Anthem

Medical Policy

Subject: High Resolution Anoscopy Screening for Anal Intraepithelial Neoplasia (AIN) and Squamous Cell Cancer of the Anus
Document #: SURG.00116 **Publish Date:** 06/28/2023
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Description/Scope

This document addresses the use of high-resolution anoscopy for screening asymptomatic individuals for as-yet-unrecognized anal dysplasia and anal cancer. This document does not address the use of high-resolution anoscopy to assist in the diagnosis or treatment of a suspicious anal lesion, anal dysplasia found in prior cytology/biopsy, or rectal trauma.

Position Statement

Investigational and Not Medically Necessary:

High-resolution anoscopy (with or without brushings/biopsies) is considered **investigational and not medically necessary** as a screening test for anal dysplasia and cancer of the anus.

Rationale

Anoscopy involves examining the perianal area and the distal rectum and is commonly performed in individuals with anorectal pain, itching, discharge, or bleeding. High-resolution anoscopy (HRA), also known as colposcopy of the anal canal, is considered more complex than standard anoscopy in that it involves the careful examination of the anal canal using an anoscope and a high-resolution (10–40x magnification) colposcope. During the procedure, an anoscope is inserted approximately 2 inches into the anal canal. Then, a standard gynecologic colposcope is used to magnify the area in order to identify any suspicious lesions. With the aid of 3% acetic acid, suspicious areas are identified as “acetowhite.” Lugol’s iodine solution may also be applied to identify normal mucosa. Acetic acid is continually applied during the examination to manipulate folds, hemorrhoids, or prolapsing mucosa. If suspicious lesions are found, biopsies are taken and sent for microscopic examination.

HRA has been investigated as a method to identify abnormal anal cytology in high-risk populations and has been proposed as an adjunct tool in anal cytology screening. Based on similarities between anal intraepithelial neoplasia (AIN) and cervical intraepithelial neoplasia (CIN), anal Papanicolaou (Pap) smear cytology has been proposed for both screening high-risk individuals and surveillance after treatment of AIN. Screening tools to identify cellular abnormalities in anal tissue include cytology testing of the anal squamous epithelium and genotypic HPV testing for infection with high-risk oncogenic types. HRA with biopsy of lesions has been proposed as a means to confirm abnormalities detected during screening.

The prevention of anal cancer is desirable because anal cancer is correlated with poor survival when identified at late stages. There is an increased risk of developing anal cancer among specific groups, including recipients of a solid organ transplant, females with a history of cervical or vulvar high-grade squamous intraepithelial lesion (HSIL) or cancer, people living with HIV (PLWH). These individuals are also known to have an increased risk of anal HSIL. Because some lesions regress without medical intervention, there is a lack of consensus as to whether “watchful waiting” is most appropriate or if HSIL should be treated immediately..

Currently, there is limited evidence in the form of randomized trials or cohort studies that demonstrate improved survival or clinical outcome with anal cytology screening, However, a recent study provides indirect evidence that screening to identify suspicious anal lesions followed by HRA directed biopsy results in an improved clinical outcome. Palefsky and colleagues (2022) reported on the efficacy of ablative treatment for HSIL. In the Anal Cancer/HSIL Outcomes Research (ANCHOR) trial, 4459 participants, 35 years of age or older who had biopsy-proven HSIL, were randomly assigned to active monitoring or treatment. At a median follow-up of 25.8 months, anal cancer was diagnosed in 21 of 2219 participants undergoing active monitoring (402 cases per 100,000 person-years). At 48 months the cumulative incidence of progression to anal cancer was 1.8%. The study found that the rate of progression to cancer was higher amongst the active-monitoring group than published estimates from cancer–HIV registry matches, even after accounting for trial participants with HSIL. The study also demonstrated that “the percentage of stage I or II cancers that were diagnosed in the active-monitoring group was higher than that reported in national data”. The time to progression to anal cancer was associated with the size of the lesion, with lesions that were more than 50% of the anal canal or perianal region progressing faster than smaller lesions. Researchers found that treatment of anal HSIL resulted in a 57% lower rate of progression from HSIL to anal cancer than no treatment (p=0.03) among PLWH who were 35 years of age or older. The authors acknowledged that the higher rate of progression to cancer among the active-monitoring cohort might be a reflection of the early cancer detection in the trial. The authors also acknowledge that limitations of the study included but were not limited to the need for additional research to improve screening algorithms to detect HSIL and improvement of screening algorithms to identify individuals in need of referral for HRA. Additional considerations should include the evaluation of the effect of treatment and frequent monitoring on quality of life.

