

November 1, 2020

**RE: Medical Policy and Clinical UM Guidelines notification letter**

Dear Provider:

Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Colorado (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 Colorado. 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 February 1, 2021:**

- **MED.00134 Non-invasive Heart Failure and Arrhythmia Management and Monitoring System:** This document addresses the use of a non-invasive heart failure and arrhythmia management and monitoring system as an early indicator for heart failure decompensation and arrhythmia detection.
  - The use of a non-invasive heart failure and arrhythmia management and monitoring system (for example,  $\mu$ -Cor™ Heart Failure and Arrhythmia Management System) is considered Investigational & Not Medically Necessary for all indications.
- **SURG.00156 Implanted Artificial Iris Devices:** This document addresses the use of artificial irises to treat individuals with congenital or traumatic aniridia or individuals with iris defects.
  - The use of implanted artificial iris devices is considered Investigational & Not Medically Necessary for all indications, including as a treatment of congenital or traumatic aniridia.
- **SURG.00157 Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis:** This document addresses the use of minimally invasive techniques to inactivate the the posterior nasal nerve (PNN) and to thereby decrease the symptoms of chronic rhinorrhea or nasal congestion.
  - Minimally invasive treatment of the posterior nasal nerve area, such as cryotherapy or radiofrequency therapy, to decrease the symptoms of allergic or nonallergic rhinitis is considered Investigational & Not Medically Necessary in all cases.

**Revised Medical Policies and Adopted Clinical UM Guidelines effective February 1, 2021:**

- **GENE.00052 Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling:** This document addresses whole genome sequencing, whole exome sequencing, and gene panel testing.
  - Removed Medically Necessary criteria for NSCLC for tumor burden assessment.
  - Added molecular profiling as Medically Necessary for unresectable or metastatic solid tumors when criteria are met.
  - Made minor grammatical revision in Lynch Syndrome criteria.

- **SURG.00077 Uterine Fibroid Ablation: Laparoscopic, Percutaneous or Transcervical Image Guided Techniques:** This document addresses laparoscopic and percutaneous ablative techniques for the treatment of symptomatic uterine fibroids, including radiofrequency ablation using a transcervical approach.

  - Revised title. Previous title: Uterine Fibroid Ablation: Laparoscopic or Percutaneous Image Guided Techniques.
  - Expanded scope of document to include transcervical image guided techniques.
  - Added radiofrequency ablation using a transcervical approach in combination with imaging guidance as a treatment of uterine fibroids as Investigational & Not Medically Necessary.
  
- **SURG.00112 Implantation of Occipital, Supraorbital or Trigeminal Nerve Stimulation Devices (and Related Procedures):** This document addresses peripheral nerve stimulation (also referred to as implanted peripheral nerve stimulation) which involves the implantation of a permanent device to deliver small electrical impulses to the occipital, supraorbital or trigeminal nerves.

  - Revised title. Previous title: Occipital Nerve and Supraorbital Nerve Stimulation.
  - Revised scope of document to address implanted nerve stimulation devices and related procedures.
  - Added implantation of a trigeminal nerve stimulation device (and related procedures) as Investigational & Not Medically Necessary for all indications.
  
- **CG-DME-07 Augmentative and Alternative Communication (AAC) Devices with Digitized or Synthesized Speech Output:** This document addresses augmentative and alternative communication (AAC) devices with digitized or synthesized speech output.

  - Clarified language and added detail related to required documentation in Medically Necessary criteria.
  - Changed "medical" and "non-medical" to "augmentative and non-augmentative" in Not Medically Necessary section.

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 **Colorado** 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 Colorado, 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 Colorado](#).

