Updates to Medical Policies and Clinical UM Guidelines

Effective January 15, 2014

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 January 15, 2014

- **DME.00037 Cooling Devices and Combined Cooling/Heating Devices**: This policy addresses both passive and active cooling devices, as well as devices that combine compression or heat therapy for the relief of pain and swelling due to trauma, surgery and other conditions. This policy does not address the use of whole body or head cooling devices for adult or pediatric individuals with acute neurologic injury or after sudden cardiac death.
  - Active or passive cooling devices (with or without pneumatic compression) are considered investigational and not medically necessary for all uses, including but not limited to recovery after orthopedic surgery or trauma.
  - Active or passive devices that combine cooling and heating are considered investigational and not medically necessary for all uses.

- **DRUG.00055 Denosumab (Prolia®, Xgeva™)**: This policy addresses the use of denosumab, which is a subcutaneous, fully human monoclonal antibody that is specifically designed to target the human receptor activator of nuclear factor kappa-B ligand (RANKL) for the treatment of individuals with osteoporosis, treatment induced bone loss, bone metastases, giant cell tumor of the bone, and for all other indications, including multiple myeloma and rheumatoid arthritis which are currently being studied.
  - Outlines the medically necessary and investigational and not medically necessary criteria for denosumab, both Prolia and Xgeva

- **DRUG.00057 Canakinumab (Ilaris®)**: This policy addresses the indications for use of canakinumab which is a humanized monoclonal antibody, interleukin-1 beta (IL-1 β) inhibitor drug that works by binding human IL-1β and neutralizes its activity by blocking its interaction with IL-1 receptors.
  - Outlines the medically necessary, not medically necessary, and investigational and not medically necessary criteria for canakinumab

- **DRUG.00058 Pharmacotherapy for Hereditary Angioedema**: This policy addresses four drugs that have been specifically developed for the treatment or prevention of hereditary angioedema (HAE) attacks. Berinert® and Cinryze® (both C1-esterase inhibitor, human) supplement deficient or defective C1- esterase-inhibitor (C1-INH). Kalbitor® (ecallantide) and Firazyr® (icatibant) act by inhibiting kallikrein or blocking bradykinin receptors which are the primary mediators for HAE.
  - Outlines the medically necessary, and investigational and not medically necessary criteria for the use of Berinert, Firazyr, Kalbitor and Cinryze to treat hereditary angioedema
LAB.00030 Measurement of Serum Concentrations of Infliximab (IFX) or Antibodies-to-Infliximab (ATI): This policy addresses the measurement of serum concentrations of infliximab (IFX) and antibodies-to-infliximab (ATI) in individuals with various conditions. Such testing has been proposed as a way to detect individuals with poor or lack of response to infliximab treatment with the goal of altering treatment to optimize outcomes.

- The measurement of serum concentrations of infliximab (IFX) or antibodies-to-infliximab (ATI), including, but not limited to the PROMETHEUS® Anser™ IFX test, is considered investigational and not medically necessary for all indications.

Revised Medical Policies and Adopted Clinical UM Guidelines Effective January 15, 2014:

GENE.00001 Genetic Testing for Cancer Susceptibility: This policy addresses genetic testing for individuals who are at higher than average risk for the development of cancer.

- Added genetic testing for cancer susceptibility using panels of genes (with or without next generation sequencing), including, but not limited to CancerNext™, BreastNext™, ColoNext™, or OvaNext™ as investigational and not medically necessary unless all components of the panel have been determined to be medically necessary based on the criteria in the policy. Individual components for a panel may be considered medically necessary when criteria are met.

RAD.00035 Coronary Artery Imaging: Contrast-Enhanced Coronary Computed Tomography Angiography (CCTA), Coronary Magnetic Resonance Angiography (MRA), and Cardiac Magnetic Resonance Imaging (MRI): This policy addresses contrast-enhanced computed tomography angiography (CTA) of the coronary arteries (coronary CTA or CCTA), magnetic resonance angiography (MRA) and magnetic resonance imaging (MRI) of the coronary arteries.

- Revised medically necessary position statement to state that contrast-enhanced coronary computed tomography angiography (CCTA), coronary magnetic resonance angiography (MRA), or cardiac magnetic resonance imaging (MRI) is considered medically necessary for the evaluation of suspected anomalous coronary arteries in pediatric individuals (age less than 18 years).

SURG.00037 Treatment of Varicose Veins (Lower Extremities): This policy addresses various modalities for the treatment of valvular incompetence (i.e., reflux) of the greater or lesser saphenous veins and associated varicose tributaries as well as telangiectatic dermal veins.

- Added mechanochemical ablation of any vein as investigational and not medically necessary.

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.

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 in WellPoint’s medical policies. Review procedures have been refined to facilitate claim investigation.

You can access the complete list of WellPoint Medical Policies and Clinical UM Guidelines from unicarestateplan.com > Providers > WellPoint Medical Policies > adopted clinical UM guidelines.
Attachment A

The revised medical policies listed below will become effective for services rendered on or after January 15, 2014.

<table>
<thead>
<tr>
<th>Medical Policy Number</th>
<th>Medical Policy Title</th>
<th>Medical Policy / Clinical Guideline Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURG.00007</td>
<td>Vagus Nerve Stimulation</td>
<td>Updated the coding section and system edits to pend the following codes for medical necessity review for additional diagnosis:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>95974</strong> Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>95975</strong> Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)</td>
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