Vectra® DA Blood Test for Rheumatoid Arthritis

Policy Number: 2.04.119  
Origination: 4/2016  
Last Review: 4/2017  
Next Review: 4/2018

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will not provide coverage for Vectra® DA Blood Test for Rheumatoid Arthritis. This is considered investigational.

When Policy Topic is covered
n/a

When Policy Topic is not covered
The use of a multi-biomarker disease activity score for rheumatoid arthritis (RA) (eg, Vectra DA score) is considered investigational in all situations.

Considerations
Effective January 1, 2016, there will be a specific CPT code for this test: 81490 Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic algorithm reported as a disease activity score.

Prior to January 1, 2016, there was not a specific CPT code for this test.

For Medicare, the Palmetto GBA website instructed that the test be submitted with the unlisted chemistry code 84999 and the MolDX code ZBC85 in the comment/narrative field.

It has been reported that for other payers, it might be submitted using 11 units of code 83520 (Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified) and 1 unit of 86140 (C-reactive protein).

Description of Procedure or Service

<table>
<thead>
<tr>
<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals:</td>
<td>Interventions of interest are:</td>
<td>Comparators of interest are:</td>
<td>Relevant outcomes include:</td>
</tr>
<tr>
<td>• With rheumatoid</td>
<td>• Vectra DA test</td>
<td>• Alternative disease activity measures</td>
<td>• Test accuracy</td>
</tr>
<tr>
<td>arthritis</td>
<td></td>
<td></td>
<td>• Test validity</td>
</tr>
</tbody>
</table>


Assessment of disease activity in rheumatoid arthritis (RA) is an important component of management, because a main goal of treatment is to maintain low disease activity or remission. There are a variety of available instruments for measuring RA disease activity. They use combinations of physical exam findings, radiologic results, and serum biomarkers to construct a disease activity score. A multi-biomarker disease activity (MBDA) instrument is a disease activity measure that is comprised entirely of serum biomarkers. The Vectra DA test is a commercially available MBDA blood test that uses 12 biomarkers to construct a disease activity score ranging from 0 (low) to 100 (high).

For individuals who have RA who are evaluated with the Vectra DA test, the evidence includes post hoc analyses of randomized controlled trials and prospective cohort studies. Relevant outcomes are test accuracy and validity, other test performance measures, symptoms, change in disease status, functional outcomes, and quality of life. Evidence from the available studies correlates Vectra DA with disease progression, response to therapy, and/or other previously validated disease activity measures such as the Disease Activity Score with 28 joints (DAS28). These studies have established that the Vectra DA score is a predictor of disease progression and that decreases in the score correlate with disease response. They have also shown moderate correlations between Vectra and the DAS28. A smaller number of studies have evaluated clinical utility by examining changes in decision making associated with use of Vectra, but these studies are limited by the design because they used simulated cases or physician surveys and did not report any outcomes data. This body of evidence on the Vectra DA test is insufficient to determine whether it is as good as or better than other disease activity measures, and it is uncertain whether it is as accurate as the DAS28. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Background**

RA is a disorder characterized by chronic joint inflammation leading to painful symptoms, progressive joint destruction and loss of function. The disorder is relatively common and is associated a high burden of morbidity for affected patients.

Treatment of RA has undergone a shift from symptom management to a more proactive strategy of minimizing disease activity and delaying disease progression. (1) The goal of treatment is to reduce irreversible joint damage that occurs from ongoing joint inflammation and synovitis by keeping disease activity as low as possible. The availability of an increasing number of effective disease-modifying antirheumatic drugs has made achievement of remission, or sustained
low disease activity, a feasible goal in a large proportion of patients with RA. This treatment strategy has been called a “tight control” approach.

The concept of “tight control” in the management of RA has gained wide acceptance as evidence from clinical trials have demonstrated that outcomes are improved with a tight control strategy. In a tight control strategy, treatment targets are used that are mainly based on measures of disease activity. In a systematic review published in 2010, Schoels et al identified 7 trials that evaluated the efficacy of tight control.(2) Four of these trials randomized patients to either a tight control using treatment targets or routine management. The treatment targets used were heterogeneous, including symptom-based measures, joint scores on exam, validated treatment activity measures, lab values, or combinations of these factors. In all four trials, there was a significant decrease in the Disease Activity Score (DAS) and in the likelihood of achieving remission for patients in the tight control group.

