) scan to Medically Necessary Position Statement.</li> <li>Revised dopamine transporter (DaT) scan criterion in Investigational &amp; Not Medically Necessary Position Statement.</li> </ul>
RAD.00004	Peripheral Bone Mineral Density Measurement	<ul style="list-style-type: none"> <li>Medical policy archived 11/12/2019.</li> <li>Combined content of RAD.00004 and CG-MED-39 into a single Clinical UM Guideline (CG-MED-39, retitled "Bone Mineral Density Measurement").</li> </ul>
RAD.00040	PET Scanning Using Gamma Cameras	<ul style="list-style-type: none"> <li>Medical policy archived 09/25/2019.</li> </ul>
SURG.00129	Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring	<ul style="list-style-type: none"> <li>Removed Not Medically Necessary indication for nasal surgery.</li> </ul>
CG-DRUG-01	Off label drug and approved orphan drug use	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0141 Off-Label Drug and Approved Orphan Drug Use on 09/01/2019.</li> </ul>
CG-DRUG-38	Pemetrexed Disodium (Alimta®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0094 Alimta (pemetrexed) on 06/10/2019.</li> </ul>
CG-DRUG-42	Asparagine Specific Enzymes (Asparaginase)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0096 Asparagine Specific Enzymes on 06/10/2019.</li> </ul>
CG-DRUG-49	Doxorubicin Hydrochloride Liposome Injection	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0098 Doxorubicin Hydrochloride Liposome on 09/01/2019.</li> </ul>
CG-DRUG-50	Paclitaxel, protein-bound (Abraxane®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0099 Abraxane (paclitaxel protein-bound) on 09/01/2019.</li> </ul>
CG-DRUG-51	Romidepsin (Istodax®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0100 Istodax (romidepsin) on 09/01/2019.</li> </ul>
CG-DRUG-62	Fulvestrant (FASLODEX®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0103 Faslodex (fulvestrant) on 09/01/2019.</li> </ul>
CG-DRUG-63	Levoleucovorin Calcium (Fusilev®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0104 Levoleucovorin Agents on 06/10/2019.</li> </ul>
CG-DRUG-66	Panitumumab (Vectibix®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-</li> </ul>

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
		0105 Vectibix (panitumumab) on 06/10/2019.
<b>CG-DRUG-67</b>	Cetuximab (Erbix)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0106 Erbitux (cetuximab) on 09/01/2019.</li> </ul>
<b>CG-DRUG-68</b>	Bevacizumab (Avastin®) for Non-Ophthalmologic Indications	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0107 Bevacizumab for Non-ophthalmologic Indications (Avastin, Mvasi) on 09/01/2019.</li> </ul>
<b>CG-DRUG-70</b>	Eribulin mesylate (Halaven®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0108 Halaven (eribulin) on 09/01/2019.</li> </ul>
<b>CG-DRUG-71</b>	Ziv-aflibercept (Zaltrap®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0109 Zaltrap (ziv-aflibercept) on 09/01/2019.</li> </ul>
<b>CG-DRUG-72</b>	Pertuzumab (Perjeta®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0110 Perjeta (pertuzumab) on 06/10/2019.</li> </ul>
<b>CG-DRUG-75</b>	Romiplostim (Nplate®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0111 Nplate (romiplostim) on 09/01/2019.</li> </ul>
<b>CG-DRUG-76</b>	Plerixafor Injection (Mozobil™)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0089 Mozobil (plerixafor) on 08/01/2019.</li> </ul>
<b>CG-DRUG-77</b>	Radium Ra 223 Dichloride (Xofigo®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0112 Xofigo (Radium Ra 223 Dichloride) on 09/01/2019.</li> </ul>
<b>CG-DRUG-79</b>	Siltuximab (Sylvant®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transition to ING-CC-0113 Sylvant (siltuximab) on 11/01/2019.</li> </ul>
<b>CG-DRUG-80</b>	Cabazitaxel (Jevtana®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0114 Jevtana (cabazitaxel) on 09/01/2019.</li> </ul>
<b>CG-DRUG-96</b>	Ado-trastuzumab emtansine (Kadcyla)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0115 Kadcyla (ado-trastuzumab) on 06/10/2019.</li> </ul>
<b>CG-DRUG-98</b>	Bendamustine Hydrochloride	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0116 Bendamustine agents on 06/10/2019.</li> </ul>
<b>CG-DRUG-99</b>	Elotuzumab (Empliciti™)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0117 Empliciti (elotuzumab) on 09/01/2019.</li> </ul>
<b>CG-DRUG-100</b>	Interferon gamma-1b (Actimmune®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0085 Actimmune (interferon gamma-1B) on 09/01/2019.</li> </ul>
<b>CG-DRUG-101</b>	Ixabepilone (Ixempra)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0090 Ixempra (ixabepilone) on 09/01/2019.</li> </ul>
<b>CG-DRUG-102</b>	Olaratumab (Lartruvo)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0091 Lartruvo (olaratumab) on 09/01/2019.</li> </ul>
<b>CG-DRUG-106</b>	Brentuximab Vedotin (Adcetris®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0092 Adcetris (brentuximab) on 06/10/2019.</li> </ul>
<b>CG-DRUG-113</b>	Inotuzumab ozogamicin (Besponsa®)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0131 Besponsa (inotuzumab ozogamicin) on 09/01/2019.</li> </ul>
<b>CG-GENE-02</b>	Analysis of RAS Status  Previous title: Analysis of KRAS Status	<ul style="list-style-type: none"> <li>Revised Medically Necessary criteria to include NRAS.</li> <li>Revised Not Medically Necessary criteria to include all other indications for NRAS.</li> </ul>
<b>CG-GENE-12</b>	PIK3CA Mutation Testing	<ul style="list-style-type: none"> <li>Content moved from GENE.00044.</li> <li>Revised title. Previous title: Analysis of PIK3CA Status in Tumor Cells.</li> <li>Revised Medically Necessary indications to include the use of a circulating tumor DNA (ctDNA) test to detect mutations of the PIK3CA gene.</li> <li>Investigational &amp; Not Medically Necessary changed to Not Medically</li> </ul>

