HIGHMARK

March 2025

MEDICAL POLICY UPDATE

IN THIS ISSUE

Policy

Policy Titles	Anticipated Issue Date	30 Day Notification Information
E-32 - Nebulizers	05/05/2025	This policy was scheduled for annual review. No indications for a change in coverage at this time.
E-34 - Respiratory Assist Devices	05/05/2025	This policy was scheduled for annual review. No indications for a change in coverage at this time.
E-36 - Speech Generating Devices	05/05/2025	This policy is scheduled for annual review. There are no changes to coverage criteria.
G-27 - Clinical Trials	05/05/2025	This policy is scheduled for annual review. There are no revisions being made.
L-263 - Biochemical Markers of Bone Remodeling	05/05/2025	This policy is scheduled for annual review. Administrative changes made.
S-241 - Fecal Microbiota Transplantation	05/12/2025	This policy is scheduled for annual review. Administrative changes made.
S-82 - Intra-Arterial/Intravenous Therapeutic Procedures	05/12/2025	This policy is scheduled for annual review. Minor administrative changes made.

MA I-127 - Blinatumomab (Blincyto)	03/19/2025	This policy is up for annual review. There are no indications for a change in coverage.
I-137 - Obinutuzumab (Gazyva) (Also, MA)	05/19/2025	This policy is scheduled for annual review. There are no indications for a change in coverage.
I-161 - Irinotecan Liposomal (Onivyde) (Also, MA)	05/19/2025	This policy is scheduled for annual review. No indications for a change in coverage at this time.
MA I-185 - Inotuzumab Ozogamicin (Besponsa)	05/19/2025	This policy is scheduled for annual review. No indications for a change in coverage at this time.
I-241 - Amivantamab-vmjw (Rybrevant)	05/26/2025	This policy is scheduled for annual review. No indications for a change in coverage at this time.
I-246 - Tisotumab vendotin-tftv (Tivdak)	05/05/2025	This policy is scheduled for annual review. No indications for a change in coverage at this time. Coding was updated per NCCN recommendations.
MA I-250 - Amivantamab-vmjw (Rybrevant)	05/26/2025	This policy is scheduled for annual review. No indications for a change in coverage at this time.
MA I-255 - Tisotumab vedotin-tftv (Tivdak)	05/05/2025	This policy is up for annual review. There are no indications for a change in in coverage at this time. Coding was updated per NCCN recommendations.
I-290 - (Tarlatamab-dlle) Imdelltra	05/26/2025	This policy is up for annual review. There are no indications for a change in coverage at this time.
MA I-300 - (Tarlatamab-dlle) Imdelltra	05/26/2025	This policy is up for annual review. There are no indications for a change in coverage at this time.
S-277 - Laser Interstital Thermal Therapy	05/05/2025	This policy is scheduled for annual review. time. Administrative changes were made.
Q-4 - Private Duty Nursing	05/05/2025	This policy is scheduled for annual review. No indications for a change in coverage at this time.
V-16 - Speech Therapy	05/05/2025	This policy is scheduled for annual review. No indications for a change in coverage at this time.
Z-105 - Prescription Digital Therapeutics	05/12/2025	This policy is scheduled for annual review. Minor administrative changes made.
E-90 - TOMAC	05/05/2025	This is a new policy for Tonic Motor Activation System (TOMAC).
L-311 - Laboratory Thyroid Testing in Adults	06/30/2025	This is a new policy. It establishes coverage criteria for laboratory thyroid testing in adults.
S-346 – Intravascular Lithotripsy	06/02/2025	This is a new policy for Pennsylvania, West Virginia, and Delaware.

