Coverage and clinical guideline update

Coverage guidelines effective July 1, 2019

SPECIAL NOTE:

The services addressed in ALL the coverage guidelines presented in this document will require authorization for all our products offered by HealthKeepers, Inc. with the exception of Anthem HealthKeepers Plus (Medicaid) and the Commonwealth Coordinated Care Plus (Anthem CCC Plus) plan. Other exceptions are Medicare Advantage and the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP). A pre-determination can be requested for our Anthem PPO products.

Anthem Blue Cross and Blue Shield in Virginia and our affiliate, HealthKeepers, Inc., will implement the following new and revised coverage guidelines effective July 1, 2019. These guidelines impact all our products – with the exception of Anthem HealthKeepers Plus (Medicaid), the Commonwealth Coordinated Care Plus (Anthem CCC Plus) plan, Medicare Advantage, and the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP). Furthermore, the guidelines were among those recently approved at the Medical Policy and Technology Assessment Committee meeting held on January 24, 2019.

The services addressed in these coverage guidelines will require authorization for all of our HealthKeepers, Inc. products with the exception of Anthem HealthKeepers Plus (Medicaid), the Anthem CCC Plus plan, Medicare Advantage, and the Federal Employee Program.

A pre-determination can be requested for our PPO products.

Services related to specialty pharmacy drugs (non-cancer related) require a Medical Necessity review, which includes site of care criteria, as outlined in the applicable coverage or clinical UM guideline listed below.

The guidelines address in this edition are:

- Multiplex Autoantigen Microarray Testing for Systemic Lupus Erythematosus (LAB.00036)
- Treatment of Varicose Veins (Lower Extremity) (SURG.00037)
- Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament Disorders, Autoimmune, Inflammatory and Degenerative Diseases (TRANS.00035)
- Genetic Testing for DMD Mutations (Duchenne or Becker Muscular Dystrophy) (CG-GENE-05)
- Paraesophageal Hernia Repair (CG-SURG-92)

**Multiplex Autoantigen Microarray Testing for Systemic Lupus Erythematosus (LAB.00036)**

This new coverage guideline 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 erythematosus is considered *investigational and not medically necessary*.

The CPT code associated with this new coverage guideline is 0062U.

**Treatment of Varicose Veins (Lower Extremity) (SURG.00037)**

This coverage guideline addresses various modalities 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.

It has been revised to include sclerotherapy or echosclerotherapy when used in conjunction with a balloon catheter (for example, KAVS procedure) as *investigational and not medically necessary*.

The CPT and HCPCS codes associated with this revised coverage guideline are 36465, 36466, 36468, 36470, 36471, 36473, 36474, 36475, 36476, 36478, 36482, 36483, 37241, 37799, 0524T, 96999, S2202.

**Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament Disorders, Autoimmune, Inflammatory and Degenerative Diseases (TRANS.00035)**

This revised coverage guideline addresses the use of mesenchymal stem cell therapy for the treatment of joint and ligament disorders due to injury or degeneration, as well as autoimmune, inflammatory and degenerative diseases.

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.

The CPT codes associated with this revised coverage guideline are 17999, 20999, 38230, 38232, 38999, 64999.
Genetic Testing for DMD Mutations (Duchenne or Becker Muscular Dystrophy) (CG-GENE-05)

This new clinical UM guideline addresses genetic testing for Duchenne muscular dystrophy or Becker muscular dystrophy.

Genetic testing for Duchenne or Becker muscular dystrophy is **medically necessary** for a suspected diagnosis to determine eligibility for pharmaceutical therapy.

Preconception or prenatal genetic testing of a parent or prospective parent to determine carrier status of Duchenne or Becker muscular dystrophy is considered **medically necessary** when the following criteria are met:

A. Mother or prospective mother has a first or second degree relative on the maternal side who is affected with Duchenne or Becker muscular dystrophy, or the first degree relative has an affected child with Duchenne or Becker muscular dystrophy and genetic testing is performed to determine the pattern of inheritance and to guide subsequent reproductive decisions; and

B. Genetic counseling has been performed.

Genetic testing for Duchenne or Becker muscular dystrophy is **not medically necessary** when the criteria are not met.

The CPT codes associated with this new clinical UM guideline are 81161 and 81408.

Paraesophageal Hernia Repair (CG-SURG-92)

This new clinical UM guideline addresses paraesophageal hernia (PEH) repair.

Paraesophageal hernia repair is considered **medically necessary** for symptomatic individuals with all of the following indications:

1. A paraesophageal hernia is demonstrated on diagnostic imaging or endoscopic study; and

2. One of the following conditions exists:
   
   i. Gastric outlet obstruction caused by the hernia; or
   
   ii. Persistent anemia without other identified causes after evaluation; or
   
   iii. Suspected or documented gastric strangulation; or
   

Paraesophageal hernia repair during operation for Roux-en-Y gastric bypass, sleeve gastrectomy, or the placement of an adjustable gastric band is considered **medically necessary** when all the criteria below are met:

1. The bariatric procedure has been determined to be medically necessary*; and

2. A paraesophageal hernia is detected during operation for Roux-en-Y gastric bypass, sleeve gastrectomy, or the placement of an adjustable gastric band.

Recurrent paraesophageal hernia repair is considered **medically necessary** when all of the criteria below are met:
3. A paraesophageal hernia is demonstrated on diagnostic imaging or endoscopic study performed after the previous repair; and

4. A condition listed in criterion A persists or recurs:
   i. Gastric outlet obstruction caused by the hernia; or
   ii. Persistent anemia without other identified cause after evaluation; or
   iii. Suspected or documented gastric strangulation; or

Paraesophageal hernia repair is considered not medically necessary when the criteria are not met and for all other indications.

The CPT codes associated with this new clinical UM guideline are 43280, 43281, 43282, 43283, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, and 43338.

These coverage guidelines became available for review on our website at www.anthem.com after February 27, 2019.