June 28, 2017

[Provider Name]
[Contact Title]
[Address]
[City], [State] [Zip]

Dear Provider:

Anthem Blue Cross (Anthem) is pleased to provide you with our new and updated Medical Policies and Clinical UM Guidelines. The major new policies and changes are summarized below, and additional updates are in Attachment A. Please refer to the specific policy for coding, language, and rationale updates and changes that are not summarized below.

**New Medical Policies effective October 1, 2017**

- **MED.00121 Implantable Interstitial Glucose Sensors**: This document addresses the use of implantable interstitial glucose sensors (for example, the Eversense™ Continuous Glucose Monitoring System).

- **MED.00122 Wilderness Programs**: This document addresses wilderness programs, including services such as adventure therapy or wilderness therapy when part of wilderness programs provided in an outdoor environment and proposed as a treatment option for a variety of medical conditions or behavioral health disorders.

- **SURG.00148 Spectral Analysis of Prostate Tissue by Fluorescence Spectroscopy**: This document addresses the use of spectral analysis of prostate tissue by fluorescence spectroscopy, which involves using fiber optics to differentiate between normal prostate tissue and suspicious prostate tissue.

- **SURG.00149 Percutaneous Ultrasonic Ablation of Soft Tissue**: This document addresses the use of percutaneous ultrasonic ablation (emulsification) of soft tissue for the treatment of any condition.

- **SURG.00150 Leadless Pacemakers**: This document addresses a single chamber implantable transcatheter pacing system to monitor and regulate the heart rate and rate-responsive bradycardia.

**New Medical Policies effective November 1, 2017**

NOTE: Pre-service clinical review of the specialty pharmacy drugs in italics below will be managed by AIM Specialty Health® (AIM), a separate company administering the program on behalf of Anthem.

- **DRUG.00099 Cerliponase Alfa (Brineura™)**: This document addresses the use of cerliponase alfa (Brineura), a recombinant human tripeptidyl peptidase 1 enzyme replacement therapy in the treatment of late infantile neuronal ceroid lipofuscinosis type 2.

- **DRUG.00101 Kevzara (sarilumab)**: This document addresses the use of sarilumab (Kevzara) in adults with moderately to severely active rheumatoid arthritis and for other conditions.

- **DRUG.00103 Abaloparatide (Tymlos™) Injection**: This document addresses the use of abaloparatide (Tymlos™) injection, which is a novel synthetic 34 amino acid peptide and is intended for subcutaneous use. Abaloparatide is an analog of human parathyroid hormone related peptide, PTHrP (1-34) that selectively activates the parathyroid hormone type 1 receptor for the treatment of postmenopausal osteoporosis in a select population of women considered at high risk for fractures.

- **DRUG.00107 Avelumab (Bavencio®)**: This document addresses the use of avelumab (Bavencio), a programmed death ligand-1 (PD-L1) blocking antibody approved by the FDA for treatment of metastatic Merkel cell carcinoma.
• **DRUG.00108 Edaravone (Radicava™):** This document addresses the use of edaravone (Radicava). Edaravone is a free radical scavenger approved by the FDA for treatment of amyotrophic lateral sclerosis (ALS).

• **DRUG.00109 Durvalumab (IMFINZI™):** This document addresses the use of durvalumab (IMFINZI), a human G1k monoclonal programmed death ligand 1 (PD-L1) antibody for the treatment of locally advanced or metastatic urothelial carcinoma under certain conditions.