S-346 – Intravascular Lithotripsy	06/30/2025	This is a new policy for New York.
EviCore Musculoskeletal Guideline	07/01/2025	Highmark will be adopting updated eviCore Spine Surgery Guidelines.
MCG Summary of Changes Version 29	06/30/2025	Highmark will be adopting the 29th edition of MCG.
I-34 - Ipilimumab (Yervoy)	05/05/2025	This policy was scheduled for annual review. Criteria was revised to further clarify the approved age range for the approved indications. Coding was also updated per NCCN recommendations.
I-41 - Carfilzomib (Kyprolis)	05/19/2025	This policy was scheduled for annual review. Coding was updated to current NCCN recommendations.
MA I-57 - Carfilzomib (Kyprolis)	05/19/2025	This policy was scheduled for annual review. Coding was updated to current NCCN recommendations.
MA I-59 - Ipilimumab (Yervoy)		This policy was scheduled for annual review. Criteria was revised to further clarify the approved age range for the approved indications. Coding was also updated per NCCN recommendations.
I-94 - Intravitreal Injections	03/31/2025	This policy is being updated to include Susvimo's new FDA approved expanded indication for Diabetic Macular Edema.
I-117 - Panitumumab (Vectibix) (Also, MA)	3/31/2025	This policy was scheduled for annual review. The policy was updated with the recent FDA expanded indication for KRAS G12C-mutated metastatic colorectal cancer. Coding was also updated per NCCN recommendations.
I-120 - Programmed Death Receptor (PD-1)/ Programmed Death-Ligand (PD-L1) Blocking Antibodies (Also, MA)	05/12/2025	This policy was scheduled for annual review. There are no indications for a change in coverage at this time. Coding was updated per NCCN recommendations.
I-127 - Blinatumomab (Blincyto)	03/31/2025	This policy was scheduled for annual review. The expanded indication for treatment of CD19-positive Philadelphia chromosome-negative B-cell precursor ALL in the consolidation phase was added. Additional administrative language changes were made.
I-130 - Complement Inhibitors	04/14/2025	Soliris new to market biosimilars, Bkemv and Epysqli, added to policy as non-preferred products.
I-136 - Brentuximab Vedotin (Adcetris) (Also, MA)	03/31/2025	This policy was scheduled for annual review. Coding updated for new FDA approved indication and current NCCN recommendations.
I-145 - Testosterone Androgens (also MA)	03/31/2025	This policy was revised to add new to market, Azmiro.

I-185 - Inotuzumab Ozogamicin (Besponsa)	05/19/2025	This policy was scheduled for annual review. Language was updated for consistency with FDA label.
I-260 - Tremelimumab (Imjudo)	05/19/2025	This policy was scheduled for annual review. Administrative language changes were made, and coding was updated to current NCCN recommendations.
I-265 - Mosunetuzumab-axgb (Lunsumio)	05/12/2025	This policy was scheduled for annual review. Coding was updated to current NCCN recommendations.
MA I-271 - Tremelimumab (Imjudo)	05/19/2025	This policy was scheduled for annual review. Coding was updated to current NCCN recommendations.
MA I-275 - Mosunetuzumab-axgb (Lunsumio)	05/12/2025	This policy was scheduled for annual review. Coding was updated to current NCCN recommendations.
L-265 - Comprehensive Tumor Sequencing (NY)	05/05/2025	This policy was scheduled for annual review. Policy criteria was revised for clarification. Administrative changes were made.
L-265 - Comprehensive Tumor Sequencing (PA, WV, DE)	05/05/2025	This policy is being archived. For services rendered on or after the date of the archived policy, please refer to MCG.
O-12 - Foot Orthotics for Conditions Other Than Diabetes	05/12/2025	This policy was scheduled for annual review. The policy position was reorganized.
S-36 - Removal of Benign or Premalignant Skin Lesions	05/05/2025	This policy was scheduled for annual review. Policy criteria was revised for clarification. Administrative changes were made.
S-133 - Endovascular/Endoluminal Stent Grafts	05/12/2025	This policy was scheduled for annual review. The policy position was reorganized. Criteria was updated. Place of service was updated. Administrative changes were made.
S-271 - Hematopoietic Cell Transplantation: Experimental/Investigational Services	05/05/2025	This policy was scheduled for annual review. Criteria revised to remove "sarcoma, soft tissue."
S-552 - Sclerotherapy (Liquid or Microfoam)	05/05/2025	This policy was scheduled for annual review. This policy has been revised to include medically necessary criteria for treatment of the great saphenous veins.
Y-12 - Urinary Incontinence Therapy	05/05/2025	This policy was scheduled for annual review. Policy criteria was revised for clarification. Administrative changes were made.
Z-7 - Electrical Nerve Stimulation	05/05/2025	This policy has criteria updates.