For a strategy of tight control to be successful, a reliable and valid measurement of disease activity is necessary. There are numerous disease activity measurements that can be used in clinical care. Composite measures include information from multiple sources, including patient self-report, physician examination and/or biomarker measurement. Composite measures are the most comprehensive but have the disadvantage of being more cumbersome and difficult to complete. Patient-reported measures are intended to be simpler, and rely only on information that patients can provide expeditiously, but have the disadvantage of being more subjective. Measurements that rely only on biomarkers are objective and do not require patient input but do involve the cost and inconvenience of laboratory tests.

The most widely used and validated in clinical research is the DAS28 score. This is a composite measure that includes examination of 28 joints for swelling and tenderness, combined with a patient report of disease activity and measurement of C-reactive protein (CRP) (or erythrocyte sedimentation rate). This score has been widely validated and used for both research and clinical care and is often considered the criterion standard for measuring disease activity. However, it requires a thorough joint examination, patient-reported symptoms, and laboratory testing. Therefore, there have been many attempts to create a valid disease activity measure that is simpler.

There is a fairly large body of evidence comparing the performance of different disease activity measures in clinical care, including a number of systematic reviews. In a systematic review of disease activity measures sponsored by the American College of Rheumatology in 2012, more than 60 measurement instruments were identified.(3) Through a 5-stage process that included review by an expert advisory panel in RA disease activity and detailed evaluation of psychometric properties, the work group selected 6 that were most useful and feasible for point-of-care clinical care. These were the Clinical Disease Activity Index (CDAI), DAS28, Patient Activity Scale (PAS), Patient Activity Scale II (PAS-
II), Routine Assessment of Patient Index (RAPI) data with 3 measures, and the SDAI.

In another systematic review, Gaujoux-Viala et al compared 4 composite indices, DAS, DAS28, SDAI, and CDAI.\(^{(4)}\) In general, the concordance between measures was good, with \(\rho\) values in the range of 0.7. An exception to this level of concordance was in the definition of remission, for which the DAS28 had lower levels of concordance with other measures, with \(\rho\) values ranging from 0.48 to 0.63. All of the measures had fair-to-good correlations with an independent health status measure, the Health Assessment Questionnaire and with radiologic examination of joint structural damage.

Salaffi et al compared the responsiveness of numerous disease activity measures, including patient self report measures and composite indices, over a 6-month period of treatment with disease modifying drugs.\(^{(5)}\) The composite indices evaluated were DAS28, SDAI, CDAI, and the Mean Overall Index for RA. The patient-reported measures evaluated were the Clinical Arthritis Index, the Rheumatoid Disease Activity Index, the Routine Assessment of Patient Index Data (RAPID3), and PAS. Across all measures, there was wide variability in internal responsiveness, with the highest value obtained for the DAS28 measure. There were some differences in responsiveness between the measures, but all were considered suitable for use in clinical care. When comparing the patient-reported measures with the composite measures, there was no difference in internal or external responsiveness.

**Vectra DA test**

The Vectra DA test (Crescendo Bioscience, South San Francisco, CA) consists of 12 individual biomarkers. These are\(^{(6)}\):

- Interleukin-6 (IL-6)
- Tumor necrosis factor receptor type I (TNFRI)
- Vascular cell adhesion molecule 1 (VCAM-1)
- Epidermal growth factor (EGF)
- Vascular endothelial growth factor A (VEGF-A)
- YKL-40
- Matrix metalloproteinase 1 (MMP-1)
- Matrix metalloproteinase 3 (MMP-3)
- CRP
- Serum amyloid A (SAA)
- Leptin
- Resistin

**Rationale**

This evidence review was developed in April 2014 and has been updated periodically with literature review of the MEDLINE database. The most recent update with literature review covers the period through April 26, 2016.
Multi-biomarker disease activity (MBDA) tests for disease activity in rheumatoid arthritis (RA) are best evaluated in the framework of a prognostic test, because such frameworks provide prognostic information that assists in treatment decisions. Assessment of a prognostic tool typically focuses on 3 categories of evidence: (1) technical performance; (2) clinical validity (ie, statistically significant association between the test result and health outcomes); and (3) clinical utility (ie, demonstration that use of the prognostic information clinically can alter clinical management and/or improve health outcomes compared with patient management without use of the prognostic tool). In some cases, it is important to evaluate whether the test provides incremental information above the standard workup to determine if the test has utility in clinical practice.

