Corporate Medical Policy

Cervical Cancer Screening AHS – G2002

Description of Procedure or Service

Description
Cervical cancer screening detects cervical precancerous lesions and cancer through cytology, HPV testing, and if needed, colposcopy (Feldman, Goodman, & Peipert, 2018).

The principal screening test to detect cancer in asymptomatic women is the Papanicolaou (Pap) smear. It involves cells being scraped from the cervix during a pelvic examination and spread onto a slide. The slide is then sent to an accredited laboratory to be stained, observed and interpreted (Feldman & Crum, 2017).

Human papilloma virus (HPV) has been associated with development of cervical intraepithelial neoplasia, and FDA approved HPV tests detecting the presence of viral DNA from high risk strains have been developed and validated as an adjunct primary cancer screening method (Feldman & Crum, 2017).

For more information specifically regarding HPV, please refer to Diagnostic Testing of Most Common Sexually Transmitted Infections - AHS-G2157.

***Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.

Policy

BCBSNC will provide coverage for cervical cancer screening when it is determined the medical criteria or reimbursement guidelines below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

When cervical cancer screening is covered

Reimbursement for cervical cancer screening for women under 21 years of age is allowed when one of the following criteria are met:
- History of HIV and other immunocompromised conditions,
- Previous diagnosis of cervical cancer
- Previous diagnosis of cervical dysplasia
- History of an organ transplant
Reimbursement for cervical cancer screening for women 21 – 29 years of age using conventional or liquid based Papanicolaou (Pap) smears is allowed at a frequency of every 3 years.

Reimbursement for cervical cancer screening for women 30 – 65 years of age using conventional or liquid based Pap smear at a frequency of every 3 years, or cervical cancer screening using the the high-risk HPV test alone at a frequency of every 5 years, or co-testing (cytology with concurrent high-risk HPV testing) at a frequency of every 5 years, is allowed.

Reimbursement for testing for high-risk strains HPV-16 and HPV-18 is allowed if BOTH the following co-testing criteria are present:

- Cytology negative AND
- HPV positive

Reimbursement for cervical cancer screening for women >65 years of age who are considered high-risk (women with a high-grade precancerous lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised) is allowed.

Reimbursement for repeat cervical cancer screening by Pap smear or HPV testing in one year is allowed if a previous cervical cancer screen had an abnormal cytology and/or was positive for HPV or women is at high risk for cervical cancer (organ transplant, exposure to the drug DES, immunocompromised women).

When cervical cancer screening is not covered

Reimbursement is not allowed for cervical cancer screening for women under 21 years of age unless one of the criteria listed above are met.

Reimbursement is not allowed for routine cervical cancer screening in women >65 years of age who are not considered high-risk and have an adequate screening history:

- 3 consecutive negative Pap smears, or
- 2 consecutive negative HPV tests within 10 years before cessation of screening, with the most recent test occurring within 5 years

Reimbursement is not allowed for cervical cancer screening (at any age) for women who have undergone surgical removal of uterus and cervix and have no history of cervical cancer or pre-cancer.

Reimbursement is not allowed for:

- Inclusion of low-risk strains of HPV in co-testing, as the clinical utility has not been established.
- Other technologies for cervical cancer screening because of insufficient evidence of clinical utility.

Policy Guidelines

Background
The American Cancer Society estimates that 13,240 new cases of cervical cancer will be diagnosed in 2018 with approximately 4,170 women dying from cervical cancer (ACS, 2018). To screen for cervical cancer, a Pap test or HPV test is performed. Co-testing with both is also a common clinical practice. To obtain the cell sample for cytology, during a speculum exam cells are scraped from both the ectocervix (external surface) and endocervix (cervical canal) to evaluate the squamocolumnar junction where most neoplasia occur. Cytological examination can be performed as either a traditional Pap smear where the swab is rolled directly on the slide for observation or liquid-based thin layer cytology examination where the swab is swirled in a liquid solution so that the free cells can be trapped and plated as a monolayer on the glass slide. One advantage of the liquid cytology assay is that the
same sample can be used for HPV testing whereas a traditional Pap smear requires a second sample to be taken. HPV testing is typically a nucleic acid-based assay that checks for the presence of high-risk types of HPV, especially types 16 and 18. HPV testing can be performed on samples obtained during a cervical exam; furthermore, testing on samples obtained from vaginal swabs, tampons, and urine samples have been reported (Feldman & Crum, 2017).