**Revised Medical Policies and Clinical UM Guidelines effective October 1, 2017**

• **DRUG.00062 Obinutuzumab (Gazyva®):** This document addresses the indications and criteria for the use of obinutuzumab (Gazyva).
  - Clarified that obinutuzumab is Medically Necessary as a first-line treatment of CLL/SLL without del(17P) mutation when used in combination with chlorambucil
  - Revised Medically Necessary criteria for the treatment of follicular lymphoma by adding additional chemotherapy regimens to be used in combination with obinutuzumab

• **GENE.00001 Genetic Testing for Cancer Susceptibility:** This document addresses genetic testing to determine whether an individual is at risk for the development of cancer based on a genetic test.
  - Added Medically Necessary criteria regarding genetic counseling

• **GENE.00002 Preimplantation Genetic Diagnosis Testing:** This document addresses the use of preimplantation genetic diagnosis (PGD) and preimplantation genetic screening (PGS) which is performed as part of an assisted reproductive procedure.
  - Revised the first Medically Necessary statement to be “screening” instead of “diagnosis”
  - Moved Medically Necessary criteria regarding balanced translocation to the Medically Necessary statement addressing diagnosis
  - Clarified Medically Necessary position statement regarding “gender selection” to replace the term “gender” with “sex”
  - Added Medically Necessary criteria regarding genetic counseling

• **GENE.00007 Cardiac Ion Channel Genetic Testing:** This document addresses genetic testing of cardiac ion channel mutations in persons with suspected channelopathies, such as long QT syndrome (LQTS), in order to determine the risk for sudden cardiac death (SCD).
  - Added Medically Necessary criteria regarding genetic counseling
  - Made minor language changes in position statement

• **GENE.00012 Preconception or Prenatal Genetic Testing of a Parent or Prospective Parent:** This document addresses preconception or prenatal genetic testing on a parent or prospective parent to determine carrier status of an autosomal recessive disorder, an x-linked disorder, or a disorder with variable penetrance.
  - Revised title (changed “Preconceptional” to “Preconception”)
  - Added “familial dysautonomia” as a Medically Necessary indication when criteria met for preconception or prenatal genetic screening of a parent or prospective parent to determine carrier status of inherited disorders
  - Revised Medically Necessary position statement for cystic fibrosis carrier screening to address using a standard panel usually consisting of 23 or more of the common gene mutations
  - Added Not Medically Necessary position statements for use of: a) complete DNA sequencing of the cystic fibrosis transmembrane conductance regulator (CFTR) gene; b) gene analysis of known CFTR familial variants; and c) gene analysis of CFTR duplication/deletion variants to determine cystic fibrosis carrier status
  - Added Medically Necessary position statement to address genetic screening to determine carrier status of spinal muscular atrophy
  - Added Medically Necessary criteria regarding genetic counseling
  - Made minor language and formatting changes in position statement

• **GENE.00017 Genetic Testing for Diagnosis and Management of Hereditary Cardiomyopathies (including ARVD/C):** This document 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).
  - Added Medically Necessary criteria regarding genetic counseling
• **GENE.00026 Cell-Free Fetal DNA-Based Prenatal Testing**: This document addresses cell-free fetal DNA-based prenatal testing for fetal aneuploidies (including fetal sex chromosome aneuploidies), fetal sex determination and microdeletions.
  o Added Medically Necessary criteria regarding genetic counseling

• **GENE.00028 Genetic Testing for Colorectal Cancer Susceptibility**: This document addresses genetic testing for individuals who are at higher than average risk for the development of colorectal cancer.
  o Added Medically Necessary criteria regarding genetic counseling
  o Reformatted Medically Necessary criteria

• **GENE.00029 Genetic Testing for Breast and/or Ovarian Cancer Syndrome**: This document addresses genetic testing for individuals who are at higher than average risk for the development of breast and/or ovarian cancer.
  o Added Medically Necessary criteria regarding genetic counseling
  o Updated formatting

• **GENE.00030 Genetic Testing for Endocrine Gland Cancer Susceptibility**: This document addresses genetic testing for individuals who are at higher than average risk for the development of endocrine gland cancer, including medullary thyroid cancer.
  o Added Medically Necessary criteria regarding genetic counseling
  o Updated formatting

