Updates to Medical Policies and Clinical UM Guidelines

Effective January 15, 2012

UniCare is pleased to provide you with our updated and new medical policies and clinical UM guidelines. The major new policies and changes are summarized below. Additional changes are included in Attachment A at the end of this document. Please refer to the specific policy for coding, language, and rationale updates and changes that are not summarized in this notice.

New Medical Policies Effective January 15, 2012

- **DME.00035 Electric Tumor Treatment Field (TTF):** This policy addresses electrical fields known as “tumor treatment fields (TTF),” which are created by low-intensity, alternating intermediate frequency electric currents delivered to the malignant tumor site by insulated electrodes placed on skin surface of the tumor site. As a result of the unique shape and electrical characteristics of dividing tumor cells, TTF exposure may damage the dividing cells through anti-microtubule mechanisms and could stop tumor growth while sparing normal tissue.
  
  - The use of devices to generate electric tumor treating fields (TTF) as a treatment for malignant tumors is considered investigational and not medically necessary

- **RAD.00060 Digital Breast Tomosynthesis:** This policy addresses digital breast tomosynthesis (DBT) (three-dimensional [3-D] mammography), which is being investigated as an adjunct and alternative to x-ray mammography for the screening and diagnosis of breast cancer. DBT combines the use of tomography and 3-D reconstruction with breast imaging to improve the visibility of breast lesions.
  
  - Digital breast tomosynthesis is considered investigational and not medically necessary for all indications

- **SURG.00117 Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence; Urinary Retention:** This policy addresses sacral nerve stimulation (SNS) and percutaneous tibial nerve stimulation (PTNS) in those with chronic, refractory urinary and fecal incontinence as well as urinary retention.
  
  - Outlines medically necessary, and investigational and not medically necessary indications for sacral nerve stimulation (SNS) for urinary incontinence and retention, and fecal incontinence
  - Lists investigational and not medically necessary indications for percutaneous tibial nerve stimulation (PTNS)
  - Moved information and criteria on sacral nerve stimulation for urinary indications and PTNS from SURG.00010 to this new policy
  - Sacral nerve stimulation and PTNS for fecal incontinence now addressed on this policy

- **SURG.00125 Radiofrequency and Pulsed Radiofrequency Ablation of Trigger Point Pain:** This policy addresses the treatment of trigger point pain with radiofrequency (RF) or pulsed radiofrequency (PRF) ablation.
  
  - Radiofrequency (RF) and pulsed radiofrequency (PRF) ablation treatment of trigger points are considered investigational and not medically necessary
• SURG.00126 Ablation of Soft Tissue Using Irreversible Electroporation (IRE): This policy addresses use of the Nanoknife® Oncobionic System for soft tissue ablation, which is classified by the U.S. Food and Drug Administration (FDA) as a Class II electrosurgical cutting and coagulation device.
  
  o Ablation of soft tissue using irreversible electroporation (IRE) is considered investigational and not medically necessary for all indications

Revised Medical Policies and Adopted Clinical UM Guidelines
Effective January 15, 2012

• DRUG.00044 Belimumab (Benlysta®): This policy addresses the use of belimumab for the treatment of individuals age 18 or older with active, antibody-positive systemic lupus erythematosus (SLE), and for other indications.
  
  o Removed SLE clinical manifestations requirement and list from medically necessary criteria
  o Added psychosis and seizures as examples of active central nervous system lupus in medically necessary criteria
  o Clarified steroid requirement in medically necessary criteria
  o Removed “females who are pregnant or nursing” as contraindication
  o Clarified investigational and not medically necessary contraindication addressing steroid doses

• TRANS.00014 Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts): This policy addresses ventricular assist devices, percutaneous ventricular assist devices and artificial hearts.
  
  o Title revised, previously titled: Mechanical Circulatory Assist Devices (Ventricular Assist Devices and Artificial Hearts)
  o Expanded scope of policy
  o Added the use of percutaneous ventricular assist devices (e.g., TandemHeart® System, Impella Recover® LP 2.5 Percutaneous Cardiac Support System, and Impella Recover® LP 5.0 Percutaneous Cardiac Support System) as investigational and not medically necessary

• CG-DRUG-13 Hepatitis B Interferon Antiviral Therapy: This guideline addresses the treatment of chronic hepatitis B infection with FDA approved injectable agents Interferon alfa-2b and Peginterferon alfa-2a.
  
  o Added compensated liver disease to medically necessary clinical indications as a required criteria
  o Clarified not medically necessary statement and added uncontrolled depression to the list of contraindications

WellPoint Medical Policies and Clinical UM Guidelines are developed by our Medical Policy and Technology Assessment Committee. The Committee, which includes WellPoint medical directors and representatives from practicing physician groups, meets quarterly to review current scientific data and clinical developments. Medical Policies and Clinical UM Guidelines are subject to the approval of the Physician Relations Committee.

All coverage written or administered by UniCare 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 forth in WellPoint’s Medical Policies. Review procedures have been refined to facilitate claim investigation.

Coverage and administrative services are provided by UniCare Life & Health Insurance Company, a separately incorporated and capitalized subsidiary of WellPoint, Inc. ® Registered mark of WellPoint, Inc. © 2011 WellPoint, Inc.
Attachment A

The revised medical policies listed below will become effective for services rendered on or after January 15, 2012.

<table>
<thead>
<tr>
<th>Medical Policy Number</th>
<th>Medical Policy Title</th>
<th>Medical Policy Changes</th>
</tr>
</thead>
</table>
| SURG.00054            | Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection | Updated system edits to match policy position statement and coding section for the following codes:  
• 33880  Endovascular repair of descending thoracic aorta; involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin  
• 33881  Endovascular repair of descending thoracic aorta; not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin  
• 33883  Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta; initial extension  
• 33884  Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta; each additional proximal extension (list separately in addition to code for primary procedure)  
• 33886  Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta  
• 33889  Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral  
• 33891  Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision  
• 34800  Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis  
• 34802  Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)  
• 34803  Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (2 docking limbs)  
• 34804  Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis  
• 34805  Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniliac or aorto-unifemoral prosthesis |
<table>
<thead>
<tr>
<th>Medical Policy Number</th>
<th>Medical Policy Title</th>
<th>Medical Policy Changes</th>
</tr>
</thead>
</table>
| SURG.00054 (continued)| Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection (continued) | • 34806 Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (list separately in addition to code for primary procedure)  
• 34808 Endovascular placement of iliac artery occlusion device (list separately in addition to code for primary procedure)  
• 34812 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral  
• 34813 Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (list separately in addition to code for primary procedure)  
• 34820 Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral  
• 34825 Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel  
• 34826 Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (list separately in addition to code for primary procedure)  
• 75952 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation  
• 75953 Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation  
• 75956 Endovascular repair of descending thoracic aorta; involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation  
• 75957 Endovascular repair of descending thoracic aorta; not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation  
• 75958 Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta; radiological supervision and interpretation |
| SURG.00054 (continued) | Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection (continued) | **75959** Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation  
**93982** Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report |
|---|---|---|
| SURG.00017 | Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT) | Updated system edits to match policy position statement and coding section for the following codes:  
**77371** Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based  
**77372** Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based  
**77373** Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions  
**G0173** Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session  
**G0251** Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment  
**G0339** Image guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment  
**G0340** Image guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum 5 sessions per course of treatment |