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
ADMIN.00006	Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline	<ul style="list-style-type: none"> <li>Replaced single quotation marks with double quotation marks, hyphenated the words decision making and placed an asterisk after the comma in the Description/Scope section.</li> <li>Added Neurocritical Care, Micrographic Dermatologic Surgery Under Physician Specialty Societies' table.</li> <li>Added Complex to Pediatric Otolaryngology in the Subspecialty Certificate section of the table.</li> <li>Reformatted general and vascular surgery under the General Certificate section of the table.</li> </ul>
LAB.00011	Analysis of Proteomic Patterns	<ul style="list-style-type: none"> <li>Expanded scope of Investigational &amp; Not Medically Necessary statement to address all indications.</li> </ul>
RAD.00062	Intravascular Optical Coherence Tomography (OCT)	<ul style="list-style-type: none"> <li>Medical policy archived on 10/07/2020.</li> </ul>
SURG.00128	Implantable Left Atrial Hemodynamic Monitor	<ul style="list-style-type: none"> <li>Clarified Investigational &amp; Not Medically Necessary statement for left atrial hemodynamic monitoring utilizing implantable device, updating list of examples to include V-LAP™ System.</li> </ul>
CG-DME-44	Electric Tumor Treatment Field (TTF)	<ul style="list-style-type: none"> <li>Removed definition of tumor progression from clinical indications section and added note to refer reader to Discussion section for MacDonald criteria.</li> </ul>
CG-GENE-03	BRAF Mutation Analysis	<ul style="list-style-type: none"> <li>Added BRAF V600 mutation analysis as Medically Necessary for Langerhans cell histiocytosis and central nervous system tumors to identify those who would benefit from treatment with an FDA-approved BRAF inhibitor.</li> <li>Reformatted Medically Necessary clinical indications.</li> </ul>
CG-MED-55	Site of Care: Advanced Radiologic Imaging	<ul style="list-style-type: none"> <li>Revised title.</li> <li>Changed wording to "site of care" from "level of care" throughout document.</li> </ul>
CG-MED-63	Treatment of Hyperhidrosis	<ul style="list-style-type: none"> <li>Revised formatting in clinical indications section.</li> </ul>
CG-MED-69	Inhaled Nitric Oxide	<ul style="list-style-type: none"> <li>Clarified Medically Necessary criteria.</li> </ul>
CG-MED-83	Site of Care: Specialty Pharmaceuticals	<ul style="list-style-type: none"> <li>Revised title. Previous title: Level of Care: Specialty Pharmaceuticals.</li> <li>Changed wording to "site of care" from "level of care" throughout document.</li> </ul>
CG-REHAB-04	Rehabilitative and Habilitative Services: Physical Medicine/Physical Therapy	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2020.</li> </ul>
CG-REHAB-05	Rehabilitative and Habilitative Services: Occupational Therapy	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2020.</li> </ul>
CG-REHAB-06	Rehabilitative and Habilitative Services: Speech-Language Pathology	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2020.</li> </ul>

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
<b>CG-REHAB-08</b>	Private Duty Nursing in the Home Setting	<ul style="list-style-type: none"> <li>Clarified wording in Not Medically Necessary statement by removing the word "licensed".</li> </ul>
<b>CG-REHAB-11</b>	Cognitive Rehabilitation	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2020.</li> </ul>
<b>CG-SURG-27</b>	Gender Reassignment Surgery	<ul style="list-style-type: none"> <li>Added penile prostheses to Medically Necessary criteria addressing phalloplasty procedures.</li> </ul>
<b>CG-SURG-52</b>	Site of Care: Hospital-Based Ambulatory Surgical Procedures and Endoscopic Services	<ul style="list-style-type: none"> <li>Revised title. Previous title: Level of Care: Hospital-Based Ambulatory Surgical Procedures and Endoscopic Services.</li> <li>Changed wording to "site of care" from "level of care" throughout document.</li> </ul>
<b>CG-SURG-59</b>	Vena Cava Filters	<ul style="list-style-type: none"> <li>Added "but not limited to" at the beginning of the list of contraindications to anticoagulation therapy in the Medically Necessary criteria for vena cava placement in acute venous thromboembolism.</li> </ul>
<b>CG-SURG-74</b>	Total Ankle Replacement	<ul style="list-style-type: none"> <li>Clinical UM Guideline archived 10/01/2020.</li> </ul>
<b>CG-SURG-83</b>	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	<ul style="list-style-type: none"> <li>Revised Medically Necessary criteria addressing weight loss by removing the 6 month requirement and instead including past participation in a weight loss program with inadequate weight loss despite a committed attempt at conservative medical therapy.</li> <li>Removed the ReShape Integrated Dual Balloon System and the MAESTRO Rechargeable System from Not Medically Necessary section as they are no longer available.</li> </ul>