Analytical Validity
A study by Marchand and colleagues explored the optimal collection technique for Pap testing. Their study consisted of two different cytology labs and 128 clinicians over the course of one year. They discovered that in conventional Pap testing the sequence of collection—the cytobrush for the endocervix and the spatula for the ectocervix—had no effect on the quality of the assay. 47% of the clinicians who had high levels of absent endocervical cells on their samples used the cytobrush method alone. The authors conclude, “The combination of the Cytobrush (endocervix) and spatula (ectocervix) is superior for a quality Pap smear. The sequence of collection was not important in conventional Pap smears. The broom alone performs poorly (Marchand, Mundt, Klein, & Agarwal, 2005).”

Urine-based HPV DNA testing as a screening tool would be a less invasive method than cervical examinations and swabs. A 2014 study by Mendez et al. using both urine samples and cervical swabs from 52 female patients, however, showed that there was only 76% agreement between the two methodologies. The urine testing correctly identified 100% of the uninfected individuals but only 65% of the infected as compared to the cervical swab controls (Mendez et al., 2014). An extensive meta-analysis of 14 different studies using urinary testing, on the other hand, reported an 87% sensitivity and 94% specificity of the urine-based methodology for all strains of HPV, but the sensitivity for high-risk strains alone was only 77%. The specificity for the high-risk strains alone was reported to be higher at 98%. “The major limitations of this review are the lack of a strictly uniform method for the detection of HPV in urine and the variation in accuracy between individual studies. Testing urine for HPV seems to have good accuracy for the detection of cervical HPV, and testing first void urine samples is more accurate than random or midstream sampling. When cervical HPV detection is considered difficult in particular subgroups, urine testing should be regarded as an acceptable alternative (Pathak, Dodds, Zamora, & Khan, 2014).”

Clinical Validity and Utility
The National Cancer Institute reports that “Regular Pap screening decreases cervix cancer incidence and mortality by at least 80% (NCI, 2018).” They do note that Pap testing can result in the possibility of additional diagnostic testing, especially in younger women, when unwarranted, especially in cases of possible low-grade squamous intraepithelial lesions (LSILs); however, even though 50% of women undergoing Pap testing required additional, follow-up diagnostic procedures, only 5% were treated for LSILs. The NCI also reports that “HPV-based screening provides 60% to 70% greater protection against invasive cervical carcinoma, compared with cytology (NCI, 2018).”

The National Comprehensive Cancer Network (NCCN) in their guidelines for cervical cancer (NCCN, 2018) states that, although the rates of both incidence and mortality of squamous cell carcinoma of the cervix has been declining over the last thirty years, “adenocarcinoma of the cervix has increased over the past 3 decades, probably because cervical cytologic screening methods are less effective for adenocarcinoma.” A study in the United Kingdom supports this because the risk-reduction associated with 3-yearly screening was reduced by 75% for squamous carcinoma and 83% for adenosquamous carcinoma, but adenocarcinoma was reduced only by 43% (Sasieni, Castanon, & Cuzick, 2009). Another extensive study of more than 900,000 women in Sweden showed that PCR-based HPV testing for the high-risk types 16 and 18 is better at predicting the risk of both in situ and invasive adenocarcinoma. The authors conclude, “infections with HPV 16 and 18 are detectable up to at least 14 years before diagnosis of cervical adenocarcinoma. Our data provide prospective evidence that the association of HPV 16/18 with cervical adenocarcinoma is strong and causal (Dahlstrom et al., 2010).”