Policy

New Policy: Highmark Blue Cross Blue Shield has established a new policy for Intravascular Lithotripsy

Highmark Blue Cross Blue Shield has established new criteria for intravascular lithotripsy.

This new Medical Policy will apply to professional providers and facility claims. The effective date is June 2, 2025, for Delaware, Pennsylvania, and West Virginia, and June 30, 2025, for New York.

Place of Service: Inpatient/Outpatient

Please refer to Medical Policy S-346, Intravascular Lithotripsy, for additional information.

Coverage Criteria Established for Azmiro

Highmark Blue Cross Blue Shield has established new criteria for Testosterone Androgens. New to market product, Azmiro, has been added to the policy with other current testosterone cypionate products.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is March 31, 2025.

Place of Service: Inpatient/ Outpatient

Please refer to Medical Policy I-145, Testosterone Androgens, for additional information.

Biosimilar Preferred Products Established for Eculizumab

Highmark Blue Cross Blue Shield has revised criteria for Complement Inhibitors.

Eculizumab (Soliris) is the preferred product for all individuals and indications.

In order for a request for a non-preferred product [eculizumab-aagh (Epysqli) or eculizumab-aeeb (Bkemv)] to be approved the individual must have had an adequate therapeutic trial and experienced a documented drug therapy failure or intolerance to the preferred product or the preferred product is contraindicated.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is April 14, 2025.

Place of Service: Outpatient- Infusion

Please refer to Medical Policy I-130, Complement Inhibitors, for additional information.

Revised Criteria: Highmark Blue Cross Blue Shield has revised the criteria for Electrical Nerve Stimulation

Highmark Blue Cross Blue Shield has revised criteria for electrical nerve stimulation. Coverage criteria has been added for vagus nerve stimulation for depression. Peripheral nerve stimulation criteria has been expanded and is considered not medically necessary.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is May 5, 2025.

Place of Service: Inpatient/Outpatient

Please refer to Medical Policy Z-7, Electrical Nerve Stimulation, for additional information.

MCG v.29 to be Released and Become Effective June 30, 2025

Highmark Blue Cross Blue Shield will be adopting MCG Guidelines v.29 beginning June 30, 2025. The following areas will experience criteria updates, new guidelines, title, goal length of stay changes, or location changes:

- Mean Arterial Blood Pressure Calculator added
- Inpatient & Surgical Care
    - Five New observation care guidelines added
    - New readmission risk content added
    - Table of contents updated
    - Care planning sections removed
    - Care task list removed
    - Evaluation list removed
    - Nine Inpatient and Surgical care Goal Length of Stay changes
    - 17 guideline name changes
    - 136 guidelines were moved to their respective groups
- Multiple Condition Management