Although the results of the Palefsky (2022) study demonstrated that treatment of anal HSIL resulted in a lower rates of progression from HSIL to anal cancer than no treatment, some research has suggested that not all anal HSIL detected in screening requires intervention. Goldstone and colleagues (2019) conducted an open-label, randomized, multisite clinical trial of human immunodeficiency virus (HIV)–infected adults aged at least 27 years of age with 1-3 biopsy-proven anal HSILs (index HSILs) without prior history of HSIL treatment with infrared coagulation (IRC). Subjects were randomized 1:1 to HSIL ablation with IRC (treatment) or no treatment (active monitoring [AM]). Participants in the treatment arm (TA) were followed every 3 months with digital anorectal examination, anal cytology, and HRA with biopsy of areas with suspected HSILs. Biopsy-proven metachronous or recurrent HSILs were treated with IRC within 4 weeks of diagnosis. Participants were followed up for 24 months after the initial (baseline) treatment. At 12 and 24 months, subjects in the TA underwent biopsy at index lesion sites (even if no lesion was seen) and sites with lesions suspected of being new HSILs. All of the treated participants completed a symptom diary for 10 days following treatment. In the AM arm, all participants were examined using digital anorectal examination, anal cytology, and HRA every 3 months. Anal biopsy specimens were obtained only for lesions suspicious for possible progression to invasive cancer, to prevent possible treatment effect from multiple biopsies. At 12 months following enrollment, participants in the AM arm underwent biopsy at index lesion sites (even if no lesion was seen) and sites with lesions believed to be new HSILs. Participants in the AM arm with HSILs at 12 months were able to cross over to IRC treatment for an additional 12 months, undergoing HRA every 3 months with ablation of metachronous or recurrent HSILs. The primary end point was complete index lesion clearance (CILC) at 12 months. The researchers found complete index HSIL clearance occurred more often in the TA than in the AM arm (62% vs 30%; risk difference, 32%; 95% confidence interval

[CI], 13%–48%; p<0.001). This also demonstrated that up to 30% of anal HSILs spontaneously regress. Complete or partial clearance occurred more commonly in the treatment group (82% vs 47%; risk difference, 35%; 95% CI, 16%–50%; p<0.001). No serious adverse events were considered related to treatment or study participation. (Goldstone, 2019).

Revollo and colleagues (2020) evaluated the impact of a screening program to detect anal cancer precursors on the incidence of cases of invasive anal squamous-cell carcinoma (IASCC) in persons with HIV-1. Researchers conducted a single-center, retrospective analysis of a prospective group of outpatients with HIV-1 attending a reference HIV unit from January 2005 onward. All subjects were invited to participate in a continued structured screening program for anal cancer prevention. The screening protocol included a clinical examination at baseline and a digital rectal examination (DRE) and collection of a sample from the anal canal for cytological examination. If the result was normal, the participant was assessed again on a yearly basis. However, if the cytology result was abnormal (atypical squamous cells of undetermined significance [ASCUS], low-grade squamous intraepithelial lesion [LSILs], or HSILs), HRA was completed within the next 3 months. If lesions were not visualized on HRA, no biopsy was done, and cytology re-evaluation was scheduled for 6–12 months later. If lesions were identified with HRA, a directed biopsy was performed. If the results of the directed biopsy were normal or AIN-1, a new visit including cytology was scheduled 6 months later. If the result was AIN2/AIN3, the participant was treated with infrared coagulation or surgery as soon as possible. Following treatment, the participant underwent a cytological examination again after 3 to 6 months. If the cytology was normal, the subject was visited again at 6–12 months, and underwent a new digital rectal examination; however, if it was abnormal (ASCUS, LSILs, or HSILs) a new HRA was conducted as soon as possible. Any participant with anal symptoms during follow-up was referred to the proctology section and a full examination was done.