• **GENE.00031 Genetic Testing for PTEN Hamartoma Tumor Syndrome**: This document addresses mutation testing of the phosphatase and tensin homolog (PTEN) gene.
  o Added Medically Necessary criteria regarding genetic counseling
  o Updated formatting

• **GENE.00035 Genetic Testing for TP53 Mutations**: This document addresses genetic testing for TP53 mutations.
  o Added Medically Necessary statement for use of TP53 gene mutation testing for individuals diagnosed with hypodiploid acute lymphocytic leukemia when criteria met
  o Added Medically Necessary criteria regarding genetic counseling

• **GENE.00040 Genetic Testing for CHARGE Syndrome**: This document addresses genetic testing for CHARGE syndrome, a rare genetic condition associated with multiple congenital anomalies.
  o Added Medically Necessary criteria regarding genetic counseling

• **GENE.00043 Genetic Testing of an Individual’s Genome for Inherited Diseases**: This document addresses the indications and criteria for the use of obinutuzumab (Gazyva).
  o Added Medically Necessary criteria regarding genetic counseling

**Reminder - Specialty pharmacy program expands to include utilization review of drug dosage and frequency beginning September 1, 2017**

The February 2017 Provider Update notification letter shared information about the expansion of the specialty pharmacy program to include reviews for drug dosage and frequency. Please note that the implementation of the new clinical guideline Drug Dosage, Frequency, and Route of Administration CG-DRUG-53 was delayed, but will begin with dates of service on and after September 1, 2017 as noted below.

As part of pre cert process the following information will be required:

1. Weight, height, age, gender
2. Dosage per treatment, directions per treatment (frequency), and duration (length of therapy)
Reminder - Specialty pharmacy program includes utilization review of clinically equivalent agents as of June 1, 2017

The February 2017 Provider Update notification letter shared information about the expansion of the specialty pharmacy program to include reviews for clinically equivalent agents. Please note that the implementation of CG-DRUG-64 was delayed, but will begin with dates of service on and after June 1, 2017. **Please note that for CG-DRUG-29 and DRUG.00017, the hyaluronan injections are no longer part of this program and therefore will not be reviewed as part of clinically equivalent agent management.** As a reminder, we are sharing the details about this upcoming change for ease of reference below.

<table>
<thead>
<tr>
<th>Clinical Guideline</th>
<th>Impacted Products</th>
<th>Clinically Equivalent/Cost Effective Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDA-Approved Biosimilar Products; CG-DRUG-64</td>
<td>Inflectra®</td>
<td>Remicade®</td>
</tr>
</tbody>
</table>

Anthem Medical Policies and Clinical UM Guidelines are developed by our Medical Policy and Technology Assessment Committee. The Committee, which includes Anthem 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 Anthem 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 Anthem’s Medical Policies. Review procedures have been refined to facilitate claim investigation.

The complete list of our Medical Policies and Clinical UM Guidelines may be accessed on the Anthem web site at [https://www11.anthem.com/ca/home-providers.html](https://www11.anthem.com/ca/home-providers.html). Click “Enter” under Welcome to Anthem Blue Cross, under “Learn More” click “Services described in the Medical Policies, UM Clinical Guidelines and/or Pre-certification Requirements”, then select “Medical Policies and Clinical UM Guidelines (for Local Plan members)”, scroll down to the bottom of the page and click “Continue”.

The expanded Specialty Pharmacy drug program and Genetic Testing Medical Policies apply to local Anthem members who have these services medically managed by AIM. The services do not apply to the following plans: HMO, BlueCard®, Medicare Advantage, Medicaid, Medicare Supplement, and Federal Employee Program® (FEP®).

Ordering physicians may submit a request for services to AIM through the AIM ProviderPortalSM (available 24/7 to process orders in real-time), through the Availity Web Portal or by calling the AIM call center at **1-877-291-0360**, Monday–Friday, 7:00 a.m.–5:00 p.m. Pacific Time.

We thank you for your continued efforts on behalf of our members and your partnership toward improved access to quality health care for Californians.

