March 1, 2019

RE: Medical Policy and Clinical UM Guideline changes 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 Colorado/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 June 1, 2019:

- **LAB.00036 Multiplex Autoantigen Microarray Testing for Systemic Lupus Erythematosus:** This document addresses multiplex autoantigen microarray testing for evaluation of systemic lupus erythematosus (SLE), a chronic autoimmune disease.
    - Multiplex autoantigen microarray testing to screen for, diagnose, or manage systemic lupus erythematous is considered Investigational and Not Medically Necessary.

Revised Medical Policies and Adopted Clinical UM Guidelines effective June 1, 2019:

- **MED.00110 Growth Factors, Silver-based Products and Autologous Tissues for Wound Treatment and Soft Tissue Grafting:** This document addresses the use of recombinant human platelet-derived growth factor (becaplermin [Regranex®]), antimicrobial silver wound dressings, (for example, Acticoat, Actisorb™, and Silversorb®), autologous blood-derived wound products, (for example, Aurix™ [formerly Autologel™], Vitagel®), platelet rich plasma (PRP), bone marrow aspirate concentrate, and bioengineered autologous skin-derived products (for example, SkinTE™).
    - Added bioengineered autologous skin-derived products (for example, SkinTE) as Investigational and Not Medically Necessary for all indications.

- **MED.00126 Fractional Exhaled Nitric Oxide and Exhaled Breath Condensate Measurements for Respiratory Disorders:** This document addresses the measurement of exhaled nitric oxide and exhaled breath condensate for the diagnosis and monitoring of asthma and other respiratory disorders.
    - Added nasal nitric oxide as Investigational and Not Medically Necessary in the diagnosis and monitoring of asthma and other respiratory disorders.

- **SURG.00037 Treatment of Varicose Veins (Lower Extremities):** This document addresses various modalities (listed below) for the treatment of valvular incompetence (reflux) of the great saphenous vein (GSV) 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.

- Replaced "non-surgical management" with "conservative therapy" in the Medically Necessary criteria.
- Added sclerotherapy used in conjunction with a balloon catheter (for example, KAVS procedure) as Investigational and Not Medically Necessary.

- **TRANS.00035 Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament Disorders, Autoimmune, Inflammatory and Degenerative Diseases:** This document addresses the use of mesenchymal stem cell (MSC) therapy for the treatment of joint and ligament disorders due to injury or degeneration, as well as autoimmune, inflammatory and degenerative diseases.
  - Updated title. Previous title: Mesenchymal Stem Cell Therapy For Orthopedic Indications.
  - Expanded the document's scope to address non-FDA approved uses of mesenchymal stem cell therapy.
  - Revised Position Statement: "Mesenchymal stem cell therapy is considered Investigational and Not Medically Necessary for the treatment of joint and ligament disorders caused by injury or degeneration as well as autoimmune, inflammatory and degenerative diseases."

