Updates to Medical Policies and Clinical UM Guidelines

Effective May 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 May 15, 2014

DRUG.00059 Romiplostim (Nplate®): This document addresses romiplostim which is a subcutaneously administered thrombopoietin (TPO) receptor agonist that stimulates bone marrow megakaryocytes to produce platelets.
- Outlines the medically necessary and investigational and not medically necessary criteria for romiplostim

DRUG.00060 Plerixafor (Mozobil™): This document addresses the indications and criteria for the use of plerixafor injection which is a hematopoietic stem cell mobilizer that is given subcutaneously (SQ) to increase circulating hematopoietic stem cells (HSCs) in the peripheral blood for collection and subsequent autologous transplantation.
- Outlines the medically necessary and investigational and not medically necessary criteria for plerixafor

DRUG.00061 Radium Ra 223 Dichloride (Xofigo®): This document addresses the use of radium Ra 223 dichloride which is an injection of an alpha particle-emitting radioactive therapeutic agent which mimics calcium to bind with bone minerals in areas of bone metastases. The agent has an anti-tumor effect which occurs due to energy transfer from the radioactive material from nearby cancer cells.
- Outlines the medically necessary and investigational and not medically necessary criteria for radium Ra 223 dichloride

GENE.00032 Molecular Marker Evaluation of Thyroid Nodules: This document addresses the use of molecular markers in the evaluation of thyroid nodules.
- The use of mutation analysis for molecular marker evaluation of thyroid nodules is considered investigational and not medically necessary
- The use of a gene expression classifier for molecular marker evaluation of thyroid nodules is considered investigational and not medically necessary

GENE.00033 Genetic Testing for Inherited Peripheral Neuropathies: This document addresses genetic testing for genes identified as associated with peripheral neuropathy.
- Genetic testing for inherited peripheral neuropathy is considered investigational and not medically necessary for all indications, including but not limited to:
  - to confirm a diagnosis of a suspected inherited peripheral neuropathy (for example, Charcot-Marie-Tooth neuropathy [CMT] or hereditary neuropathy with liability to pressure palsies [HNPP]); or
MED.00113 Therapeutic Apheresis: This document addresses therapeutic apheresis which is a procedure by which blood is removed from the body, separated into components, manipulated and returned to the individual. The therapeutic apheresis procedures addressed in this document utilize devices approved by the U.S. Food & Drug Administration (FDA).

- Outlines the medically necessary and investigational and not medically necessary indications for the uses of therapeutic apheresis

RAD.00064 Myocardial Sympathetic Innervation Imaging with or without Single-Photon Emission Computed Tomography (SPECT): This document addresses use of the AdreView™ injectable tracer agent (iobenguane I 123 injection, MIBG) for cardiac imaging to assist with identification of increased risk for short-term mortality associated with heart failure (HF).

- Myocardial sympathetic innervation imaging with 123 iodine meta-iodobenzylguanidine (MIBG) is considered investigational and not medically necessary for all indications, including the evaluation of heart failure

Adopted Clinical UM Guidelines Effective January 1, 2014

CG-SURG-38 Lumbar Laminectomy, Hemi-Laminectomy, Laminotomy and/or Discectomy (Previously on Milliman guidelines (MCG) W0091 and W0100): This document addresses the uses of lumbar laminectomy, hemi-laminectomy, laminotomy and/or discectomy.

- Outlines the medically necessary and not medically necessary indications for lumbar laminectomy, hemi-laminectomy, laminotomy and/or discectomy

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

DRUG.00055 Denosumab (Prolia®, Xgeva™): This document addresses the use of denosumab 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.

- Clarified Denosomab (Xgeva) medically necessary statement for bone metastases to indicate 'solid tumors' excludes prostate cancer
- Added Denosumab (Xgeva) as medically necessary for bone metastases from castration-recurrent prostate cancer
- Updated Rationale, Coding and Reference sections

SURG.00055 Cervical Artificial Intervertebral Discs: This document addresses the use of FDA approved cervical artificial intervertebral discs as treatments for symptomatic cervical disc disease when conservative treatment options have been unsuccessful.

- Added Mobi-C Cervical Disc Prosthesis to list of PMA-cleared devices considered investigational and not medically necessary
- Clarified investigational and not medically necessary statement addressing hybrid constructs
- Added cervical artificial intervertebral disc implantation in an individual with a previous fusion at another cervical level as investigational and not medically necessary
- Updated Description, Rationale, Background, Reference and Index sections
SURG.00060 Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS): This document addresses the use of implantable neurostimulation techniques including spinal cord stimulators and subcutaneous target stimulation (also known as peripheral subcutaneous field stimulation).

- Revised medically necessary criteria regarding permanent electrode placement
- Added thalamic pain syndrome as investigational and not medically necessary indication
- Updated Rationale, Coding and Reference sections

SURG.00068 Implantable Infusion Pumps: This document addresses the use of implantable infusion pumps for long-term, continuous or intermittent drug infusion.

- Removed Head/neck cancers (intra-arterial injection of chemotherapeutic agents) as medically necessary indication
- Updated Rationale and Reference sections

SURG.00103 Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir): This document addresses surgical devices used in the treatment of refractory open-angle glaucoma (OAG) to reduce intraocular pressure (IOP).

- Added the Ex-PRESS Mini Glaucoma Shunt as investigational and not medically necessary for all other indications not listed in the medically necessary criteria
- Updated Rationale, References, Coding and Index sections

SURG.00104 Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis: This document addresses the proposed use of extraosseous subtalar joint implantation and subtalar arthroereisis.

- Title revised, previously titled: Subtalar Arthroereisis
- Expanded scope of policy
- Added extraosseous subtalar joint implantation as investigational and not medically necessary
- Updated Description, Rationale, Background, Coding, Definitions, Reference, and Index sections

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 www.unicarestateplan.com > Providers > WellPoint Medical Policies > adopted clinical UM guidelines.