Technical Performance
Eastman et al described aspects of the technical performance of the Vectra DA MBDA test in 2012.(7) The 12 biomarkers in the Vectra DA test were measured using multiplexed sandwiched immunoassays with biomarker-specific-capture antibodies. The total MBDA score had good reproducibility over time, with a coefficient of variation of less than 2%. Cross-reactivity by serum rheumatoid factor, other RA antibodies, and/or common RA therapies, was minimal.

Centola et al published a study on the development of the Vectra DA test in 2013.(8) This publication described a multistage process for development and validation of the score. In the first phase, the screening phase, proteins were identified that could be readily measured and had the potential to be associated with RA disease activity. A comprehensive total of 130 candidate biomarkers were selected. In the second phase, 4 separate patient cohorts were used to refine the biomarkers based on their correlations with multiple measures of disease activity. In the final phase, assay optimization and training, the biomarkers with the greatest predictive ability were optimized for multiplex assay. In addition, the combined cohorts of patients were used for algorithm training using a number of statistical techniques. The final model included 12 individual biomarkers and an algorithm that generated a score between 0 (low) and 100 (high).

Clinical Validity
Evidence on clinical validity consists primarily of studies that correlate the Vectra DA score with other disease activity measures, markers of disease progression, and/or response to therapy. These are either observational cohort studies, or post hoc analyses of randomized controlled trials (RCTs). This review of evidence will include RCTs and prospective cohort studies.

Post Hoc Analyses of Completed RCTs
Post hoc analyses of at least 5 RCTs have evaluated the clinical validity of the Vectra DA score. These RCTs were conducted for different reasons and, therefore, have different patient populations and interventions.

BeST Trial
Two publications have reported on the evaluation of the Vectra DA score from the BeST trial, which was a multicenter RCT of 508 patients with early RA randomized
to 4 different treatment strategies. For both of these studies, a subset of patients who had serum samples available were included. Of the 508 patients, 125 patients had serum samples, 91 had baseline samples, 89 had 1-year follow-up samples, and 55 patients had both baseline and follow-up serum samples available.

Comparison of patients who had samples available and those who did not revealed that the population with serum samples differed from the population that did not on sex (75% vs 65% female, p=0.04), median number of tender joints (11 vs 14, p<0.001), and median number of erosions seen on imaging (1.0 vs 2.0, p=0.005).

In the first study, Hirata et al studied the correlation between the Vectra DA score and scores for other validated measures of disease activity.(9) Validated measures were the Disease Activity Score with 28 joints (DAS28), Simplified Disease Activity Index (SDAI), Clinical Disease Activity Index (CDAI), and the Health Assessment Questionnaire Disease Index (HAQ-DI). Vectra DA scores correlated significantly with DAS28 scores (Spearman ρ=0.66, p<0.001), as did the changes in scores between baseline and 1 year (Spearman ρ=0.55, p<0.001). Vectra DA scores correlated significantly with SDAI, CDAI, and HAQ-DI scores at the p<0.001 level. The second study, by Markusse et al, evaluated how well the Vectra DA score predicted the progression of radiographic joint damage and compared the predictive ability of the Vectra DA score with the DAS28 score.(10) Radiographic progression was defined as a change of at least 5 points on the Sharp/van der Heijde Score (SHS) over a 1-year period. Receiver operating characteristic analysis was performed, with an area under the curve (AUC) for the Vectra DA test of 0.77 (95% confidence interval [CI], 0.64 to 0.90), which was higher than the AUC for the DAS28 (0.52, 95% CI, 0.39 to 0.66).