A report by Chen and colleagues in 2011 reviewed HPV testing and the risk of the development of cervical cancer. Of the 11,923 women participating in the study, 86% of the women who tested positive for HPV did not develop cervical cancer with ten years. The authors concluded, “HPV
negativity was associated with a very low long-term risk of cervical cancer. Persistent detection of HPV among cytologically normal women greatly increased risk. Thus, it is useful to perform repeated HPV testing following an initial positive test (Chen et al., 2011)."

In 2018, the results of the multi-year HPV FOCAL randomized clinical trial testing of the use of HPV testing alone for detection of cervical intraepithelial neoplasia (CIN) grade 3 or worse (CIN3+) were published. More than 19,000 women participated in the study split between the intervention group (HPV testing alone) and the control group (liquid-based cytology). “Baseline HPV-negative women had a significantly lower cumulative incidence of CIN3+ at 48 months than cytology-negative women (CIN3+ incidence rate, 1.4/1000 [95% CI, 0.8-2.4]; CIN3+ risk ratio, 0.25 [95% CI, 0.13-0.48]). Among women undergoing cervical cancer screening, the use of primary HPV testing compared with cytology testing resulted in a significantly lower likelihood of CIN3+ at 48 months. Further research is needed to understand long-term clinical outcomes as well as cost-effectiveness (Ogilvie et al., 2018).” In a commentary concerning the findings of this trial, the author notes that multiple randomized trials have shown that primary HPV screening linked to subsequent identification and treatment of cervical precancer is more effective than Pap testing in reducing the incidence of cervical cancer and precancer, at the cost of lower specificity and more false-negative subsequent colposcopic assessments (Massad, 2018).” The author does address the limitations of the FOCAL study, including that the study concluded prior to seeing what effects, if any, women vaccinated against HPV 16 and HPV 18 would have since the adolescents vaccinated upon FDA approval of the vaccine would not have necessarily been included within the study. They also state that a limitation of the FOCAL trial is “the use of a pooled HPV test for screening, incorporating all carcinogenic HPV types in a single positive or negative result (Massad, 2018).”

State and Federal Regulations, as applicable
The FDA has approved the APTIMA HPV 16 18/45 Genotype Assay, a nucleic acid amplification test (NAAT), for the qualitative detection of mRNA for HPV 16, 18, and 45 from Gen-Probe Incorporated on 10/12/2012; however, this test cannot distinguish between 18 and 45. Previously, on 10/28/2012, the FDA approved Gen-Probe Incorporated’s APTIMA HPV Assay, an NAAT that tests for 14 high-risk types of HPV but is unable to distinguish between the 14 types. The COBAS HPV test by Roche Molecular Systems, Inc. was approved by the FDA on 04/19/2011 as a NAAT for 14 high-risk types of HPV. This test can specifically identify HPV 16 and 18 but cannot distinguish from the other 12 types of HPV. Hologic, Inc. has two FDA-approved HPV NAAT tests—Cervista HPV 16/18 and Cervista HPV HR and GENFIND DNA Extraction Kit. Both were approved on 03/12/2009. The former is a fluorescent, isothermal-based reaction that detects HPV 16 and 18 whereas the latter screens for DNA from the 14 high-risk HPV strains (FDA, 2018a). On 07/02/2018, the FDA released an approval order statement (P100020/S025) “for an expansion of the intended use for the FDA-approved cobas HPV Test to include cervical specimens collected in SurePath Preservative Fluid as a specimen type” (FDA, 2018b). This approval allows for the cobas HPV Test to be used as a first-line cervical cancer screening using the SurePath preservative, a medium often used for Pap tests (Rice, 2018). For more information regarding HPV, please refer to AHS-G2157 Diagnostic testing of STIs.

Additionally, many labs have developed specific tests that they must validate and perform in house. These laboratory-developed tests (LDTs) are regulated by the Centers for Medicare and Medicaid (CMS) as high-complexity tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88). As an LDT, the U. S. Food and Drug Administration has not approved or cleared this test; however, FDA clearance or approval is not currently required for clinical use.