Researchers estimated the incidence of IASCC and performed a comparative analysis between subjects enrolled in the screening program (screening group) and those who declined to participate (non-screening group). To minimize any selection bias, a propensity score analysis was applied. A total of 3111 subjects with HIV-1 (1596 men-who-have-sex-with-men [MSM], 888 men-who-have-sex-with-women [MSW], 627 women; mean age, 41 years), with a median follow-up of 4.7 years (14 595 patient-years of follow-up); 1691 (54%) joined in the screening program. Ten participants were diagnosed with IASCC: 2 (MSM) in the screening group and 8 (4 MSM, 2 MSW, and 2 women) in the non-screening group. Incidence rates for IASCC were 21.9 (95% CI, 2.7-70.3) and 107.0 (95% CI, 46.2-202.0) per 100 000 person-years, respectively. Following a propensity score adjustment, the difference was significant in favor of the screening group (hazard ratio, 0.17; 95% CI, 0.03-0.86). The authors found that the number of cases of IASCC was significantly lower in individuals with HIV engaged in an anal cytology screening program and recommended that these results be validated in a randomized clinical trial.

The authors pointed out that currently the diagnosis is dependent on histological results which generally hinge on HRA with biopsy. Cytological results have been shown to have limited sensitivity in identifying histologically proven high-grade AIN and the prevalence of high-grade AIN is significantly lower when based on a cytological diagnosis than when based on histology. Therefore, the findings in this study may reflect an underdiagnosis of high-grade AIN. The researchers also pointed out that limitations of the study included the small sample size, the nonrandom design at screening and the limited follow-up period (just over a decade). The authors also acknowledged that due to the limited number of IASCC events, one could not exclude other factors introduced into the analysis (sexual behavior, CD4+ nadir or baseline CD4+ count, or HIV-1 plasma RNA) that could potentially be associated with IASCC development as well. The authors concluded that in this prospective cohort analysis the number of cases of IASCC was appreciably lower in PLHA (MSM, MSW, and women) who were enrolled in the preventative screening program compared with a similar group who were not, however, results from randomized clinical trials and analyses including larger cohorts are needed to further clarify the efficacy of this screening strategy.

Several specialty associations/societies have published recommendations on the use of HRA as a screening tool to identify AIN and SCC. With regards to HRA and cancer in people with HIV (PWH), the National Comprehensive Cancer Network (NCCN) states the following:

> PWH are at higher risk of AIN compared to those without HIV. High-grade AIN can be a precursor to anal cancer, and treatment of high-grade AIN may prevent the development of anal cancer. Therefore, many clinicians routinely screen PWH for HPV and anal dysplasia, even though randomized controlled trials showing that such screening programs are efficacious at reducing anal cancer incidence and mortality are lacking. In addition, the panel believes that PWH diagnosed with vulvar, vaginal, or cervical disease should have screening for anal cancer. Screening methods include anal cytology, high-resolution anoscopy, and annual digital rectal exam (DRE). Some data suggest that screening protocols that include cytology and HPV testing are most effective (NCCN, Cancer in People with HIV 2023).

The updated guidelines for prevention and treatment of opportunistic infections in HIV-infected adults and adolescents from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America state the following with regards to the use of HRA to screen for anal cancer:

> Some cost-effectiveness evaluations indicate that in patients who are HIV seropositive, screening for lesions using anal cytology and treating anal precancerous lesions to reduce risk of anal cancer in PWH infection may provide clinical benefits comparable to measures to prevent other opportunistic infection. AIN lesions are similar in many ways to CIN, but differences may exist in natural history, optimal screening, and treatment approaches to prevent cancer. At this time, no national recommendations exist for routine screening for anal cancer. However, some specialists recommend anal cytologic screening or high resolution anoscopy (HRA) for men and women who are HIV seropositive (CIII). Screening for anal cancer with anal cytology should not be done without the availability of referral for HRA. If anal cytology is performed and indicates ASC-US, then ASC cannot rule out ASC-H, LSIL, or high-grade squamous intraepithelial lesion (HSIL), then it should be followed by HRA (BIII) (Panel on Opportunistic Infections, 2023).

Strength of the recommendation "B" refers to “moderate recommendation for the statement”. Strength of the recommendation "C" refers to “optional recommendation for the statement”. Quality of Evidence for the Recommendation “III” refers to “expert opinion” (Panel on Opportunistic Infections, 2023).