Sincerely,

Jacob Asher, MD
Vice President and Chief Medical Officer
# Attachment A – 2nd Quarter 2017 Updates
Revised Medical Policies and Clinical Guidelines

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Medical Policy / Clinical Guideline Changes</th>
</tr>
</thead>
</table>
| CG-DME-01     | External (Portable) Continuous Insulin Infusion Pumps                | • Clarified Medically Necessary criteria for replacement pumps  
• Removed HCPCS code S1034 (now addressed in DME.00040) | |
| CG-DRUG-08    | Enzyme Replacement Therapy for Gaucher Disease                        | • Made minor punctuation revision in clinical indications section | |
| CG-DRUG-09    | Immune Globulin (Ig) Therapy                                          | • Added Clinically Equivalent Cost Effective Agents section | |
| CG-DRUG-27    | Clostridial Collagenase Histolyticum Injection                         | • Removed abbreviations from clinical indications section | |
| CG-DRUG-50    | Paclitaxel, protein-bound (Abraxane®)                                 | • Added "or docetaxel" to the Medically Necessary statement for when protein-bound paclitaxel may be used as a substitute in the treatment of any breast cancer secondary to documented allergic reaction to docetaxel  
• Added a Medically Necessary statement for use of protein-bound paclitaxel in the treatment of NSCLC when used as a substitute for either solvent-based paclitaxel or docetaxel when criteria are met | |
| CG-DRUG-57    | Idursulfase (Elaprase®)                                               | • Revised Medically Necessary criteria for documented iduronate 2-sulfatase gene mutation, adding "pathologic" | |
| CG-MED-55     | Level of Care: Advanced Radiologic Imaging                            | • Revised Medically Necessary statement regarding geographically accessible appropriate alternatives (this guideline is effective 9/1/17) | |
| CG-SURG-09    | Temporomandibular Disorders                                           | • Added modified condylectomy to the surgical procedures for TMD considered Medically Necessary when criteria are met  
• Removed abbreviations in clinical indications section | |
| CG-SURG-33    | Lumbar Fusion and Lumbar Total Disc Arthroplasty (TDA)               | • Removed abbreviations from clinical indications section | |
| CG-SURG-42    | Cervical Fusion                                                       | • Removed abbreviations from clinical indications section | |
| CG-SURG-55    | Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation | • Added cardiac sarcoidosis and syncope of suspected arrhythmic etiology, and moderate/severe adult CHD with unexplained syncope as Medically Necessary indications for EP evaluation of syncope  
• Clarified that management or evaluation of idiopathic VT in the absence of structural heart disease is Medically Necessary | |
| CG-DRUG-64 | FDA Approved Biosimilar Products | - Moved the criteria for the evaluation of first-line rhythm control treatment from catheter ablation section to indications for doing EPS studies
- Made minor formatting and wording changes in clinical indications section |
| DME.00040 | Automated Insulin Delivery Devices | - Revised Medically Necessary criterion for "Age 16 or older" to "Age 7 or older"
- Removed Medically Necessary criteria addressing use of an insulin pump continuously for the preceding 6 months
- Removed Medically Necessary criteria regarding documented nocturnal hypoglycemic episodes
- Added new MN and NMN statements regarding device replacement |
| DRUG.00002 | Tumor Necrosis Factor Antagonists | - Added Clinically Equivalent Cost Effective Agents section
- Added “fingernails” to the Medically Necessary criteria for use of adalimumab for chronic moderate to severe plaque psoriasis when criteria are met