Guidelines and Recommendations

2018 US Preventive Services Task Force (USPSTF, 2018)
The USPSTF updated their recommendations in 2018. The recommendations are outlined in the table below. The USPSTF did change the recommendation concerning women aged 30-65 to now include the possibility of high-risk HPV testing alone once every 5 years as a screening. They still allow the possibility of co-testing every 5 years or for Pap testing alone every 3 years.

Summary of Recommendations and Evidence (U.S. Preventive Service Task Force, (Moyer, 2012))
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<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women 21 to 29</td>
<td>Screen for cervical cancer every 3 years with cytology alone</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial. Offer or provide this service. Grade A</td>
</tr>
<tr>
<td>Women aged 30 to 65 years</td>
<td>Screen for cervical cancer every 3 years with cytology alone, every 5 years with hrHPV testing alone, or every 5 years with contesting.</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial. Offer or provide this service. Grade A</td>
</tr>
<tr>
<td>Women younger than 21</td>
<td>Do not screen for cervical cancer.</td>
<td>The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. Discourage the use of this service. Grade D</td>
</tr>
<tr>
<td>Women older than 65, who have had adequate prior screening</td>
<td>Do not screen for cervical cancer.</td>
<td>The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. Discourage the use of this service. Grade D</td>
</tr>
<tr>
<td>Women who have had a hysterectomy</td>
<td>Do not screen for cervical cancer.</td>
<td>The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benfits. Discourage the use of this service. Grade D</td>
</tr>
</tbody>
</table>

**Risk Assessment**

“All women aged 21 to 65 years are at risk for cervical cancer because of potential exposure to high-risk HPV types (hrHPV) through sexual intercourse and should be screened. Certain risk factors further increase risk for cervical cancer, including HIV infection, a compromised immune system, in utero exposure to diethylstilbestrol, and previous treatment of a high-grade precancerous lesion or cervical cancer. Women with these risk factors should receive individualized follow-up.”

**Screening Test**

“Screening with cervical cytology alone, primary testing for hrHPV alone, or both at the same time (cotesting) can detect high-grade precancerous cervical lesions and cervical cancer. Clinicians should focus on ensuring that women receive adequate screening, appropriate evaluation of abnormal results, and indicated treatment, regardless of which screening strategy is used.”

**Treatments and Interventions**

“High-grade cervical lesions may be treated with excisional and ablative therapies. Early-stage cervical cancer may be treated.”

2017 US Preventive Services Task Force (Bibbins-Domingo et al., 2017)

In 2017, “The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of performing screening pelvic examinations in asymptomatic, nonpregnant adult women. (I statement) This statement does not apply to specific disorders for which the USPSTF already recommends screening (ie, screening for cervical cancer with a Papanicolaou smear, screening for gonorrhea and chlamydia).”

2018 National Comprehensive Cancer Network (NCCN, 2018):
Concerning cervical cancer, the NCCN states, “Persistent human papillomavirus (HPV) infection is the most important factor in the development of cervical cancer. The incidence of cervical cancer appears to be related to the prevalence of HPV in the population…. Screening methods using HPV testing may increase detection of adenocarcinoma.” The NCCN lists chronic, persistent HPV infection along with persistently abnormal Pap tests as criteria to be considered for women contemplating hysterectomy.

**2018 National Cancer Institute (NCI, 2018)**

Concerning the use of Pap testing in screening, the NCI recommends: “Based on solid evidence, regular screening of appropriate women for cervical cancer with the Pap test reduces mortality from cervical cancer. The benefits of screening women younger than 21 years are small because of the low prevalence of lesions that will progress to invasive cancer. Screening is not beneficial in women older than 65 years if they have had a recent history of negative test results… Based on solid evidence, regular screening with the Pap test leads to additional diagnostic procedures (e.g., colposcopy) and treatment for low-grade squamous intraepithelial lesions (LSILs), with long-term consequences for fertility and pregnancy. These harms are greatest for younger women, who have a higher prevalence of LSILs, lesions that often regress without treatment. Harms are also increased in younger women because they have a higher rate of false-positive results.”