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
		Necessary as a result of Medical Policy to Clinical UM Guideline transition.
CG-MED-39	Bone Mineral Density Testing Measurement	<ul style="list-style-type: none"> <li>Revised title. Previous title: Central (Hip or Spine) Bone Density Measurement and Screening for Vertebral Fractures Using Dual Energy X-Ray Absorptiometry.</li> <li>Expanded document to address central and peripheral BMD testing as well as screening for vertebral fractures using DEXA.</li> <li>Content of RAD.00004 Peripheral Bone Mineral Density Measurement moved to this document.</li> </ul>
CG-MED-67	Melanoma Vaccines	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0135 Melanoma Vaccines on 09/01/2019.</li> </ul>
CG-MED-68	Therapeutic Apheresis	<ul style="list-style-type: none"> <li>Clarified Medically Necessary language for plasmapheresis or plasma exchange based on 2019 ASFA indications.</li> <li>Revised the Medically Necessary plasmapheresis or plasma exchange criteria for anti-neutrophil cytoplasmic antibodies vasculitis based on 2019 ASFA indications.</li> <li>Added acute inflammatory demyelinating polyradiculoneuropathy/Guillain-Barre syndrome, chronic inflammatory demyelinating polyradiculoneuropathy, myasthenia gravis, N-methyl D-aspartate receptor antibody encephalitis and renal transplant recipients as MN indications for immunoadsorption.</li> <li>Added Not Medically Necessary statements for red blood cell exchange and adsorptive cytapheresis when criteria are not met and for all other indications.</li> <li>Clarified Not Medically Necessary statements for plasmapheresis, low-density lipid apheresis, cytapheresis, and immunoadsorption pheresis.</li> <li>Clarified term Low-density lipid (LDL) apheresis is also known as lipoprotein apheresis.</li> <li>Removed clarifying Not Medically Necessary statement regarding immunoadsorption.</li> </ul>
CG-MED-80	Positron Emission Tomography (PET) and PET/CT Fusion	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transition to AIM Clinical Guidelines.</li> </ul>
CG-REHAB-08	Private Duty Nursing in the Home Setting	<ul style="list-style-type: none"> <li>Clarified Not Medically Necessary statement addressing nasopharyngeal and nasotracheal suctioning.</li> </ul>
CG-SURG-63	Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure	<ul style="list-style-type: none"> <li>Removed references to "FDA approved" from Clinical Indications.</li> </ul>
CG-SURG-78	Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies	<ul style="list-style-type: none"> <li>Revised title. Previous Title: Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies.</li> <li>Incorporation of CG-SURG-80 Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Treating Primary or Metastatic Liver Tumors and CG-THER-RAD-04 Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors clinical criteria into existing clinical UM guideline CG-SURG-78.</li> </ul>

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
		<ul style="list-style-type: none"> <li>Added radiofrequency ablation (RFA) and percutaneous ethanol injection (PEI) treatment as Medically Necessary for downsizing of hepatic lesions for individuals who may become eligible for transplant.</li> </ul>
<b>CG-SURG-79</b>	Implantable Infusion Pumps	<ul style="list-style-type: none"> <li>Clarified Medically Necessary clinical indications criteria for implantable infusion pumps for pulmonary arterial hypertension by adding generic name of medication.</li> </ul>
<b>CG-SURG-80</b>	Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Treating Primary or Metastatic Liver Tumors	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 11/12/2019.</li> <li>Incorporation of CG-SURG-80 and CG-THER-RAD-04 clinical criteria into existing clinical UM guideline CG-SURG-78.</li> </ul>
<b>CG-SURG-83</b>	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	<ul style="list-style-type: none"> <li>Revised "gastric bypass, using a Billroth II type of anastomosis (also known as a "mini gastric bypass")" to "One anastomosis gastric bypass, also known as mini gastric bypass" in Not Medically Necessary section.</li> <li>Added TransPyloric Shuttle and bariatric arterial embolization as Not Medically Necessary indications.</li> </ul>
<b>CG-THER-RAD-03</b>	Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy (Zevalin)	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2019. Transitioned to ING-CC-0118 Radioimmunotherapy: Zevalin; azedra; Lutathera on 09/01/2019.</li> </ul>
<b>CG-THER-RAD-04</b>	Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 11/12/2019.</li> <li>Incorporation of CG-SURG-80 and CG-THER-RAD-04 clinical criteria into existing clinical UM guideline CG-SURG-78.</li> </ul>