- Added Renflexis™ (infliximab-abda) (effective November 1, 2017 for CG-DRUG-64 FDA Approved Biosimilar Products) |
| DRUG.00003 | Chelation Therapy | - Revised Investigational and Not Medically Necessary criteria to DSM-5 language for Autism Spectrum Disorders (ASD) |
| DRUG.00006 | Botulinum Toxin | - Revised scope of document
- Moved position and language addressing treatment of hyperhidrosis with botulinum toxin from MED.00032
- Removed Investigational and Not Medically Necessary indications from the Clinically Equivalent Cost Effective Agents section |
| DRUG.00028 | Intravitreal Treatment for Retinal Vascular Conditions | - Added Clinically Equivalent Cost Effective Agents section |
| DRUG.00036 | Cetuximab (Erbitux®) | - Added appendicular carcinoma to the Colorectal and Anal Adenocarcinoma Medically Necessary statement |
| DRUG.00038 | Bevacizumab (Avastin®) for Non-Ophthalmologic Indications | - Added Medically Necessary statement for use of bevacizumab as single agent maintenance chemotherapy for recurrent, metastatic epithelial ovarian, fallopian tube, or primary peritoneal cancer when criteria are met |
| DRUG.00041 | Rituximab (Rituxan®) for Non-Oncologic Indications | - Added Medically Necessary statement for the use of rituximab in relapsing-remitting form of multiple sclerosis when criteria are met
- Revised Investigational and Not
<table>
<thead>
<tr>
<th>Drug Code</th>
<th>Drug Name</th>
<th>Changes</th>
</tr>
</thead>
</table>
| DRUG.00043 | Tocilizumab (Actemra®)         | • Added Medically Necessary statement for FDA approved use of tocilizumab in giant cell arteritis when criteria are met.  
• Removed giant cell arteritis (large cell vasculitis) from the Investigational and Not Medically Necessary statement.  
• Updated formatting in Position statement section.  
• Updated Description, Rationale, Background, Definitions, Coding, References, and Websites for Additional Information sections. |
| DRUG.00047 | Brentuximab Vedotin (Adcetris®) | • Added Medically Necessary statement for the use of brentuximab vedotin as a treatment for individuals with any of the following indications: Hodgkin lymphoma as maintenance therapy when criteria are met; Hodgkin lymphoma as a single-agent, palliative treatment when criteria are met; CD30+ non-Hodgkin lymphoma as a single-agent for adult T-cell leukemia/lymphoma when criteria are met; and CD30+ non-Hodgkin lymphoma for breast implant-associated anaplastic large cell lymphoma when criteria are met.  
• Reformatted Medically Necessary criteria |
| DRUG.00066 | Antihemophilic Factors and Clotting Factors | • Revised Medically Necessary statements for antihemophilic factor (factor VIII) recombinant, pegylated (Adynovate) to include children and perioperative management.  
• Added prophylaxis Medically Necessary criteria for Alphanate and Humate-P.  
• Added Xyntha to the prophylaxis Medically Necessary criteria for antihemophilic factor (factor VIII) recombinant. |
| DRUG.00071 | Pembrolizumab (Keytruda®)      | • Added Medically Necessary statement for the use of pembrolizumab for the treatment of individuals with colorectal cancer when criteria met.  
• Revised Medically Necessary statement for head and neck squamous cell carcinoma (HNSCC), no longer requiring criteria requirement for PD-L1 gene expression.  
• Reformatted Medically Necessary criteria. |
| DRUG.00075 | Nivolumab (Opdivo®)            | • Added Medically Necessary statement for the use of nivolumab for the treatment of individuals with colorectal cancer when criteria met.  
• Added Medically Necessary statement. |
| DRUG.00076 | Blinatumomab (Blincyto®) | • Added treatment of diffuse large B-Cell lymphoma (DLBCL) to the Investigational and Not Medically Necessary criteria