Concerning the use of HPV DNA testing, the NCI states: “Based on solid evidence, screening with the HPV DNA or HPV RNA test detects high-grade cervical dysplasia, a precursor lesion for cervical cancer. Additional clinical trials show that HPV testing is superior to other cervical cancer screening strategies. In April 2014, the U.S. Food and Drug Administration approved an HPV DNA test that can be used alone for the primary screening of cervical cancer risk in women aged 25 years and older… Based on solid evidence, HPV testing identifies numerous infections that will not lead to cervical dysplasia or cervical cancer. This is especially true in women younger than 30 years, in whom rates of HPV infection may be higher.”

Concerning co-testing, they recommend: “Based on solid evidence, screening every 5 years with the Pap test and the HPV DNA test (cotesting) in women aged 30 years and older is more sensitive in detecting cervical abnormalities, compared with the Pap test alone. Screening with the Pap test and HPV DNA test reduces the incidence of cervical cancer… Based on solid evidence, HPV and Pap cotesting is associated with more false-positives than is the Pap test alone. Abnormal test results can lead to more frequent testing and invasive diagnostic procedures.”

**2017 Choosing Wisely (ASCCP, 2017)**

The ASCCP recommends: “Don’t perform cervical cytology (Pap tests) or HPV screening in immunocompetent women under age 21. Cervical cancer is rare in adolescents and screening does not appear to lower that risk. Screening adolescents for cervical cancer exposes them to the potential harms of tests, biopsies, and procedures, without proven benefit.”

**2015 Society of Gynecologic Oncology, American Society for Colposcopy and Cervical Pathology, American College of Obstetricians and Gynecologists, American Cancer Society, American Society of Cytopathology, College of American Pathologists, and the American Society for Clinical Pathology (Huh et al., 2015)**

Since the 2011 joint guidelines issued by ACS, ASCCP, and ASCP concerning cervical cancer screening, additional reports concerning the use of primary hrHPV testing so that representatives from the Society of Gynecologic Oncology, American Society for Colposcopy and Cervical Pathology, American College of Obstetricians and Gynecologists, American Cancer Society, American Society of Cytopathology, College of American Pathologists, and the American Society for Clinical Pathology convened to issue interim clinical guidance in 2015. In the 2011 statement, primary hrHPV testing was not recommended. The 2015 recommendations include:

- “Because of equivalent or superior effectiveness, primary hrHPV screening can be considered as an alternative to current US cytology-based cervical cancer screening methods. Cytology alone and cotesting remain the screening options specifically recommended in major guidelines.”
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- “A negative hrHPV test provides greater reassurance of low CIN3+ risk than a negative cytology result.”
- “Rescreening after a negative primary hrHPV screen should occur no sooner than every 3 years.”
- “Primary hrHPV screening should not be initiated prior to 25 years of age.”

They give the following algorithm concerning screening (Huh et al., 2015):

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**FIGURE 1.** Recommended primary HPV screening algorithm. HPV, human papillomavirus; hrHPV, high risk human papillomavirus; ASC-UCS, atypical squamous cells of undetermined significance; NILM, negative for intraepithelial lesion or malignancy.

