MEDICAL POLICY – 5.01.10

Immune Prophylaxis for Respiratory Syncytial Virus

Effective Date: Oct. 1, 2017
Last Revised: Sept. 21, 2017
Replaces: 5.01.504
RELAT ED MEDICAL POLICIES: None

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | CODING | RELATED INFORMATION
EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Respiratory syncytial virus (RSV) is the most common cause of bronchiolitis and pneumonia in children. Very young children who were born too early (prematurity) or have chronic lung disease (CLD) of prematurity, congenital heart disease, or immune problems are at highest risk to get pneumonia. Providing a regular infusion of antibodies against the RSV virus during RSV season may decrease lung infections and hospital stays. This policy outlines when the Plan covers these infusions, based on guidelines of the American Academy of Pediatrics.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synagis® (palivizumab)</td>
<td>Monthly administration of immune prophylaxis for respiratory syncytial virus (RSV) with palivizumab during the RSV season may be considered medically necessary in the following infants</td>
</tr>
</tbody>
</table>
and children in accordance with current (2014) guidelines from the American Academy of Pediatrics:

- In the first year of life, ie, younger than 12 months at the start of the RSV season or born during the RSV season, for the following:
  - Infants born before 29 weeks, 0 days of gestation
  - Preterm infants with chronic lung disease (CLD) of prematurity, defined as birth at less than 32 weeks, 0 days of gestation and a requirement for more than 21% oxygen for at least the first 28 days after birth
  - Certain infants with hemodynamically significant heart disease (eg, infants with acyanotic heart disease who are receiving medication to control congestive heart failure and will require cardiac surgical procedures; infants with moderate to severe pulmonary hypertension; infants with lesions adequately corrected by surgery who continue to require medication for heart failure)
    - Decisions regarding palivizumab prophylaxis for infants with cyanotic heart defects in the first year of life may be made in consultation with a pediatric cardiologist
  - Children with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways (eg, ineffective cough, recurrent gastroesophageal tract reflux, pulmonary malformations, tracheoesophageal fistula, upper airway conditions, or conditions requiring tracheostomy)
  - Children with cystic fibrosis who have at least one of the following conditions:
    - Clinical evidence of CLD
    - Nutritional compromise

- In the second year of life, ie, younger than 24 months at the start of the RSV season:
  - Children who were born at less than 32 weeks, 0 days of gestation and required at least 28 days of supplemental oxygen after birth and who continue to require medical intervention (supplemental oxygen, chronic corticosteroid,
<table>
<thead>
<tr>
<th>Drug</th>
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<td></td>
<td>or diuretic therapy) during the 6-month period before the start of the second RSV season</td>
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<td>o Children with cystic fibrosis who have either:</td>
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<td>▪ Manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable)</td>
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<td>OR</td>
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<td>▪ Weight for length less than the 10th percentile</td>
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<td>• In the first or second year of life:</td>
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<td></td>
<td>o Children who will be profoundly immunocompromised (eg, will undergo solid organ or hematopoietic cell transplantation or receive chemotherapy) during the RSV season</td>
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<td></td>
<td>• After surgical procedures that use cardiopulmonary bypass, for children who still require prophylaxis, a postoperative dose of palivizumab may be considered medically necessary after cardiac bypass or at the conclusion of extracorporeal membrane oxygenation (ECMO) for infants and children younger than 24 months.</td>
</tr>
</tbody>
</table>

**Immune prophylaxis for RSV with Synagis® (palivizumab) is considered not medically necessary in:**

- Infants and children with hemodynamically insignificant heart disease (eg, secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)  
  OR  
- Infants with lesions adequately corrected by surgery, unless they continue to require medication for heart failure  
  OR  
- Infants with mild cardiomyopathy who are not receiving medical therapy for the condition  
  OR  
- Children with congenital heart disease in the second year of life
Drug Investigational

Synagis® (palivizumab) Other indications for immune prophylaxis for RSV are considered investigational, including but not limited to:
- Controlling outbreaks of health care-associated disease (nosocomial infection)
  OR
- Use in children with Cystic Fibrosis (CF)
  OR
- Use in children with Down syndrome
  OR
- Use in children over 2 years of age, unless criteria for medical necessity (outlined above) are satisfied.

Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>CPT</td>
<td></td>
</tr>
<tr>
<td>90378</td>
<td>Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each</td>
</tr>
</tbody>
</table>

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Related Information

Dosing and Administration

Synagis® (palivizumab) is administered by intramuscular (IM) injection in a dose of 15 mg/kg of body weight per month. The anterolateral aspect of the thigh is the preferred injection site. Routine use of the gluteal muscle for the injection site can cause sciatic nerve damage.

Clinicians may administer up to a maximum of 5 monthly doses of palivizumab (15 mg/kg per dose) during the RSV season to infants who qualify for prophylaxis. Qualifying infants born during the RSV season will require fewer doses. For example, infants born in January would
receive their last dose in March (see Initiation and Termination of Immunoprophylaxis subsection below). (American Academy of Pediatrics [AAP], 2015)

Hospitalized infants who qualify for prophylaxis during the RSV season should receive the first dose of palivizumab 48 to 72 hours before discharge or promptly after discharge.

**Breakthrough RSV**

If any infant or young child receiving monthly palivizumab prophylaxis experiences a breakthrough RSV hospitalization, monthly prophylaxis should be discontinued because of the extremely low likelihood of a second RSV hospitalization in the same season (<0.5%). (AAP 2015)

**Prevention of Health Care-Associated RSV Disease**

RSV is known to be transmitted in the hospital setting and to cause serious disease in high-risk infants. Among hospitalized infants, the best way to reduce RSV transmission is to strictly observe common infection control practices. This includes restriction of visitors to the neonatal intensive care unit during respiratory virus season, and to promptly initiate all standard-set precautions when coming into contact with RSV-infected infants. If an RSV outbreak occurs in a high-risk unit (e.g., pediatric or neonatal intensive care unit or stem cell transplantation unit), primary emphasis should be placed on proper infection control practices, especially hand hygiene. No data exist to support palivizumab use in controlling outbreaks of health care-associated disease, and palivizumab use is not recommended for this purpose.

**Interactions**

Palivizumab does not interfere with response to vaccines.

Palivizumab may interfere with RSV diagnostic tests that are immunologically based (e.g., some antigen detection-based assays).
Risk Minimization Techniques

Infants, especially high-risk infants, should never be exposed to tobacco smoke. In published studies, passive household exposure to tobacco smoke has not been associated with an increased risk of RSV hospitalization on a consistent basis. However, exposure to tobacco smoke is a known risk factor for many adverse health-related outcomes. Exposure to tobacco smoke can be controlled by the family of an infant at increased risk of RSV disease, and preventive measures will be less costly than palivizumab prophylaxis.

For all infants, particularly those who are preterm, the environment should be optimized to prevent RSV and other viral respiratory infections by doing the following: offering breast milk feeds, immunizing household contacts with influenza vaccine, practicing hand and cough hygiene, avoiding tobacco or other smoke exposure, and by not attending large group child care during the first winter season, whenever possible (AAP Technical Report, 2014).

Initiation and Termination of Immunoprophylaxis

Initiation of immunoprophylaxis in November and continuation for a total of 5 monthly doses will provide protection into April and is recommended for most areas of the United States. If prophylaxis is initiated in October, the fifth and final dose should be administered in February.

In the temperate climates of North America, peak RSV activity typically occurs between November and March, whereas in equatorial countries, RSV seasonality patterns vary and may occur throughout the year. The annual occurrence of the RSV season is predictable, but the severity, time of onset, peak activity, and end of the season cannot be predicted precisely. Substantial variation in timing of community outbreaks of RSV disease from year to year exists in the same community and between communities in the same year, even in the same region. These variations occur within the overall pattern of RSV outbreaks, usually beginning in November or December, peaking in January or February, and ending by late March or sometime in April. Communities in the southern United States, particularly in Florida, tend to experience the earliest onset of RSV activity. In recent years, the national duration of the RSV season has been 21 weeks (MMWR, 2013).