**Computer-Assisted Management in Early Rheumatoid Arthritis Trial**

Bakker et al examined the correlation between MBDA (Vectra DA) scores and DAS28 scores plus response to therapy in a subset of patients from the Computer-Assisted Management in Early Rheumatoid Arthritis (CAMERA) trial.(11) In the larger CAMERA trial, 299 patients were randomized to standard or intensive management of RA. For the Bakker subset, 74 (24.7%) of 299 patients had blood drawn for measurement of 20 biomarkers, including the 12 comprising the MBDA test. Seventy-two samples were collected at baseline and 48 samples at 6 months. The total test score, between 0 and 100, was calculated using a proprietary algorithm.

The Vectra DA score correlated significantly with the DAS28 score at baseline (Pearson r=0.72, p<0.001). When using the DAS28 CRP (C-reactive protein) cutoff of 2.7 as the criterion standard, the MBDA score discriminated between remission/low disease activity and moderate/high disease activity with an AUC of 0.86. The κ score for agreement with the DAS28 CRP cutoff for classifying disease activity was 0.34 (95% CI, 0.19 to 0.49). The MBDA (SD) score decreased following therapy, from a baseline of 53 (18) to 39 (16) at 6 months.

**Swedish Farmacotherapy Trial**

Hambardzumyan et al performed a post hoc analysis from the Swedish Farmacotherapy (SWEFOT) trial, an RCT that randomized 487 patients to 2
treatment regimens. A total of 235 (48%) patients had serum samples available and complete clinical and radiographic data. The authors evaluated the Vectra DA score as a predictor of radiographic progression, defined as a change of at least 5 points on the SHS. The Vectra DA score was a univariate predictor of radiographic progression (odds ratio [OR], 1.05 per unit increase; 95% CI, 1.02 to 1.08; p<0.001), and was an independent predictor of progression in a variety of multivariate models. For patients with a low or moderate Vectra DA score (<44), radiographic progression was uncommon, occurring in 1 (2.5%) in 40 patients.

A second publication from the SWEFOT trial reported repeat scores at multiple time points. Of the 487 patients enrolled in the SWEFOT trial, 220 (45.2%) had baseline Vectra DA scores, 205 (42.1%) had scores at 3 months, and 133 (27.3%) had scores at 1 year. Patients with low initial scores, or with a decrease in scores over time into the low range, had the lowest rate of radiographic progression at 1 year. Cross-tabulation of Vectra DA results with the DAS28, erythrocyte sedimentation rate (ESR), and CRP values was presented, but no statistics that addressing the comparative accuracy of the different measures were reported.

**Abatacept Versus Adalimumab Comparison in Biologic-Naive RA Subjects With Background Methotrexate Trial**

The Abatacept Versus Adalimumab Comparison in Biologic-Naive RA Subjects With Background Methotrexate (AMPLE) trial randomized patients with active RA and an inadequate response to methotrexate, to abatacept or adalimumab and followed patients for 2 years. Eligibility criteria included a DAS28-CRP score of at least 3.2 and a positive test for antibodies to either cyclic citrullinated peptide (CCP) or rheumatoid factor. Vectra DA scores were analyzed from stored serum samples at baseline, 3 months, 1 year, and 2 years, and correlated with other measures of disease activity (DAS28-CRP, CDAI). A total of 646 patients enrolled and 524 (81%) had results for the Vectra DA test. The concordance of disease activity states was examined between the different measures. There was no high concordance of classification into high, moderate, and low disease categories, but quantitative measures of association were not reported. The Vectra DA score was not found to be a significant predictor of radiographic progression, while the CDAI score was a significant predictor.

**Reduction of Therapy in Patients With Rheumatoid Arthritis in Ongoing Remission Trial**

The Reduction of Therapy in Patients With Rheumatoid Arthritis in Ongoing Remission (RETRO) trial enrolled patients treated with disease-modifying antirheumatic drugs (DMARDs) in clinical remission, and randomized participants to tapering DMARD or standard maintenance care. Eligibility criteria included a DAS28 ESR cutoff score lower than 2.6 for at least 6 months and follow-up was for 12 months. Of 101 patients enrolled in RETRO, Vectra DA data were available for 94 (93%). Vectra DA scores were higher in patients experiencing a relapse (32.0) than in patients who did not (22.6; p=0.001). On multivariate analysis, the Vectra DA score was a significant predictor of relapse (OR=8.54; 95% CI, 2.0 to 36.4),...
along with treatment arm (OR=5.94; 95% CI, 1.3 to 26.7) and anti-CCP status (OR=24.5; 95% CI, 3.1 to 194.0).