In 2021, ESMO published a clinical practice guideline for diagnosis, treatment and follow-up of anal cancer. The guideline indicates the following with regard to screening for anal cancer:

> In summary, screening programmes using anal cytology and high-resolution anoscopy have been proposed for high-risk populations (GBMSM and HIV-negative women with a history of anal intercourse or other HPV-related anogenital malignancies) based on achievements obtained in cervical cytology screening. However, no randomised controlled study has yet demonstrated a preventive effect of screening in these high-risk populations and thus it cannot be routinely advocated at present.

The updated practice guideline published by the HIV Medicine Association of the Infectious Diseases Society of America (Thompson, 2021) provides the following guidance:

> Persons with HPV are at increased risk for anal dysplasia and cancer. Currently, there are no national screening guidelines for the use of anal Pap tests. HPV-related anal dysplasia is seen at a lower frequency among heterosexual men. If anal cytologic screening using an anal Pap test is performed and indicates atypical or abnormal cells, then high-resolution anoscopy should be performed with biopsy of abnormal areas and appropriate therapy based on biopsy results. Access to appropriate referral and follow-up is necessary if anal Pap screening is performed (Thompson, 2021).

According to the 2012 Standards Committee of the American Society of Colon and Rectal Surgeons Practice Parameters for Anal Squamous Neoplasms, screening procedures for high-grade (HGAIN) and low-grade (LGAIN) anal intraepithelial neoplasia include anal cytology, colposcopy, biopsy and HRA (level 1C recommendation [strong recommendations based on low or very low quality of evidence]). However, the practice parameter also provided the following information regarding HRA:

> The sensitivity of anal Pap smear evaluation compared with HRA-directed biopsies ranges from 69% to 93% and specificity ranges from 32% to 59%. Unfortunately, anal cytology in high-risk cohorts such as MSM has false-negative cytology in up to 23% of HIV-negative and 45% for HIV-positive patients. Although some economic modeling studies have suggested that frequent anal cytology may be a cost-effective method to prevent anal cancer, there have not been any randomized or cohort studies to demonstrate improved survival or outcomes (Steele, 2012).

The Ontario Health Technology Advisory Committee failed to recommend anal dysplasia screening of high-risk individuals at this time due to the low and variable specificity for cytological screening (33%-81%), inadequate evidence of effectiveness for current treatment of precancerous lesions, high recurrence rates, and lack of evidence that cytological screening reduces the risk of developing anal cancer (OHTAC, 2007).

The published literature demonstrating that the use of HRA as a screening tool to identify suspicious anal lesions followed by directed biopsy results in an improved clinical outcome is limited. Specialty associations/societies have not yet reached a consensus on the role of HRA as a screening modality to identify AIN or SCC of the anus. For these reasons, the clinical utility of HRA as a screening tool for anal dysplasia and anal cancer is considered unproven, and its use is considered investigational and not medically necessary at the present time.

Background/Overview

Anal cancer is an uncommon malignancy, detected in approximately 9760 individuals per year in the United States Anal cancer rarely occurs in individuals younger than 35 years of age and is found primarily in older adults, with an average age being in the early 60s. It is also more common in White women and Black men (ACS, 2023).

Anal intraepithelial neoplasia (AIN), also termed squamous intraepithelial lesion (SIL), is a precancerous condition that can arise in the anus. Depending on the appearance of the cells, AIN or anal SIL can be divided into 2 groups:

- Low-grade SIL (or grade 1 AIN): The cells in low-grade SIL look like normal cells. Low-grade SIL often goes away without treatment and has a low chance of turning into cancer.
- High-grade SIL (or grade 2 AIN or grade 3 AIN): The cells in high-grade SIL look abnormal. High-grade SIL is less likely to go away without treatment and, with time, could become cancer. It needs to be watched closely and some cases of high-grade SIL need to be treated (ACS, 2023).

There is substantial evidence to show that HIV-positive MSM and HIV-positive women are at increased risk for AIN 2 or 3 and are at increased risk for anal cancer. Other risks for developing anal dysplasia and anal cancer include immunosuppressive therapies, concurrent human papilloma virus (HPV) related disease in other sites, multiple sexual partners, prior history of other sexually transmitted disease, history of cervical cancer, cervical intraepithelial neoplasia, and cigarette smoking.