Results from clinical trials indicate that palivizumab trough serum concentrations more than 30 days after the fifth dose will be well above the protective concentration for most infants. Five monthly doses of palivizumab will provide more than 20 weeks of protective serum antibody concentration. In the continental United States, a total of 5 monthly doses for infants and young children with congenital heart disease, chronic lung disease of prematurity, or preterm birth
before 32 weeks of gestation (31 weeks, 6 days) will provide an optimal balance of benefit and cost, even with variation in season onset and end.

Data from the Centers for Disease Control and Prevention have identified variations in the onset and offset of the RSV season in different areas of Florida that should affect the timing of palivizumab administration. Northwest Florida has an onset in mid-November, which is consistent with other areas of the United States. In North Central and Southwest Florida, the onset of RSV season typically is late September to early October. The RSV season in Southeast Florida (Miami-Dade County) typically has its onset in July. Despite varied onsets, the RSV season is of equal duration in the different regions of Florida. Children who receive palivizumab prophylaxis for the entire RSV season should receive palivizumab only during the 5 months after the onset of RSV season in their region (maximum of 5 doses).

Evidence Review

Description

Respiratory syncytial virus (RSV) is the most common cause of lower respiratory tract infections in children. There are a few factors that put certain children at a higher risk for contracting RSV. These factors are: age (<2 years old), prematurity, chronic lung disease of prematurity (formerly known as bronchopulmonary dysplasia), congenital heart disease, immunodeficiencies, and multiple congenital anomalies. Immune prophylaxis against RSV is a preventive strategy to reduce the incidence of infection and its associated morbidity, including hospitalization, in high-risk infants.

Background

Respiratory syncytial virus (RSV) infections typically occur in the winter months, starting from late October to mid-January and ending from March to May. Considerable variation in the timing of community outbreaks is observed year to year. According to U.S. Centers for Disease Control and Prevention, onset of the RSV season occurs when the median percentage of specimens testing positive for RSV is 10% higher over a 2-week period. During 1997 to 2006, an estimated 132,000 to 172,000 children younger than 5 years were hospitalized for RSV infection annually in the United States. While RSV is a near-ubiquitous infection, infants with underlying
medical issues, especially a history of prematurity with associated lung problems, are at risk of developing serious complications from bronchiolitis secondary to RSV.

Chronic lung disease (CLD) of prematurity (formerly known as bronchopulmonary dysplasia) is a general term for long-term respiratory problems in premature infants. CLD results from lung injury to newborns that consequently must use a mechanical ventilator and supplemental oxygen for breathing. With injury, lung tissues become inflamed and scarring can result. Causes of lung injury include the following: prematurity, low amounts of surfactant, oxygen use, and mechanical ventilation. Risk factors for developing CLD include birth at less than 34 weeks of gestation; birth weight less than 2000 grams (4 pounds, 6.5 ounces); hyaline membrane disease; pulmonary interstitial emphysema; patent ductus arteriosus; Caucasian race; male sex; maternal womb infection (chorioamnionitis); and family history of asthma.

Palivizumab (Synagis) is a humanized monoclonal antibody made through recombinant DNA technology, which is directed against a site on the A antigenic site of the F protein of RSV. It was originally approved by the U.S. Food and Drug Administration for RSV prevention in 1998.

Other RSV preventive agents, including vaccines, have been under development. A recombinant RSV fusion protein nanoparticle vaccine has been shown to induce an immune response in a phase 2 trial.