**Prospective Cohort Studies**

Curtis et al used blood samples from 3 cohorts of arthritis patients (Index for Rheumatoid Arthritis Measurement, Brigham and Women’s Hospital Rheumatoid Arthritis Sequential Study, Leiden Early Arthritis Clinic) to validate the Vectra DA test against the DAS28 CRP and other known markers of disease activity.(6) There was a positive correlation between the Vectra DA score and the DAS28 CRP score, with a Pearson $r$ correlation coefficient of 0.56 in seropositive RA patients and 0.43 in seronegative patients. The AUC for discriminating low disease activity from moderate-to-high disease activity was 0.77 in seropositive patients and 0.70 in seronegative patients, using the DAS28 CRP as the criterion standard. The Vectra DA score also correlated with other measures of disease activity, including the SDAI, the CDAI, and the Routine Assessment of Patient Index Data (RAPID3), with $r$ values ranging from 0.47 to 0.55 for seropositive patients and 0.21 to 0.29 for seronegative patients.

An additional report from the Leiden Early Arthritis Clinic Cohort was published in 2016.(16) This study used the Vectra DA score and other measures of disease activity to predict radiologic progression of disease at 1 year. One hundred sixty-three patients in this cohort had complete information on Vectra DA test and other disease activity measures. The proportion of patients with radiographic progression increased as Vectra DA scores increased. For patients with a score of less than 29, 2% met criteria for radiographic progression; for patients with a score of 60 or greater, 41% met criteria for radiographic progression. Vectra DA scores and other measures of disease activity (DAS28 CRP, swollen joint count, CRP) were predictors of radiographic progression on univariate analysis. On multivariate analysis, only the Vectra DA score was a significant predictor of progression at 1 year ($p=0.005$).

Hirata et reported in 2014 on the correlation between the Vectra DA score and response to treatment in 147 patients treated with anti-tumor necrosis factor medications for at least a year.(17) The relationship between baseline scores and response to treatment was measured for the Vectra DA test and for a number of other scores (DAS28, SDAI, CDAI). A good response, as defined by the European League Against Rheumatism clinical criteria, was achieved by 56% of patients. The mean Vectra DA score decreased from 64 to 34 during the study, and 37% of patients met the threshold for low activity (Vectra score, $<30$). The Vectra DA score decreased more in patients with a good clinical response (-29 points) than in those with a moderate response (-21 points, $p<0.001$), and decreased more in patients with a moderate response compared with nonresponders (+2 points, $p<0.007$). There was a positive correlation between the Vectra DA score and the DAS28 CRP ($r=0.46$) and the DAS28 ESR ($r=0.48$), but not with the SDAI or the CDAI.
Section Summary: Clinical Validity
Evidence for the clinical validity of the Vectra DA test consists of post hoc analyses of RCTs and prospective cohort studies that correlate the score with other measures of disease activity. Post hoc analysis of at least 5 RCTs have also examined whether the Vectra DA score is correlated with treatment response and/or radiographic progression of disease. These studies showed a positive correlation between Vectra DA and other measures in the moderate range, with reported $r$ values ranging from 0.46 to 0.72. One study reported a $\kappa$ value of 0.34 for DAS28 and Vectra DA scores, indicating a moderate level of agreement above chance. There is also some evidence that the Vectra DA score correlates with response to treatment. For discriminating levels of disease activity, 2 studies that used the DAS28 as the criterion standard reported an AUC in the moderate-to-high range, with values ranging from 0.70 to 0.86 for different populations. Another study compared the discriminatory ability of Vectra DA scores and DAS28 scores using radiographic disease progression as the reference standard and reported that the AUC was higher for Vectra DA than for DAS28.

Clinical Utility
To demonstrate clinical utility, there should be evidence that the MBDA score is at least as good a measure of disease activity as other available measures. This could be demonstrated directly by an RCT comparing a management strategy using the Vectra DA test with an alternate management strategy using another measure of disease activity and reporting clinical outcomes such as symptoms, functional status, quality of life, or disease progression on radiologic imaging. Indirect measures of clinical utility could be obtained from high-quality evidence that clinical validity of the MBDA score is equivalent to other measures used in clinical care, together with guidance on the optimal use of the score in decision making (ie, evidence linking management changes to specific results on the MBDA score).

