

May 1, 2020

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 August 1, 2020:

- **DME.00041 Low Intensity Therapeutic Ultrasound for the Treatment of Pain:** This document addresses the use of a low intensity therapeutic ultrasound device for the treatment of pain.
 - The use of a low intensity therapeutic ultrasound device is considered Investigational and Not Medically Necessary for all indications.
- **GENE.00053 Metagenomic Sequencing for Infectious Disease in the Outpatient Setting:** This document addresses metagenomic sequencing of infectious pathogens in the outpatient setting.
 - Metagenomic sequencing for infectious diseases in the outpatient setting is considered Investigational and Not Medically Necessary for all indications.
- **GENE.00054 Paired DNA and Messenger RNA (mRNA) Genetic Testing to Detect, Diagnose and Manage Cancer:** This document addresses testing for DNA in combination with mRNA proposed as a method of detecting, diagnosing and managing cancer; in particular, when DCNA genetic testing identifies variants of uncertain significance.
 - Messenger RNA (mRNA) sequence analysis alone or in conjunction with DNA sequence analysis to aid in the classification of variations of uncertain significance or to otherwise detect, diagnose or manage cancer is considered Investigational and Not Medically Necessary.
- **SURG.00154 Microsurgical Procedures for the Treatment of Lymphedema:** This document addresses select surgical procedures for the treatment of lymphedema in the upper and lower extremities.
 - Microsurgery for the treatment of lymphedema (including lymphedema as a result of a mastectomy) is considered Investigational and Not Medically Necessary, including but not limited to the following:
 1. Lymphaticolymphatic bypass;
 2. Lymphovenous bypass;
 3. Lymphaticovenular anastomosis;
 4. Vascularized lymph node transfer;
 5. Tissue/Flap transfer (for example, omental flap transfer)

- **SURG.00155 Cryoneurolysis for Treatment of Peripheral Nerve Pain:** This document addresses cryoneurolysis for treatment of peripheral nerve pain, including the relief of pain and symptoms associated with osteoarthritis of the knee.
 - Cryoneurolysis for treatment of peripheral nerve pain is considered Investigational and Not Medically Necessary for all indications, including osteoarthritis of the knee.

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

- **DME.00011 Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices:** This document addresses certain types of electrical stimulation devices.
 - Revised title. Previous title: Electrical Stimulation as a Treatment for Pain and Related Conditions: Surface and Percutaneous Devices.
 - Revised scope of document to include other conditions and devices.
 - Added cranial electrical stimulation (CES) as Investigational and Not Medically Necessary for all indications.
 - Added remote electrical neuromodulation (REN) as Investigational and Not Medically Necessary for all indications.
- **LAB.00011 Analysis of Proteomic Patterns:** This document addresses the use of proteomics, which is the qualitative and quantitative analysis of the collection of protein constituents in a biological sample.
 - Revised Investigational and Not Medically Necessary statement to include management of disease.
- **MED.00120 Gene Therapy for Ocular Conditions:** This document addresses the use of gene therapy to treat inherited ophthalmic disease.
 - Revised title. Previous title: Voretigene neparvovec-rzyl (Luxturna®).
 - Expanded scope of document to include all gene therapies for ocular conditions.
 - Removed redundant language "gene therapy".
 - Added the use of all other gene replacement therapies to treat any ocular condition as Investigational and Not Medically Necessary.
- **SURG.00032 Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention:** This document addresses the transcatheter closure of patent foramen ovale and transcatheter or open left atrial appendage (LAA) closure when performed to prevent stroke using cardiac occlusion devices.
 - Revised title. Previous title: Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention.
 - Added left atrial appendage closure via surgical (non-percutaneous) implantation of a device as Investigational and Not Medically Necessary for all indications.
- **CG-SURG-107 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.
 - Content moved from SURG.00028.
 - Investigational and Not Medically Necessary changed to Not Medically Necessary as a result of Medical Policy to Clinical UM Guideline transition.
 - Added examples of technologies for prostatic urethral lift, transurethral convective water vapor thermal ablation and waterjet tissue ablation.
 - Added Not Medically Necessary statement for prostatic urethral lift when the intent is to treat symptoms of conditions other than benign prostatic hyperplasia.

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.

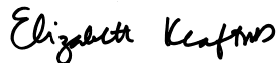
All coverage written or administered by Anthem excludes from coverage, services or supplies that are investigational and/or not medically necessary. A member's claim may not be eligible for payment if it was determined not to meet medical necessity criteria set in Anthem's medical policies. Review procedures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