HRA has been investigated as a method to identify abnormal anal cytology amongst high-risk populations and is used as an adjunct tool to the anal Pap smear. It is also proposed as a tool to visualize areas of anal mucosa at risk for dysplasia to direct biopsy.

Definitions

Anal intraepithelial neoplasia (AIN): Abnormal cellular growth in anal tissue which may eventually progress to cancer. Also termed anal squamous intraepithelial lesions (ASIL).

Anoscope: An instrument used to visualize the anus and lowest portion of the rectum.

ASC: Atypical squamous cells.

ASC-US: Atypical squamous cells of undetermined significance.

Cervical intraepithelial neoplasia (CIN): Abnormal growth and potentially premalignant changes of the squamous cells on the surface of the cervix.

DNA (deoxyribonucleic acid): A type of molecule that contains the code for genetic information.

GBMSM: Gay, bisexual and other men who have sex with men.

LSIL: Low-grade squamous intraepithelial lesion.

MSM: Men having sex with men.

PLWH: People living with HIV.

Screening: An effort or program that is used to detect a condition in an asymptomatic individual so that early detection and treatment can be provided for those who test positive for the condition.

Squamous cell cancer: Tumors which are derived from the squamous cells that line the anal margin and most of the anal canal.

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-

coverage of these services as it applies to an individual member.

When services are Investigational and Not Medically Necessary:

CPT	
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed
46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple

ICD-10 Diagnosis	
B20	Human immunodeficiency virus [HIV] disease [when specified as a screening procedure]
B97.7	Papillomavirus as the cause of diseases classified elsewhere [when specified as a screening procedure]
Z12.10	Encounter for screening for malignant neoplasm of intestinal tract, unspecified [anus]
Z12.12	Encounter for screening for malignant neoplasm of rectum
Z12.89	Encounter for screening for malignant neoplasm of other sites

References

Peer Reviewed Publications:

1. Chiao EY, Giordano TP, Palefsky JM, et al. Screening HIV-infected individuals for anal cancer precursor lesions: a systematic review. Clin Infect Dis. 2006; 43(2):223-233.
2. Goldie SJ, Kuntz KM, Weinstein MC, et al. Cost effectiveness of screening for anal squamous intraepithelial lesions and anal cancer in human immunodeficiency virus-negative homosexual and bisexual men. Am J Med. 2000; 108(8):634-641.
3. Goldstone SE, Lensing SY, Stier EA, et al. A randomized clinical trial of infrared coagulation ablation versus active monitoring of intra-anal high-grade dysplasia in adults with human immunodeficiency virus infection: an AIDS Malignancy Consortium trial. Clin Infect Dis 2019; 68:1204-1212.
4. Palefsky JM, Lee JY, Jay N, et al. Treatment of anal high-grade squamous intraepithelial lesions to prevent anal cancer. N Engl J Med. 2022; 386(24):2273-2282.
5. Palefsky JM, Rubin M. The epidemiology of anal human papillomavirus and related neoplasia. Obstet Gynecol Clin North Am. 2009; 36(1):187-200.
6. Pineda CE, Welton ML. Controversies in the management of anal high-grade squamous intraepithelial lesions, Minerva Chir; 2008; 63(5):389-399.
7. Poynten IM, Jin F, Roberts JM, et al. The natural history of anal high-grade squamous intraepithelial lesions in gay and bi-sexual men. Clin Infect Dis 2021; 72:853-861.
8. Revollo B, Videla S, Llibre JM, et al. Routine screening of anal cytology in persons with human immunodeficiency virus and the impact on invasive anal cancer: A prospective cohort study. Clin Infect Dis. 2020; 71(2):390-399.
9. Tong WW, Jin F, McHugh LC, et al. Progression to and spontaneous regression of high-grade anal squamous intraepithelial lesions in HIV-infected and uninfected men. AIDS 2013; 27:2233-2243.