Summary of Evidence

For individuals who have high-risk indications for RSV in infancy who receive immune prophylaxis for RSV, the evidence includes several randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are overall survival, symptoms, morbid events, and hospitalizations. Evidence from systematic reviews of RCTs has demonstrated that RSV prophylaxis with palivizumab is associated with reductions in RSV-related hospitalizations and intensive care unit stays. A subsequent RCT suggested that palivizumab is also associated with reductions in wheezing episodes. The evidence is sufficient to determine quantitatively that the technology results in a meaningful improvement in the net health outcome.

For individuals with cystic fibrosis without other risk factors for RSV in infancy who receive immune prophylaxis for RSV, the evidence includes an RCT, several prospective and retrospective cohort studies, and multiple systematic reviews. Relevant outcomes are overall survival, symptoms, morbid events, and hospitalizations. Although some studies have demonstrated reductions in hospitalizations in palivizumab-treated patients, studies that used contemporaneous controls did not demonstrate reductions in hospitalizations. In the available RCT, rates of adverse events were high in both the palivizumab and the placebo groups, making
it difficult to draw conclusions about the net benefit of palivizumab. A more recent nonrandomized study using noncontemporaneous controls found fewer RSV infections in palivizumab-treated patients with cystic fibrosis. Additional studies are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with immunodeficiencies without other risk factors for RSV in infancy who receive immune prophylaxis for RSV, the evidence includes case series. Relevant outcomes are overall survival, symptoms, morbid events, and hospitalizations. Descriptive findings from a consensus panel and case reports of 2 infants with primary immunodeficiencies and 2 infants with acquired immunodeficiencies in whom palivizumab was used with good compliance and efficacy have been reported in the literature. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with Down syndrome without other risk factors for RSV in infancy who receive immune prophylaxis for RSV, the evidence includes a prospective cohort study. Relevant outcomes are overall survival, symptoms, morbid events, and hospitalizations. The available cohort study reported reduced rates of RSV-related hospitalization in treated patients but had methodologic limitations, including the use of a noncontemporaneous comparative cohort from a different country. These methodological problems limited the conclusions that can be drawn. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Ongoing and Unpublished Clinical Trials**

A search of ClinicalTrials.gov in July 2017 did not identify any ongoing or unpublished trials that would likely influence this review.

**Clinical Input from Physician Specialty Societies and Academic Medical Centers**

While the various physician specialty societies and academic medical centers may provide appropriate reviewers who collaborate with and make recommendations during this process, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received through 3 physician specialty societies (7 responders) while this policy was under review in 2009. Most providing input agreed with the
policy statements approved in October 2009; these statements concur with the 2009 American Academy of Pediatrics guidelines.

Practice Guidelines and Position Statements

American Academy of Pediatrics (AAP)

The 2014 American Academy of Pediatrics (AAP) guidelines for use of palivizumab in high-risk infants recommended:

Palivizumab, a monoclonal antibody given in a series of doses during the RSV season, has been shown to have a limited effect on reducing RSV hospitalizations. Studies show it does not reduce mortality from RSV or lower rates of subsequent wheezing or asthma. Overall advances in neonatal care since palivizumab was first licensed in 1998 mean preterm infants are generally healthier, and the rate of RSV hospitalizations has declined, regardless of whether or not infants receive palivizumab prophylaxis. Evidence of these falling rates of RSV hospitalizations, along with new data about which children are at highest risk of RSV hospitalization, guided the AAP recommendation that palivizumab prophylaxis be limited to infants born before 29 weeks gestation, and to infants with certain chronic illnesses like congenital heart disease or chronic lung disease. For all infants, particularly those born at preterm, the AAP emphasizes that it’s important to minimize the risk of infection with RSV and other viruses by offering breast milk, immunizing members of the household against influenza, practicing good hand and cough hygiene, avoiding smoke exposure, limiting attendance in large group child care during the first winter season whenever possible, and avoiding contact with anyone who is ill.