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**. Select **Providers**, and **Providers Overview**. Select **Find Resources for Your State** and pick **Nevada**. On the **Provider Home** page, from the **Medical Policy, Clinical UM Guidelines, Pre-Cert Requirements tout** (*2nd blue box on the left side of page*), select **enter**. 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.00071	Pembrolizumab (Keytruda®)	• Added Child-Pugh Class A advanced hepatocellular carcinoma as Medically Necessary when criteria are met. • Clarified Medically Necessary criteria for Merkel cell carcinoma.
DRUG.00080	Monoclonal Antibodies for the Treatment of Eosinophilic Conditions	• Clarified Medically Necessary criteria addressing asthma control questionnaires for benralizumab, and for reslizumab.
DRUG.00088	Atezolizumab (Tecentriq®)	• Added SCLC as Medically Necessary when criteria are met. • Clarified Medically Necessary criteria for NSCLC.
LAB.00024	Immune Cell Function Assay	• Removed iSpot Lyme test from the Position Statement.
MED.00117	Autologous Cell Therapy for the Treatment of Damaged Myocardium	• Removed acronym from the Clinical Indications section.
OR-PR.00003	Microprocessor Controlled Lower Limb Prosthesis	• Revised Medically Necessary criteria related to mobility and stability benefit, ambulation, distance and on uneven terrain or stairs. • Clarified the Not Medically Necessary statement.
SURG.00011	Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting	• Added EpiCord, Grafix PRIME, and the sheet or membrane form of AmnioBand as Medically Necessary when criteria are met. • Revised Investigational and Not Medically Necessary statements regarding AmnioBand, EpiCord, and Grafix PRIME.
SURG.00115	Keratoprosthesis	• Medical policy archived 03/21/2019. Converted to CG-SURG-94.
SURG.00117	Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence; Urinary Retention	• Medical policy archived 03/21/2019. Converted to CG-SURG-95. • Removed acronyms from the Clinical Indications section. • Updated title. Previous title: Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence; Urinary Retention.
SURG.00122	Venous Angioplasty with or without Stent Placement or Venous Stenting Alone	• Removed arterio venous dialysis access grafts Medically Necessary statement, which is now addressed in new clinical UM guideline CG-SURG-93 Angiographic Evaluation and Endovascular Intervention for Dialysis Access Circuit Dysfunction.
SURG.00136	Intraocular Telescope	• Medical policy archived 03/21/2019. Converted to CG-SURG-96. • Removed acronyms from the Clinical Indications section.
CG-DRUG-43	Natalizumab (Tysabri®)	• Removed acronyms from the Clinical Indications section.
CG-DRUG-50	Paclitaxel, protein-bound (Abraxane®)	• Added the treatment of locally advanced or metastatic squamous NSCLC as Medically Necessary when criteria are met.

Medical Policy Number	Medical Policy Title	Medical Policy / Clinical Guideline Changes
CG-DRUG-99	Elotuzumab (Empliciti™)	• Added Elotuzumab used in combination with pomalidomide and dexamethasone as Medically Necessary when criteria are met.
CG-DRUG-106	Brentuximab Vedotin (Adcetris®)	• Updated Medically Necessary indications for untreated Hodgkin lymphoma (HL) to specify regimen. • Expanded Medically Necessary indications to include combination therapy with bendaumstine for relapsed/refractory HL and combination therapy with cyclophosphamide, doxorubicin, and prednisone for previously untreated CD30+ PTCL.
CG-MED-38	Inpatient Admission for Radiation Therapy for Cervical or Thyroid Cancer	• Corrected publish date of discharge guidelines set by the U.S. Nuclear Regulatory Commission.
CG-MED-73	Hyperbaric Oxygen Therapy (Systemic/Topical)	• Updated Clinical Indications with additional details on treatment of wounds and jaw conditions consistent with Undersea and Hyperbaric Medicine Society recommendations. • Added to Not Medically Necessary statement: Idiopathic Sudden Sensorineural Hearing Loss (ISSHL), osteonecrosis of the jaw when the cause is not radiation necrosis (osteoradionecrosis), preoperative treatment for jaw osteomyelitis, traumatic brain injury and venous stasis ulcers, pressure ulcers and non-pressure ulcers except in the subset of individuals noted in the Medically Necessary statement.
CG-SURG-27	Sex Reassignment Surgery	• Revised Medically Necessary criteria for bilateral mastectomy to require one referral letter. • Added language addressing treatment of postoperative complications and reversal procedures.
CG-SURG-77	Refractive Surgery	• Added Medically Necessary indications for small incision lenticule extraction (SMILE). • Added SMILE to Not Medically Necessary indications when medically necessary criteria are not met.
CG-SURG-83	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	• Revised Medically Necessary indications to simplify criteria regarding preoperative and postoperative documentation. • Reformatted Medically Necessary section without change in intent. • Revised criteria regarding reoperations/repeat surgery to clarify the types of surgery. • Added Not Medically Necessary statement when Medically Necessary indications are not met. • Reformatted Not Medically Necessary section without change in intent.