    - New readmission risk content added
    - Care planning sections removed
- General Recovery Care
    - One New hospital-at-home GRG guideline added
    - Benchmark length of stay codes display updated
    - Evaluation and treatment section removed
    - Six guidelines were moved
    - Five guidelines were deleted
- Ambulatory Care
    - Eight new guidelines in durable medical equipment, prosthetics, orthotics, and supplies; procedures and diagnostic tests; and specialty medications.
    - New section for Gene Therapy and Cellular Therapy Guidelines
    - Footnotes describing administration instructions removed in specialty medicine guidelines
    - 22 guideline name changes
    - Seven guidelines changed from “current role remains uncertain” to having clinical indications
    - 10 guidelines were moved
    - 33 guidelines were deleted
- Chronic Care
    - Reconcile intervention added
    - Seven new guidelines and 18 patient education handouts added
    - 55 guideline and 21 patient education handouts were renamed
- Home Care
    - Table of contents updated
    - Clinical indications for admission changes
    - General treatment course changed
    - Extended visit updates
    - Statistical companion to home care updated
    - Five guidelines have name changes
    - 40 pediatric guidelines were moved to more specific groups
    - One guideline was deleted
- Behavioral Health Care
    - Alternative care planning removed
    - Substance-related disorders guideline modified
    - Utilization statistics added to applied behavioral analysis
    - Utilization statistics added to testing procedures guideline
- Recovery Facility Care
    - Clinical indications for admission changes
    - Evaluation and Treatment Section Changes
    - Discharge planning updated
    - Evidence summary changes
    - Three guideline name changes
    - One guideline was deleted
- Transitions of Care
    - One new guideline for enrollment was added
    - One guideline was deleted
    - 20 patient education handouts were renamed
- Patient information

- Six preoperative information renamed
- Six inpatient care plans renamed
- 15 discharge information renamed
- 72 patient information handouts were moved
- Six pediatric inpatient care plan handouts moved into groups
- Two inpatient care plan handouts were deleted

- Relevant to Medicare populations
  - Updates to:
    - Behavioral Health Care guidelines
    - General Recovery Care
    - Long-Term Acute Care Hospital (LTACH) General Recovery Guidelines,
    - Home Care Optimal Recovery Guidelines and General Recovery Guidelines,
    - Inpatient & Surgical Care Hospital-at-Home guidelines,
    - Recovery Facility Care Inpatient Rehabilitation Facility (IRF) guidelines, and
    - Palliative Care (PO-5020) guideline

These revised MCG guidelines will apply to professional providers and/or facility claims. The effective date is June 30, 2025.

Reminder: Musculoskeletal Coverage Guideline Update

Highmark Blue Cross Blue Shield is providing a reminder to all providers.

The Musculoskeletal coverage guideline will be updated and take effect July 1, 2025. This applies to both professional provider and facility claims.

The updates to the Musculoskeletal guideline are as follows:

The significant changes are indicated below and affect:

- Spine Surgery Guidelines
  - CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy
  - CMM-608: Lumbar Decompression
  - CMM-611: Sacroiliac Joint Fusion or Stabilization
- Joint Surgery Guidelines
  - CMM-318: Should Arthroplasty/Replacement/Resurfacing/Revision/Arthodesis

To see any further editorial updates, follow the pathway provided below.

Spine Surgery Guideline:

Section Name / Policy Name	Section Number	Summary of change

CMM-606.4: Non-Indications	Experimental, Investigational, or Unproven (EIU) subtitled section	Removed "*Devices for disc annular repair are considered experimental, investigational, or unproven (EIU)* due to associated code (C9757) will no longer be delegated to EviCore
CMM-608.2: Initial Primary Lumbar Decompression CMM-608.4: Repeat Lumbar Decompression at the Same Level	Interlaminar Decompression Device in Open Lumbar Decompression subtitled sections	Added new criteria section to allow for FDA-approved interlaminar decompression devices (e.g., Coflex®) in conjunction with an open lumbar decompression. —Evidence supports FDA-approved interlaminar decompression devices (e.g., Coflex®) (22867/22869) can be used for stabilization obviating the need for fusion for less than grade 2 spondylolisthesis
CMM-608.5: Non-Indications	Not Medically Necessary subtitled section — Experimental, Investigational, or Unproven (EIU) subtitled section	—Removed "*interlaminar*" and "*Coflex*®" from the EIU section —Added Not Medically Necessary statements related to Coflex®
CMM-609.6: Adjacent Segment Disease	Initial relief of symptoms bullet	Removed the bullet related to relief of symptoms: ~~*Significant initial relief of symptoms following prior lumbar spinal fusion(s)*~~ This criteria was removed because requiring an *initial relief of symptom*s does not take into account if there were any issues with the previous fusion surgery (e.g., surgery was not adequate or was not performed correctly, etc.).
CMM-611.2: Minimally Invasive Sacroiliac Joint Fusion and Stabilization Indications	Indications	—Re-worded criteria statement for device/implants that should traverse and transfix the SI joint: • Now reads: *Performed using structural devices/implants that traverse **and** transfix the SI joint with the intention to fuse the SI joint* —Changed "*or stabilization*" to "*and stabilization*" in the section title and opening criteria statement language. • This change was made to support the language added