2016 American College of Obstetricians and Gynecologists (ACOG) (Chelmow & ACOG, 2016)

In Practice Bulletin #168, ACOG updated their recommendations concerning cervical cancer screening based on new studies. The table below outlines their recommendation concerning screening
ACOG does state that women who immunocompromised, including those who are HIV-positive, should start screening younger than age 21. Even though in their table, they do not recommend screening by HPV testing alone, they include the following noted caveat: “*After the Joint Recommendations were published, a test for screening with HPV testing alone was approved by the U.S. Food and Drug Administration. Gynecologic care providers using this test should follow the interim guidance developed by the American Society for Colposcopy and Cervical Pathology and the Society for Gynecologic Oncology (Huh WK, Ault KA, Chelmow D, Davey DD, Goulart RA, Garcia FA, et al. Use of primary high-risk human papillomavirus testing for cervical cancer screening: interim clinical guidance. Obstet Gynecol 2015;125:330–7.) (Chelmow & ACOG, 2016).*”

The following table outlines the ACOG recommendation concerning the management of cervical cancer screening (Chelmow & ACOG, 2016):

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommended Screening Method</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women younger than 21 years</td>
<td>No screening</td>
<td></td>
</tr>
<tr>
<td>Women aged 21–29 years</td>
<td>Cytology alone every 3 years</td>
<td></td>
</tr>
<tr>
<td>Women aged 30–65 years</td>
<td>Human papillomavirus and cytology cotesting</td>
<td>Screening by HPV testing alone is not recommended*</td>
</tr>
<tr>
<td></td>
<td>(preferred) every 5 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cytology alone (acceptable) every 3 years</td>
<td></td>
</tr>
<tr>
<td>Women older than 65 years</td>
<td>No screening is necessary after adequate negative prior</td>
<td>Women with a history of CIN 2, CIN 3, or adenocarcinoma in situ should</td>
</tr>
<tr>
<td></td>
<td>screening results</td>
<td>continue routine age-based screening for a total of 20 years after</td>
</tr>
<tr>
<td></td>
<td></td>
<td>spontaneous regression or appropriate management of CIN 2, CIN 3, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>adenocarcinoma in situ</td>
</tr>
<tr>
<td>Women who underwent total</td>
<td>No screening is necessary</td>
<td>Applies to women without a cervix and without a history of CIN 2, CIN 3,</td>
</tr>
<tr>
<td>hysterectomy</td>
<td></td>
<td>adenocarcinoma in situ or cancer in the past 20 years</td>
</tr>
<tr>
<td>Women vaccinated against HPV</td>
<td>Follow age-specific recommendations (same as unvaccinated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>women)</td>
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</tbody>
</table>

Abbreviations: CIN, cervical intraepithelial neoplasia; HPV, human papillomavirus.

*After the Joint Recommendations were published, a test for screening with HPV testing alone was approved by the U.S. Food and Drug Administration. Gynecologic care providers using this test should follow the interim guidance developed by the American Society for Colposcopy and Cervical Pathology and the Society for Gynecologic Oncology (Huh WK, Ault KA, Chelmow D, Davey DD, Goulart RA, Garcia FA, et al. Use of primary high-risk human papillomavirus testing for cervical cancer screening: interim clinical guidance. Obstet Gynecol 2015;125:330–7.) (Chelmow & ACOG, 2016).*
Billing/Coding/Physician Documentation Information (ADD LIST OF CODES)

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: 0500T, 87623, 87624, 87625, 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175, G0476, G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3001, Q0091

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources


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Policy Implementation/Update Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/19</td>
<td>New policy developed. BCBSNC will provide coverage for cervical cancer testing when it is determined to be medically necessary because the medical criteria and guidelines are met. Medical Director review 1/1/2019. Policy noticed 1/1/2019 for effective date 4/1/2019. (an)</td>
</tr>
<tr>
<td>10/29/19</td>
<td>Reviewed by Avalon Q3 CAB. No change to policy intent. Wording in the Policy, When Covered, and/or Not Covered section(s) changed from Medical Necessity to Reimbursement language, where needed. (gm)</td>
</tr>
<tr>
<td>12/10/19</td>
<td>Coding Section updated to reflect new and deleted codes per Avalon Q3 CAB. No change to policy intent. (eel)</td>
</tr>
<tr>
<td>03/31/20</td>
<td>Specialty Matched Consultant Advisory Panel 3/18/2020. No change to policy statement. (eel)</td>
</tr>
</tbody>
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