Updated Medical Policies and Clinical UM Guidelines

*Effective April 8, 2011*

UniCare is pleased to provide you with our updated and new medical policies and clinical UM guidelines in Attachment A at the end of this document. The updated polices listed below are effective for service dates on and after April 8, 2011.

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 April 8, 2011**

- **GENE.00017 Genetic Testing for Diagnosis and Management of Hereditary Cardiomyopathies (including ARVD/C):** This policy addresses genetic testing for the hereditary cardiomyopathies which includes hypertrophic (HCM), dilated (DCM), restrictive (RCM), arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVD/C) and left ventricular noncompaction (LVNC).
  - Genetic testing for determining the diagnosis and for management of hereditary cardiomyopathies is considered investigational and not medically necessary for all indications, including but not limited to, arrhythmogenic right ventricular dysplasia/cardiomyopathy, hypertrophic, dilated, restrictive, and left ventricular noncompaction cardiomyopathies

- **SURG.00119 Endobronchial Valve Devices:** This policy addresses the use of endobronchial valve devices, which are devices intended to provide one-way airflow blockage in segmental or subsegmental bronchi in individuals with pulmonary conditions complicated by air leaks or hyperinflation.
  - The use of endobronchial valve devices is considered investigational and not medically necessary for the treatment of any condition, including but not limited to, emphysema and pulmonary air leaks

- **SURG.00120 Open Treatment of Rib Fracture(s) Requiring Internal Fixation:** This document addresses the open treatment of rib fracture(s) requiring an internal fixation device.
  - The use of an internal rib fixation system is considered investigational and not medically necessary for all indications

- **SURG.00121 Transcatheter Heart Valves:** This policy addresses the transcatheter (percutaneous or catheter based) approach for heart valve replacement.
  - Heart valve replacement utilizing the transcatheter technique is considered investigational and not medically necessary for all indications

**Revised Medical Policies and Adopted Clinical UM Guidelines Effective April 8, 2011**

- **DRUG.00039 Trastuzumab (Herceptin®):** This policy addresses Trastuzumab which is a humanized recombinant DNA monoclonal antibody that targets tumor cells that over express the Human Epidermal Growth Factor Receptor 2 (HER2) protein and/or amplification of the HER2 gene.
  - Revised medically necessary criteria for breast cancer

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• **DRUG.00041 Rituximab (Rituxan®):** This policy addresses Rituximab (Rituxan®), which is a genetically engineered monoclonal antibody that targets a specific protein, known as CD20 found on the surface of normal and malignant B-lymphocytes.
  - Removed thrombotic thrombocytopenic purpura (TTP) as medically necessary off-label indication

• **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.
  - Reformatted and re-organized position statement section
  - Added general medically necessity criteria for genetic testing for susceptibility to malignant diseases not specifically listed on policy
  - Revised medically necessary criteria for BRCA1/BRCA2 and HNPCC based on NCCN guidelines in clinical oncology
  - Added the phrase "associated with genetic counseling" to the medically necessary criteria for medullary thyroid cancer and multiple endocrine neoplasia type 2 (MEN2), RET testing
  - Revised investigational/not medically necessary criteria to read "Genetic testing for cancer susceptibility is considered investigational and not medically necessary in individuals not meeting any of the criteria in sections I and II above, including but not limited to the BRACAnalysis® Rearrangement Test [BART]"

• **MED.00106 Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer:** This policy addresses the use of autologous cellular immunotherapy as a treatment method for prostate cancer. The only currently available product of this type, sipuleucel-T (Provenge®). Also referred to as a vaccine, autologous cellular immunotherapy is designed to activate an individual's immune system to respond to prostate tumor antigens.
  - Revised medically necessary position statement by including additional criteria

• **RAD.00014 Brachytherapy for Oncologic Indications:** This policy addresses brachytherapy, which is a form of radiation treatment used to stop the growth of cancer cells and involves placing radioactive material directly into or near a tumor. This allows the tumor to receive a dose of radiation while reducing the exposure to surrounding tissue.
  - Revised medically necessary criteria for breast cancer
  - Added cholangiocarcinoma as medically necessary indication when criteria are met
  - Revised medically necessary criteria for the temporary seed implantation for prostate cancer

• **RAD.00030 Wireless Capsule Endoscopy for Esophageal and Small Bowel Imaging and the Patency Capsule:** This policy addresses wireless capsule endoscopy (WCE) of the small bowel and esophagus, and the use of a patency capsule, intended to ensure that there are no strictures in the digestive tract to impede passage of the wireless endoscopy capsule.
  - Replaced colonoscopy and panendoscopy with upper and lower endoscopy as examples of appropriate tests for evaluating bleeding in adults or children two years or older
  - Clarified and expanded medically necessary language addressing initial evaluation of individuals with suspected Crohn's disease
  - Added investigation of iron deficiency anemia as medically necessary when criteria are met
  - Added wireless capsule endoscopy for individuals with known or suspected gastrointestinal obstruction, stricture or fistulae as investigational and not medically necessary
• **RAD.00041 Intensity Modulated Radiation Therapy (IMRT):** This policy addresses IMRT, which is a technique of external conformal radiation planning and delivery, in which non-uniform intensity beams produce unique radiation dose distributions that are intended to better target the lesion with better sparing of surrounding normal tissue than with conventional radiation therapy, thereby limiting side effects.
  o Revised post-prostatectomy criteria for dose escalation greater than or equal to 66 Gy (previously 70 Gy)
  o Clarified definition of head and neck cancer
  o Clarified medically necessary criteria for individuals who require repeat irradiation of a field that has received prior irradiation

Additionally, coding updates in the claim systems related to previously existing medical necessity criteria in the policy position statement for prostate cancer, thyroid cancer, and CNS lesions may result in investigational and not medically necessary determinations for these conditions. Please note that this will only be applied to individuals in a new course of treatment after **April 8, 2011**, the implementation date according to your plan notification timeframe. Individuals in an ongoing course of treatment as of the implementation date will not be impacted by this change.