In 2014, AAP also published clinical guidelines on the diagnosis, management, and prevention of bronchiolitis (updating 2006 guidelines), and made the following recommendations about the use of palivizumab for RSV prevention (see Table 1):

Table 1. Guideline on the Diagnosis, Management, and Prevention of Bronchiolitis

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>QOE</th>
<th>SOR</th>
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<tbody>
<tr>
<td>&quot;Clinicians should not administer palivizumab to otherwise healthy&quot;</td>
<td>B</td>
<td>Strong</td>
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</table>
**Recommendation**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>QOE</th>
<th>SOR</th>
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<tbody>
<tr>
<td>infants with a gestational age of 29 weeks, 0 days or greater.”</td>
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<tr>
<td>“Clinicians should administer palivizumab during the first year of life to</td>
<td>B</td>
<td>Moderate</td>
</tr>
<tr>
<td>infants with hemodynamically significant heart disease or chronic lung disease</td>
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<tr>
<td>of prematurity defined as preterm infants &lt;32 weeks 0 days’ gestation who</td>
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<td>require &gt;21% oxygen for at least the first 28 days of life.”</td>
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<tr>
<td>“Clinicians should administer a maximum 5 monthly doses (15 mg/kg/dose) of</td>
<td>B</td>
<td>Moderate</td>
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<tr>
<td>palivizumab during the respiratory syncytial virus season to infants who</td>
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<tr>
<td>qualify for palivizumab in the first year of life.”</td>
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</table>

QOE: Quality of Evidence  
SOR: Strength of Recommendation

**Medicare National Coverage**

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

**Regulatory Status**

In June 1998, the biologic drug palivizumab (Synagis®; MedImmune, Gaithersburg, MA) was approved for marketing by FDA through a biologics license application (BLA) for use in the prevention of serious lower respiratory tract disease caused by RSV in pediatric patients at high risk of RSV disease. In 2004, FDA approved a liquid formulation of Synagis®, supplied as a sterile solution ready for injection, thus providing improved convenience for administration. This formulation is used in the physician office or home setting. There are no therapeutic equivalents to this drug. FDA application number: (BLA) 103770.

