

August 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 November 1, 2020:

- **DME.00042 Electronic Positional Devices for the Treatment of Obstructive Sleep Apnea:** This document addresses electronic devices used in the treatment of positional obstructive sleep apnea (POSA).
 - Electronic positional therapy devices are considered Investigational & Not Medically Necessary in the treatment of obstructive sleep apnea.
- **MED.00131 Electronic Home Visual Field Monitoring:** This document addresses the use of electronic home visual field monitoring.
 - The use of electronic home visual field monitoring is considered Investigational & Not Medically Necessary for all indications.
- **MED.00132 Adipose-derived Regenerative Cell Therapy and Soft Tissue Augmentation Procedures:** This document addresses the following soft tissue augmentation procedures: Autologous adipose-derived regenerative cell therapy (for example, Lipogems); Autologous fat grafting (autologous fat transfer); and Injectable soft tissue fillers.
 - Outlines the Medically Necessary, Reconstructive, and Cosmetic & Not Medically Necessary indications for autologous fat grafting.
 - Criteria moved from existing medical policies ANC.00007 and MED.00110 with no change to criteria:
 - Autologous adipose-derived regenerative cell therapy (for example, Lipogems) is considered Investigational & Not Medically Necessary for all indications.
 - Outlines the Medically Necessary, Reconstructive, and Cosmetic & Not Medically Necessary indications for injectable soft tissue fillers.
- **MED.00133 Ingestion Event Monitors:** This document addresses ingestion event sensors for medication monitoring and adherence.
 - Ingestion event monitors are considered Investigational & Not Medically Necessary for medication monitoring and adherence and for all other indications.
- **THER-RAD.00012 Electrophysiology-Guided Noninvasive Stereotactic Cardiac Radioablation:** This document addresses the use of electrophysiology-guided noninvasive stereotactic cardiac radioablation as a treatment modality for cardiac arrhythmias, including drug and ablation refractory ventricular tachycardia (VT) and cardiomyopathy related to premature ventricular contractions (PVC).

- The use of electrophysiology-guided noninvasive stereotactic cardiac radioablation is considered Investigational & Not Medically Necessary as a treatment modality for all indications, including drug and ablation refractory ventricular tachycardia and cardiomyopathy related to premature ventricular contractions.

Revised Medical Policies and Adopted Clinical UM Guidelines effective November 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.
 - Added transcutaneous electrical modulation pain reprocessing as Investigational & Not Medically Necessary for all indications including, but not limited to, treatment of acute and chronic pain.
 - Reordered statements in alphabetical order.
- **MED.00004 Technologies for the Evaluation of Skin Lesions (including Dermatoscopy, Epiluminescence Microscopy, Videomicroscopy, Ultrasonography):** This document addresses the use of photographic, optical, video, and other imaging technologies for the evaluation of skin lesions.
 - Added reflectance confocal microscopy for the evaluation of skin lesions as Not Medically Necessary in all cases.
 - Removed Cosmetic & Not Medically Necessary statement.
- **CG-DME-46 Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Extremities in the Home Setting:** This document addresses the use of pneumatic compression devices for the prevention of deep vein thrombosis (DVT) of the extremities in the home setting.
 - Revised title. Previous title: Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Extremities.
 - Expanded scope of document.
 - Revised Medically Necessary statement to include prevention of DVT for all indications in the home setting.
- **CG-GENE-02 Analysis of RAS Status:** This document addresses DNA testing used to determine the status of the RAS gene family (HRAS, KRAS, or NRAS), which is often used to guide therapy decisions in individuals with oncologic conditions.
 - Clarified scope of document includes HRAS.
 - Added HRAS as Not Medically Necessary.
- **CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation):** This document addresses transcatheter radiofrequency ablation and cryoablation of arrhythmogenic foci in the pulmonary veins for the treatment of atrial fibrillation or atrial flutter.
 - Revised the MN statement to state: Transcatheter radiofrequency ablation or cryoablation of arrhythmogenic foci in the pulmonary veins is considered MN as a treatment of symptomatic individuals with one of the following:
 - Recurrent (2 or more episodes) paroxysmal (terminates spontaneously or with intervention within 7 days of onset) atrial fibrillation as an alternative to medical therapy; or
 - Persistent (sustained greater than 7 days) atrial fibrillation when refractory or intolerant to one or more antiarrhythmic drugs (or has a contraindication to all appropriate antiarrhythmic drug therapy)
- **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 requirement that medical treatments must have been tried and failed prior to therapeutic

apheresis to Medically Necessary category II indications with the exception of leukocytapheresis for symptomatic hyperleukocytosis.

- Removed the following medically necessary indications:
 - H.E.L.L.P Syndrome of pregnancy,
 - progressive multifocal leukoencephalopathy (natalizumab associated),
 - Sydenham's chorea,
 - symptomatic secondary polycythemia,
 - severe malaria,
 - multi organ failure syndrome,
 - pre-procedure preparation for surgery or hematopoietic stem cell transplant,
 - iron overload,
 - moderate to severe rheumatoid arthritis.
- Revised criteria addressing myasthenia gravis.
- Removed examples from the Not Medically Necessary statements.

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](#). Either enter key word or code, or select the link for [Full List page](#) to search the policy for your inquiry.

To view the list of specific clinical UM guidelines adopted by Nevada, navigate to the [View Medical Policies & UM Guidelines page](#). Scroll to the bottom of the page to the link titled [Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield in Nevada](#).