| DRUG.00077 | Monoclonal Antibodies to Interleukin-17A | • Added psoriatic arthritis to the Investigational and Not Medically Necessary statement for ixekizumab (Taltz®)

| DRUG.00079 | Bendamustine Hydrochloride | • Added treatment of nodal marginal zone lymphoma and peripheral T-cell lymphoma to the list of examples of NHL considered Medically Necessary

| DRUG.00083 | Elotuzumab (Empliciti™) | • Added Medically Necessary criteria for use of elotuzumab in combination with bortezomib and dexamethasone
• Made minor wording change in Investigational and Not Medically Necessary statement

| DRUG.00084 | Interferon gamma-1b (Actimmune®) | • Added Friedreich’s ataxia and invasive fungal infections, post-transplantation to Investigational and Not Medically Necessary statement for all other indications
• Revised formatting and grammar in position statement

| DRUG.00088 | Atezolizumab (Tecentriq®) | • Added Medically Necessary statement for use of atezolizumab for first-line treatment of locally advanced or metastatic urothelial carcinoma when criteria met
• Clarified criteria addressing second-line treatment of urothelial carcinoma and NSCLC to state that individual has not received treatment with another PD-1 or PD-L1 agent
• Removed abbreviations from the position statement

| DRUG.00097 | Olaratumab (Lartruvo™) | • Added “curative” before “treatment option” in the Medically Necessary criteria addressing radiotherapy or surgery
• Removed Medically Necessary criteria for “olaratumab use in combination with doxorubicin” and replaced it with “olaratumab is used in combination with doxorubicin and, after at least 8 cycles with doxorubicin or earlier discontinuation of doxorubicin due to toxicity, and then if
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00104</td>
<td>Nusinersen (SPINRAZA™)</td>
<td>Removed Medically Necessary statement addressing olaratumab’s use as monotherapy after disease progression</td>
</tr>
<tr>
<td></td>
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<td>Consolidated two separate Medically Necessary statements into a single statement</td>
</tr>
<tr>
<td>GENE.00006</td>
<td>Epidermal Growth Factor Receptor (EGFR) Testing</td>
<td>Revised Medically Necessary criteria for age of onset of SMA-associated signs and symptoms from &quot;before 6 months of age&quot; to &quot;before 21 months of age&quot;</td>
</tr>
<tr>
<td></td>
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<td>Clarified Medically Necessary statement regarding EGFR testing for individuals undergoing TKI inhibitor therapy</td>
</tr>
<tr>
<td>GENE.00009</td>
<td>Gene-Based Tests for Screening, Detection and Management of Prostate Cancer</td>
<td>Added CPT code 0005U as Investigational and Not Medically Necessary.</td>
</tr>
<tr>
<td>GENE.00032</td>
<td>Molecular Marker Evaluation of Thyroid Nodules</td>
<td>Added Medically Necessary statement for the use of a gene expression classifier for molecular marker evaluation of a thyroid nodule for use with fine needle aspirates, after initial cytopathology is indeterminate (that is, atypia of undetermined significance [AUS], follicular lesion of undetermined significance [FLUS], suspicious for follicular neoplasm [SFN], follicular neoplasm [FN], and suspicious for malignancy)</td>
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<tr>
<td></td>
<td></td>
<td>Added Investigational and Not Medically Necessary statement for repeat testing of the same nodule and when the Medically Necessary criteria are not met</td>
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<tr>
<td></td>
<td></td>
<td>CPT code 81545 for Afirma gene expression classifier test will now pend for Medically Necessary criteria</td>
</tr>
<tr>
<td>MED.00032</td>
<td>Treatment of Hyperhidrosis</td>
<td>Revised scope of document</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moved position statement and all other language addressing treatment of hyperhidrosis with botulinum toxin to DRUG.00006</td>
</tr>
<tr>
<td>MED.00076</td>
<td>Inhaled Nitric Oxide</td>
<td>Removed abbreviations from the position statement</td>
</tr>
<tr>
<td>RAD.00030</td>
<td>Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule</td>