**References**


<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/01/99</td>
<td>Add to Prescription Drug Section - New Policy</td>
</tr>
<tr>
<td>11/02/99</td>
<td>Replace policy - Policy reviewed and updated.</td>
</tr>
<tr>
<td>09/21/00</td>
<td>Replace policy - Policy reviewed and updated.</td>
</tr>
<tr>
<td>07/01/02</td>
<td>Replace policy - Policy language revised pertaining to dates of RSV season, making it generic. No criteria changes for prophylactic administration.</td>
</tr>
<tr>
<td>06/17/03</td>
<td>Replace policy - Policy reviewed; no changes required.</td>
</tr>
<tr>
<td>11/16/03</td>
<td>Replace policy - Policy updated with revised recommendations for the use of palivizumab (Synagis) in infants of 32–35 weeks gestational age</td>
</tr>
<tr>
<td>01/13/04</td>
<td>Replace policy - Policy changed from PR to BC. Policy updated; added indication for infants with hemodynamically significant heart disease and for those born between 32-35 weeks gestation with additional high-risk factors. Policy based on AAP guidelines. Policy held for notification, effective 4/15/04.</td>
</tr>
<tr>
<td>03/08/05</td>
<td>Replace policy - Policy reviewed; references added; RSV immune prophylaxis in stem cell transplantation added to the investigational policy statement.</td>
</tr>
<tr>
<td>01/10/06</td>
<td>Replace policy - Policy reviewed with literature search; no change to policy statement. Information added regarding new liquid formulation of Synagis to policy guidelines.</td>
</tr>
<tr>
<td>02/06/06</td>
<td>Codes updated - No other changes.</td>
</tr>
<tr>
<td>06/16/06</td>
<td>Update Scope and Disclaimer - No other changes.</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
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<td>---------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>11/13/07</td>
<td>Replace policy - Policy reviewed with literature search; no change to policy statement.</td>
</tr>
<tr>
<td>12/16/08</td>
<td>Minor Update - Policy statement clarified regarding definition of weeks of gestation.</td>
</tr>
<tr>
<td>10/13/09</td>
<td>Replace policy - Policy updated with literature search. The policy statement has been modified to reflect the 2009 AAP. References added.</td>
</tr>
<tr>
<td>11/10/09</td>
<td>Minor Update - Minor update was made to number 4 in the policy statement: &quot;infants born before 35 wks of gestation&quot; was deleted and &quot;Infants less than one year of age&quot; was added.</td>
</tr>
<tr>
<td>12/14/10</td>
<td>Replace policy - Policy updated with literature search. References 15 and 16 added. Policy statements unchanged. Reviewed by a practicing pediatrician.</td>
</tr>
<tr>
<td>12/29/10</td>
<td>Codes Updated - Code 90378 added; no other changes.</td>
</tr>
<tr>
<td>12/16/11</td>
<td>Replace policy – Policy updated with literature search. Policy statement number 4 modified with removal of &quot;born before 35 weeks of gestation&quot; to be consistent with the AAP guidelines. Other policy statements are unchanged. Codes updated: CPT codes 96365, 96366 and 963372; ICD-10 codes added.</td>
</tr>
<tr>
<td>10/14/13</td>
<td>Replace policy. Policy updated with literature search through June 18, 2013. References 3 and 6 added; references 1, 10 and 15 updated. Policy statements unchanged. CPT code 90772, 96365, 96366 and 96372, along with ICD-9 Procedure Code 99.29, removed from policy; these are not reviewed due to the dollar amount charged.</td>
</tr>
<tr>
<td>09/08/14</td>
<td>Annual Review. Policy updated with literature review through July, 2014. References 1-2, 16-17, 20-22, 25, 27-28, 30, 32 added; reference 31 updated; others renumbered/removed. Policy statements revised to reflect the 2014 updated guidance from AAP. Coding update: ICD-9 and ICD-10 codes removed; these do not facilitate administration of the policy.</td>
</tr>
<tr>
<td>11/10/15</td>
<td>Annual Review. Immune prophylaxis in children over 2 years old was added to the Investigational policy statement. Policy updated with literature review through September 8, 2015; references 2, 7, 10, 33-34 added. Policy statement updated as noted.</td>
</tr>
<tr>
<td>11/01/16</td>
<td>Interim Review, approved October 11, 2016. Supportive language added to address age application criteria in compliance with non-discrimination act.</td>
</tr>
<tr>
<td>03/07/17</td>
<td>Minor formatting update; separated investigational and medically necessary indications.</td>
</tr>
<tr>
<td>10/01/17</td>
<td>Annual Review, approved September 21, 2017. Policy updated with literature review through June 22, 2017; references 2, 9, 16, 19, and 22-24 added. Policy statements</td>
</tr>
</tbody>
</table>
Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2017 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
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  • Written information in other formats (large print, audio, accessible electronic formats, other formats)
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  • Qualified interpreters
  • Information written in other languages

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Toll free 855-332-4535, Fax 425-918-5592. TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

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Arabic (Arabic):
العربية


Français (French):

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan ladan. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravé Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kék aksyon avan sèt ten limit pou ka kenbe kouvèti asirans sante w la osa pou yo ka ede w avèk depans yo. Se dwa w pou resewva enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rate nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):

Hmoob (Hmong):

Iloko (Ilocano):
Daytoy a Pakdaak ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaak mabalbin nga adda ket naglaon iti napateg nga impormasion maipanggip iti aplikasyonowo yeno coverage babaen iti Premera Blue Cross. Daytoy ket mabalbin dagiti importante a pelta iti daytoy a pakdaak. Mabalbin nga adda rumbang nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalaidayo ti coverage ti salun-ayo yeno tulong kadagiti gastos. Adda karbenganyo a maganga iti daytoy nga impormasion ken tulong iti bukodyo a pagasasao nga awan ti bayadanyo. Tumawag ti numero nga osa 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):