Sincerely,



Jo Ann Nishimoto, MD
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
ANC.00007	Cosmetic and Reconstructive Services: Skin Related	<ul style="list-style-type: none"> Moved information addressing dermal fillers, collagen injections and hyaluronic acid gel products to new policy MED.00132 Adipose-derived Regenerative Cell Therapy and Soft Tissue Augmentation Procedures.
DME.00009	Vacuum Assisted Wound Therapy in the Outpatient Setting	<ul style="list-style-type: none"> Removed Investigational & Not Medically Necessary statement addressing battery-powered devices.
DME.00034	Standing Frames	<ul style="list-style-type: none"> Added non-powered standing frame as Medically Necessary when criteria are met. Revised Investigational & Not Medically Necessary statement to be a Not Medically Necessary statement. Clarified that a powered standing frame is Not Medically Necessary.
GENE.00010	Panel and other Multi-Gene Testing for Polymorphisms to Determine Drug-Metabolizer Status	<ul style="list-style-type: none"> Revised title: Previous title: Panel Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status. Revised position statement to state: "The use of panel and multi-gene tests for polymorphisms to determine drug-metabolizer status is considered Investigational & Not Medically Necessary."
LAB.00016	Fecal Analysis in the Diagnosis of Intestinal Disorders	<ul style="list-style-type: none"> Added fecal analysis panels as a diagnostic test for the evaluation of intestinal dysbiosis, irritable bowel syndrome, malabsorption or small intestinal overgrowth of bacteria as Investigational & Not Medically Necessary.
MED.00110	Silver-based Products and Autologous Skin-, Blood- or Bone Marrow-derived Products for Wound and Soft Tissue Applications	<ul style="list-style-type: none"> Revised title: Previous title: Growth Factors, Silver-based Products and Autologous Tissues for Wound Treatment, Soft Tissue Grafting, and Regenerative Therapy. Moved information addressing autologous adipose-derived regenerative cell therapy to MED.00132 Adipose-derived Regenerative Cell Therapy and Soft Tissue Augmentation Procedures.
SURG.00007	Vagus Nerve Stimulation	<ul style="list-style-type: none"> Added a requirement to the Medically Necessary revision/replacement language that current device is not functioning properly. Updated Investigational & Not Medically Necessary statement addressing replacement or revision.
SURG.00026	Deep Brain, Cortical, and Cerebellar Stimulation	<ul style="list-style-type: none"> Reformatted Medically Necessary statement addressing primary dystonia. Added unilateral or bilateral deep brain stimulation of the anterior nucleus of the thalamus as Medically Necessary for individuals with epilepsy when criteria are met. Revised and clarified the Investigational & Not Medically Necessary statement addressing all other conditions.
SURG.00047	Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia and Gastroparesis	<ul style="list-style-type: none"> Added peroral endoscopic myotomy (POEM) for the treatment of primary achalasia as Medically Necessary when criteria are met. Added POEM as Not Medically Necessary when criteria are not met and for all other indications. Updated Investigational & Not Medically Necessary statement.
SURG.00121	Transcatheter Heart Valve Procedures	<ul style="list-style-type: none"> Added valve-in-valve transcatheter mitral valve repair as Investigational & Not Medically Necessary for all indications as a separate statement.
TRANS.00035	Other Stem Cell Therapy	<ul style="list-style-type: none"> Revised title: Previous title: Non-Hematopoietic Adult Stem Cell Therapy.

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
		<ul style="list-style-type: none"> • Revised scope. • Moved content from TRANS.00036 to this policy. • Revised position statement to read: <ul style="list-style-type: none"> - Stem cell therapy, including but not limited to mesenchymal stem cell therapy is considered Investigational & Not Medically Necessary for the prevention and treatment of all conditions including but not limited to peripheral vascular disease, and orthopedic, autoimmune, inflammatory and degenerative conditions. - Added Note to position statement: This document does not address stem cell therapy used for disorders affecting the hematopoietic system that are inherited, acquired, or result from myeloablative treatment, or hematopoietic stem cell transplantation.
TRANS.00036	Stem Cell Therapy for Peripheral Vascular Disease	<ul style="list-style-type: none"> • Medical policy archived 07/08/2020. Combined with TRANS.00035.
CG-MED-59	Upper Gastrointestinal Endoscopy in Adults	<ul style="list-style-type: none"> • Updated document number for Ablative Techniques as a Treatment from Barrett's Esophagus to CG-SURG-101.
CG-MED-74	Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry	<ul style="list-style-type: none"> • Clarified scope of document. • Clarified Medically Necessary statement addressing mobile cardiac telemetry. • Added Medically Necessary statement to address replacement of implantable ambulatory event monitors. • Added separate Not Medically Necessary statement for mobile cardiac telemetry.
CG-MED-77	SPECT/CT Fusion Imaging	<ul style="list-style-type: none"> • Added the use of SPECT/CT fusion imaging as Medically Necessary for melanoma sentinel lymph node biopsy, when visualization using conventional methods is inadequate.
CG-SURG-27	Gender Reassignment Surgery	<ul style="list-style-type: none"> • Added text to Medically Necessary statement for mastectomy referring reader to see Further Considerations section for individuals under 18 years of age. • Added new Further Considerations section addressing mastectomy procedures for individuals under 18 years of age.