<td>Removed abbreviations from the position statement</td>
</tr>
<tr>
<td>RAD.00043</td>
<td>Computed Tomography Scans for Lung Cancer Screening</td>
<td>Revised title (Previous title: Computed Tomography Scans with or without Computer Assisted Detection [CAD] for...</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Updates</td>
</tr>
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</tr>
<tr>
<td>RAD.00059</td>
<td>Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial</td>
<td>- Updated formatting</td>
</tr>
<tr>
<td></td>
<td>Embolization (TAE) for Malignant Lesions Outside the Liver except Central Nervous System (CNS) and Spinal Cord</td>
<td>- Removed abbreviations from the position statement</td>
</tr>
<tr>
<td>SURG.0001</td>
<td>Carotid, Vertebral and Intracranial Artery Stent Placement with or without</td>
<td>- Clarified symptomatic or asymptomatic stenosis is necessary to meet criteria including in those who cannot move the neck and those with a tracheostomy for the Medically Necessary criteria for extracranial carotid artery stent placement with or without angioplasty</td>
</tr>
<tr>
<td></td>
<td>Angioplasty</td>
<td></td>
</tr>
<tr>
<td>SURG.0016</td>
<td>Stereotactic Radiofrequency Pallidotomy</td>
<td>- Revised punctuation</td>
</tr>
<tr>
<td>SURG.0037</td>
<td>Treatment of Varicose Veins (Lower Extremities)</td>
<td>- Clarified Medically Necessary statement for sclerotherapy or echosclerotherapy to clarify that “greater than 3.0 mm in diameter” refers to all of the veins being treated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Replaced the term “Giacomini vein” with “intersaphenous vein” in the Medically Necessary and Investigational and Not Medically Necessary statements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Clarified Medically Necessary statements to indicate that reflux is “confirmed by Doppler or duplex ultrasound evaluation and report”</td>
</tr>
<tr>
<td>SURG.0049</td>
<td>Mandibular/Maxillary (Orthognathic) Surgery</td>
<td>- Made minor grammar and punctuations revisions</td>
</tr>
<tr>
<td>SURG.0065</td>
<td>Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies</td>
<td>- Removed abbreviations from the position statement</td>
</tr>
<tr>
<td>SURG.0068</td>
<td>Implantable Infusion Pumps</td>
<td>- Made minor grammar revisions in the position statement</td>
</tr>
<tr>
<td>SURG.0081</td>
<td>Total Ankle Replacement</td>
<td>- Removed abbreviations from the position statement</td>
</tr>
<tr>
<td>SURG.00121</td>
<td>Transcatheter Heart Valve Procedures</td>
<td>- Revised Medically Necessary statement for TAVR with CoreValve System to include the CoreValve Evolut R System and CoreValve Evolut PRO System</td>
</tr>
<tr>
<td>THER-RAD.00001</td>
<td>Brachytherapy for Oncologic Indications</td>
<td>- Added Gleason grade groups to prostate cancer Medically Necessary criteria</td>
</tr>
<tr>
<td>THER-RAD.00004</td>
<td>External Beam Intraoperative Radiation Therapy</td>
<td>- Clarified Medically Necessary statement for external beam intraoperative radiation therapy as the sole source of additional radiotherapy at the time of surgical excision when criteria are met</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Added a Medically Necessary statement for use of partial breast irradiation (PBI)</td>
</tr>
<tr>
<td>TRANS.00024</td>
<td>Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome</td>
<td></td>
</tr>
</tbody>
</table>
|----------------|-------------------------------------------------------------------------------------------------
| Added a note regarding the pediatric population to the de novo or primary myelodysplastic syndrome or juvenile myelomonocytic leukemia (JMML) Medically Necessary criteria |
| Revised Individual Selection Criteria regarding hepatic insufficiency to require either a bilirubin or INR result |

with external beam intraoperative PBI as an alternative to whole breast irradiation in the treatment of early stage breast cancer when criteria are met
- Added an Investigational and Not Medically Necessary statement for external beam intraoperative PBI for the treatment of breast cancer when the Medically Necessary criteria are not met
- Updated formatting in the position statement