• **RAD.00057 Near-Infrared Coronary Imaging and Near-Infrared Intravascular Ultrasound Coronary Imaging:** This policy addresses near-infrared coronary imaging and near-infrared intravascular ultrasound coronary imaging.
  o Clarified position statement addressing near-infrared coronary imaging
  o Added near-infrared intravascular ultrasound coronary imaging as investigational and not medically necessary

• **SURG.00066 Percutaneous Neurolysis for Chronic Back Pain:** This policy addresses percutaneous radiofrequency neurolysis (RF), pulsed radiofrequency (PRF), lasers, cryodenervation and chemical neurolysis for cervical/lumbosacral facet pain.
  o Revised cervical level for which neurolysis is considered medically necessary to C2-C3 (previously C1-C2)

• **SURG.00106 Ablative Techniques as a Treatment for Barrett’s Esophagus:** This policy addresses the use of radiofrequency ablation and cryoablation for treating Barrett’s esophagus.
  o Expanded scope of policy
  o Added cryoablation as a treatment of Barrett’s esophagus as investigational and not medically necessary

• **TRANS.00027 Hematopoietic Stem Cell Transplantation for Pediatric Solid Tumors:** This policy addresses hematopoietic stem cell transplantation for pediatric solid tumors including neuroblastoma, primitive neuroectodermal tumors (PNETs) of the central nervous system, ependymoma, pineoblastoma, Ewing sarcoma, Wilms’ tumor, osteosarcoma, retinoblastoma, and rhabdomyosarcoma.
  o Clarified that policy addresses primitive neuroectodermal tumors (PNETs) of the central nervous system, ependymoma and pineoblastoma
  o Clarified criteria for PNET, ependymoma and pineoblastoma in the medically necessary, and investigational and not medically necessary statements
  o Added hematopoietic stem cell harvesting for a future transplantation for PNET, ependymoma and pineoblastoma as investigational and not medically necessary when criteria are not met
• **CG-DRUG-09 Immune Globulin (Ig) Therapy:** This guideline addresses immune globulin or immunoglobulin (Ig), which is a blood product that is given for the treatment of inflammatory, autoimmune or other diseases featuring low antibody levels. Ig is also used for removal of harmful antibodies and for blocking damage from immune cells.
  - Expanded scope of guideline to address all routes of administration (subcutaneous, intramuscular and intravenous)
  - Clarified medically necessary criteria for hypogammaglobulinemia and recurrent bacterial infection associated with B-cell chronic lymphocytic leukemia (CLL)

WellPoint Medical Policies and Clinical UM Guidelines are developed by our national 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 (WellPoint?) 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 at [www.unicarestateplan.com > Providers > WellPoint Medical Policies > adopted clinical UM guidelines.](www.unicarestateplan.com)
## Attachment A

The revised medical policies listed below will become effective for *services rendered on or after April 8, 2011.*

<table>
<thead>
<tr>
<th>Medical Policy Number</th>
<th>Medical Policy Title</th>
<th>Medical Policy / Clinical Guideline Changes</th>
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| ANC.00007             | Cosmetic and Reconstructive Services; Skin Related                                  | Updated system edits to match policy position statement and coding section for the following codes:  
  - **17106** Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm  
  - **17107** Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm  
  - **17108** Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm |
| DME.00034             | Standing Frames                                                                     | The following code has been added to this policy and is considered Investigational and Not Medically Necessary when criteria not met:  
  - **E2230** Manual wheelchair accessory, manual standing system  
  - **E2301** Power wheelchair accessory, power standing system |
| DRUG.00006            | Botulinum Toxin                                                                     | Updated the coding section and system edits to pend the following codes for medical necessity review for additional diagnosis:  
  - **J0585** Injection, onabotulinumtoxinA, 1 unit  
  - **J0586** Injection, abobotulinumtoxinA, 5 units  
  - **J0587** Injection, rimabotulinumtoxinB, 100 units |
| MED.00032             | Treatment of Hyperhidrosis                                                           | Updated system edits to match policy position statement and coding section for the following codes:  
  - **64650** Chemodenervation of eccrine glands; both axillae  
  - **64653** Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day |
| RAD.00033             | Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors (SIR-Spheres and TheraSpheres) | The following code has been added to this policy and is considered Investigational and Not Medically Necessary when criteria not met:  
  - **79445** Radiopharmaceutical therapy, by intra-arterial particulate administration |

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<th>Code</th>
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| SURG.00007 | Vagus Nerve Stimulation Therapy                                              | - 95974 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of waveform, 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  
|         |                                                                             | - 95975 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of waveform, 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) |
| TRANS.00022 | Autologous Cell Therapy for the Treatment of Damaged Myocardium              | - J1440 Injection, filgrastim (G-CSF), 300 mcg  
|         |                                                                             | - J1441 Injection, filgrastim (G-CSF), 480 mcg  |