Elizabeth Kraft, 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
BEH.00002	Transcranial Magnetic Stimulation	<ul style="list-style-type: none"> Medical policy archived 07/01/2020.
GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	<ul style="list-style-type: none"> Added MammaPrint as a technique of managing the treatment of breast cancer as Medically Necessary when criteria are met. Added MammaPrint as Investigational & Not Medically Necessary for repeat testing. Revised other Not Medically Necessary and Investigational & Not Medically Necessary statements regarding MammaPrint. Removed Breast Cancer Gene Expression Ratio (also known as Theros H/I), BreastNext and THEROS Breast Cancer Index tests from Investigational & Not Medically Necessary statement. The BreastNext test is addressed in GENE.00052 Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling and the other two tests are obsolete.
GENE.00026	Cell-Free Fetal DNA-Based Prenatal Testing	<ul style="list-style-type: none"> Added new CPT PLA code 0168U effective 04/01/2020 for Vanadis® NIPT.
GENE.00052	Whole Genome Sequencing, Exome Sequencing, Gene Panels, and Molecular Profiling	<ul style="list-style-type: none"> Added new CPT PLA code 0171U effective 04/01/2020 for MyMRD® NGS Panel, considered Investigational & Not Medically Necessary.
LAB.00019	Serum Markers for Liver Fibrosis in the Evaluation and Monitoring of Chronic Liver Disease	<ul style="list-style-type: none"> Added new CPT codes 0014M, 0166U effective 04/01/2020 for Enhanced Liver Fibrosis™ (ELF™) Test and LiverFAST™ test, considered Investigational & Not Medically Necessary.
MED.00007	Prolotherapy for Joint and Ligamentous Conditions	<ul style="list-style-type: none"> Medical policy archived 04/15/2020.
MED.00074	Computer Analysis and Probability Assessment of Electrocardiographic-Derived Data	<ul style="list-style-type: none"> Medical policy archived 04/15/2020.
RAD.00012	Ultrasound for the Evaluation of Paranasal Sinuses	<ul style="list-style-type: none"> Medical policy archived 04/15/2020.
SURG.00016	Stereotactic Radiofrequency Pallidotomy	<ul style="list-style-type: none"> Medical policy archived 04/15/2020. Converted to CG-SURG-108.
SURG.00023	Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures	<ul style="list-style-type: none"> Corrected ICD-10-CM diagnosis code range T81.40XA-T81.40XS (T81.4XXA-T81.4XXS deleted).
SURG.00028	Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH)	<ul style="list-style-type: none"> Medical policy archived 07/01/2020. Converted to CG-SURG-107.
SURG.00067	Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty	<ul style="list-style-type: none"> Medical policy archived 04/15/2020.

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
SURG.00096	Surgical and Ablative Treatments for Chronic Headaches	<ul style="list-style-type: none"> Added existing CPT codes 14040, 14041, 14060, 14061, 64716, 64771, 64772, 64787 and diagnosis codes G50.1, M54.81, R51 based on inquiries and society guidelines; considered Investigational & Not Medically Necessary for headache diagnoses.
SURG.00103	Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	<ul style="list-style-type: none"> Clarified Medically Necessary statement for Ex-PRESS Glaucoma Filtration Device. Added the XEN Glaucoma Treatment System as Medically Necessary when criteria are met. Updated the Investigational & Not Medically Necessary statement.
SURG.00127	Sacroiliac Joint Fusion	<ul style="list-style-type: none"> Clarified Medically Necessary statement for minimally invasive/percutaneous sacroiliac joint fusion by adding separate line for criteria that states: "individual has a history of pelvic girdle trauma which has caused chronic sacroiliac joint pain or functional impairment".
SURG.00137	Focused Microwave Thermotherapy for Breast Cancer	<ul style="list-style-type: none"> Removed ICD-10-PCS codes 0H5TXZZ, 0H5UXZZ, 0H5VXZZ deleted 09/30/2019.
SURG.00139	Intraoperative Assessment of Surgical Margins During Breast-Conserving Surgery with Radiofrequency Spectroscopy or Optical Coherence Tomography	<ul style="list-style-type: none"> Removed 19499 NOC (no longer applicable; replaced by 0546T 07/01/2019).
SURG.00150	Leadless Pacemaker	<ul style="list-style-type: none"> Added ICD-10-PCS procedure code 02HK3NZ.
THER-RAD.00009	Intraocular Epiretinal Brachytherapy	<ul style="list-style-type: none"> Medical Policy archived 04/15/2020.
CG-GENE-12	PIK3CA Mutation Testing for Malignant Conditions	<ul style="list-style-type: none"> Revised descriptor for 0155U.
CG-MED-82	Intravenous versus Oral Drug Administration in the Outpatient and Home Setting	<ul style="list-style-type: none"> Clinical UM Guideline archived 04/15/2020.
CG-REHAB-04	Rehabilitative and Habilitative Services: Physical Medicine/Physical Therapy	<ul style="list-style-type: none"> Added HCPCS code G2168 for PT assistant services in home health setting (effective retro to 01/01/2020).
CG-REHAB-05	Rehabilitative and Habilitative Services: Occupational Therapy	<ul style="list-style-type: none"> Added HCPCS code G2169 for OT assistant services in home health setting (effective retro to 01/01/2020).
CG-SURG-27	Gender Reassignment Surgery	<ul style="list-style-type: none"> Added existing CPT code 19318 (reduction mammoplasty) used for removal of breast tissue.
CG-SURG-108	Stereotactic Radiofrequency Pallidotomy	<ul style="list-style-type: none"> Content moved from SURG.00016. 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.