One RCT identified tested the impact of the Vectra DA score on simulated decision making by experienced rheumatologists.(18) Eighty-one rheumatologists without previous experience with the Vectra DA test were randomized to decision making with and without the Vectra DA score, using 3 validated clinical vignettes representing typical clinical care in RA. A quality score for each vignette was calculated using predefined criteria. Quality scores in the group receiving the Vectra DA score improved by 3% over the control group ($p=0.02$). The largest benefits in the Vectra DA group were improvements in the quality of disease activity and treatment decisions in 12% of patients ($p<0.01$), and more appropriate use of biologics and DMARDs ($p<0.01$).

In a study using physician surveys, Li et al examined the impact of an MBDA score on treatment decisions for patients with RA.(19) This study examined the treatment decisions made by 6 health care providers, all of whom had shown previous interest in using the MBDA score. A total of 108 patients were enrolled who were at least 18 years old, had a diagnosis of RA, completed a MBDA test, and had a survey completed by a physician. Surveys of treatment decisions were done before and after the results of the MBDA score was provided. After receiving the MBDA score, treatment plans were changed in 38 (38%) of 101 cases (95%
Changes in treatment decisions included the type of drug in 21 of 38 cases and the dose or route of administration of a drug in 17 of 38 cases. No data were collected on outcomes associated with the different treatment decisions.

**Section Summary: Clinical Utility**

There is limited evidence that treatment decisions can be influenced by the Vectra DA score. This evidence comes from simulated cases and/or surveys of physician behavior. There are no RCTs comparing use of the Vectra DA score with an alternative method of measuring disease activity; as a result, there is no direct evidence that the Vectra DA test improves outcomes. Other disease activity measures have been associated with improvements in health outcomes in clinical trials. Thus, the evidence from RCTs on other measures, together with the correlation of the Vectra DA test with these measures, is indirect evidence that outcomes may be improved with use of the test. However, there is insufficient evidence to determine whether the Vectra DA test is as good as other more established disease activity measures in improving outcomes.

**Ongoing and Unpublished Clinical Trials**

A search of ClinicalTrials.gov in June 2016 did not identify any ongoing or unpublished trials that would likely influence this review.

**Summary of Evidence**

For individuals who have rheumatoid arthritis (RA) who are evaluated with the Vectra DA test, the evidence includes post hoc analyses of randomized controlled trials and prospective cohort studies. Relevant outcomes are test accuracy and validity, other test performance measures, symptoms, change in disease status, functional outcomes, and quality of life. Evidence from the available studies correlates Vectra DA with disease progression, response to therapy, and/or other previously validated disease activity measures such as the Disease Activity Score with 28 joints (DAS28). These studies have established that the Vectra DA score is a predictor of disease progression and that decreases in the score correlate with disease response. They have also shown moderate correlations between Vectra and the DAS28. A smaller number of studies have evaluated clinical utility by examining changes in decision making associated with use of Vectra, but these studies are limited by the design because they used simulated cases or physician surveys and did not report any outcomes data. This body of evidence on the Vectra DA test is insufficient to determine whether it is as good as or better than other disease activity measures, and it is uncertain whether it is as accurate as the DAS28. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Practice Guidelines and Position Statements**

No guidelines or statements were identified.

**U.S. Preventive Services Task Force Recommendations**

Not applicable.
Medicare National Coverage
There are no Medicare national coverage determinations for the Vectra DA test. In July 2013, Palmetto GBA, the Medicare contractor in California, issued a positive coverage decision for the Vectra DA test. Because all Vectra DA tests are processed out of the Crescendo Bioscience laboratory in California, the test will be covered for Medicare patients in the United States.

References:

Billing Coding/Physician Documentation Information

81490 Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic algorithm reported as a disease activity score
84999 Unlisted chemistry procedure

ICD-10 Codes
M05.00-M06.9 Rheumatoid arthritis code range

Additional Policy Key Words
N/A

Policy Implementation/Update Information
4/1/16 New Policy; considered investigational.
4/1/17 No policy statement changes.

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.