Government Agency, Medical Society, and Other Authoritative Publications:

1. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015. MMWR Recomm Rep 2015; 64 (No. RR-3):1-137.
2. NCCN Clinical Practice Guidelines in Oncology™. © 2023 National Comprehensive Cancer Network, Inc. For additional information visit the NCCN website: http://www.nccn.org.index.asp. Accessed on March 12, 2023.
    - Anal Carcinoma V1.2023. Revised January 9, 2023.
    - Cancer in People with HIV V1.2023. Revised December 20, 2022.
3. Ontario Health Technology Advisory Committee (OHTAC). Anal dysplasia screening. OHTAC Recommendation. Toronto, ON: Ontario Ministry of Long-Term Care, Medical Advisory Secretariat; July 2007. Available at: http://www.hqontario.ca/english/providers/program/ohtac/tech/recommend/rec_ads_20070927.pdf. Accessed on March 12, 2023.
4. Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. National Institutes of Health, Centers for Disease Control and Prevention, HIV Medicine Association and Infectious Diseases Society of America (2023).. Available at: https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/Adult_OI.pdf. Accessed on March 12, 2023.
5. Rao S, Guren MG, Khan K et al. Anal cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Annals Oncol. 2021; 32(9):1087-1100.
6. Steele SR, Varma MG, Melton GB, et al. Practice parameters for anal squamous neoplasms. Dis Colon Rectum. 2012; 55(7):735-749.
7. Thompson MA, Horberg MA, Agwu AL, et al. Primary Care Guidance for Persons with Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America. Clin Infect Dis. 2021; 73(11):e3572-e3605.

Websites for Additional Information

1. American Cancer Society Detailed Guide: Anal Cancer What Is Anal Cancer? Last revised: November 13, 2017. Available at: http://www.cancer.org/cancer/analcancer/detailedguide/anal-cancer-what-is-anal-cancer. Accessed on March 12, 2023.
2. American Cancer Society. Key Statistics for Anal Cancer. Last revised January 12, 2023. Available at: https://www.cancer.org/cancer/anal-cancer/about/what-is-key-statistics.html. Accessed on April 21, 2023.

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Document History

Status	Date	Action

Reviewed	05/11/2023	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated Rationale, Background/Overview, References, Websites for Additional Information, and History sections.
Reviewed	05/12/2022	MPTAC review. Updated Rationale, Definitions, References, Websites for Additional Information, and History sections.
Reviewed	05/13/2021	MPTAC review. Updated References, Websites for Additional Information, and History sections.
Reviewed	05/14/2020	MPTAC review. Updated Description/Scope, Rationale, References, Websites for Additional Information and History sections.
Reviewed	06/06/2019	MPTAC review. Updated Rationale, Definitions, References, Websites for Additional Information and History sections.
Reviewed	07/26/2018	MPTAC review. The document header wording updated from “Current Effective Date” to “Publish Date.” Updated Rationale, References, Websites for Additional Information and History sections.
Reviewed	08/03/2017	MPTAC review. Updated Rationale, References and History sections.
Reviewed	08/04/2016	MPTAC review. In the title and throughout the document the term “high resolution anoscopy” was changed to “high-resolution anoscopy”. Updated Review date, Rationale, Definitions, References, Websites for Additional Information and History sections of the document.
	01/01/2016	Updated Coding section with 01/01/2016 HCPCS changes, removed G6027, G6028 deleted 12/31/2015; also removed ICD-9 codes.
Reviewed	08/06/2015	MPTAC review. Updated Review date, Rationale, References and History sections of the document.
	01/01/2015	Updated Coding section with 01/01/2015 CPT and HCPCS changes; removed 0226T, 0227T deleted 12/31/2014.
Reviewed	08/14/2014	MPTAC review. Updated Review date, Rationale, References and History sections of the document.
Reviewed	08/08/2013	MPTAC review. Updated Review date, References and History sections of the document.
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Reviewed	08/18/2011	MPTAC review. Updated Review date, References and History sections of the document.
Reviewed	08/19/2010	MPTAC review. Updated Review date, Rationale, References and History sections of the document.
New	05/13/2010	MPTAC review. Initial document development.

Applicable to Commercial HMO members in California: When a medical policy states a procedure or treatment is investigational, PMGs should not approve or deny the request. Instead, please fax the request to Anthem Blue Cross Grievance and Appeals at fax # 818-234-2767 or 818-234-3824. For questions, call G&A at 1-800-365-0609 and ask to speak with the Investigational Review Nurse.

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.