		requiring that the device/implant should traverse **and** transfix the SI joint with the intention to fuse the SI joint
CMM-611.4 Non-Indications	Not Medically Necessary - Minimally Invasive or Percutaneous Sacroiliac (SI) Joint Fusion and Stabilization subtitled section	—Added language "***and*** *transfix*" with examples to the not medically necessary statement for Minimally invasive or percutaneous SI joint fusion and stabilization using products/implants that do NOT traverse the SI joint. • Now reads: *Minimally invasive or percutaneous SI joint fusion and stabilization using products/implants that do NOT traverse **and** transfix the SI joint (e.g., allograft wedge between the sacrum and ilium, non-metallic implants) with the intention to fuse the SI joint is considered not medically necessary.*
CMM-611.4 Non-Indications	Not Medically Necessary - Minimally Invasive or Percutaneous Sacroiliac (SI) Joint Fusion and Stabilization subtitled section	—Changed "*or stabilization*" to "*and stabilization*" in the subsection title and where found in the non-indications language • This change was made to support the language added requiring that the device/implant should traverse **and** transfix the SI joint with the intention to fuse the SI joint

Joint Surgery Guidelines

Section Name / Policy Name	Section Number	Summary of change
Reverse Total Shoulder Arthroplasty (Replacement) - Indications	Rotator Cuff Tear Pathology subtitled section: — Pseudoparalysis criteria bullet	Re-worded Pseudoparalysis bullet: *Pseudoparalysis with a massive ~~from an~~ unrepairable/irreparable rotator cuff tear ~~(i.e., active forward flexion less than 90 degrees with full passive motion)~~* *— Added "massive" to clarify the size of the of unrepairable/irreparable rotator cuff tear required for Pseudoparalysis* — Removed the "*i.e.*" language association with Pseudoparalysis ~~*(i.e., active forward flexion less than 90 degrees with full passive motion)*~~ • The removed "*i.e.,*" language

		describes Pseudoparesis (as now defined) and is redundant because the definition of Pseudoparesis includes these elements
Reverse Total Shoulder Arthroplasty (Replacement) - Indications	Rotator Cuff Tear Pathology subtitled section: — Pseudoparesis criteria bullet	Added indication for —*Pseudoparesis with a massive unrepairable/irreparable rotator cuff tear* surgical fixation is not considered a reasonable option...". • The types of fractures were removed and the bullet now reads: "A femoral head or femoral neck fracture is present and conservative management or surgical fixation is not considered a reasonable option.“ • Also removed the bullet "A non-displaced intracapsular fracture is present and surgical fixation is not considered a reasonable option". Based on the above change, this bullet is not needed as the above change would be inclusive of this scenario.

At that time, coverage guidelines can be accessed utilizing the live link from the medical policy website.

If you wish to see the updates prior to the implementation date, please go to eviCore website under the Future tab for Musculoskeletal utilizing the following pathway:

- Provider Resource Center→Policies & Programs→Medical Policies→Medical Policy Search→Licensed Criteria (top blue bar)→EVICORE CLINICAL GUIDELINES (body of page)→Access Guidelines→ Select appropriate Musculoskeletal guideline→*Search Health Plan* by typing in Highmark→Click on Highmark and then click on magnifying glass→Click on FUTURE→ Click on the chosen Musculoskeletal Guideline

Comments on These Medical Policies?

We want to know what you think about our new medical policy changes. Send us an email with any questions or comments that you may have on the new medical policies in this edition of Medical Policy Update.

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