HIGHMARK

June 2025

MEDICAL POLICY UPDATE

IN THIS ISSUE

Policy

Policy Titles	Anticipated Issue Date	30 Day Notification Information
G-47 – Concussion Testing	08/11/2025	This policy is scheduled for annual review. There are no indications for a change in coverage.
E-88 – Nerivio	08/11/2025	This policy is scheduled for annual review. Policy criteria has been updated.
M-54 – Ambulatory and Outpatient Cardiac Hemodynamic Monitoring of Heart Failure	08/11/2025	This policy is scheduled for annual review. There are no indications for a change in coverage.

M-70 – Ambulatory Blood Pressure Monitoring	08/11/2025	This policy is scheduled for annual review. There are no indications for a change in coverage.
M-74 – Home Prothrombin Time INR Monitoring for Anticoagulation Management	08/11/2025	This policy is scheduled for annual review. There are no indications for a change in coverage.
S-144 – Islet Cell Transplantation	08/11/2025	This policy is scheduled for annual review. There are no indications for a change in coverage.
E-16 – Cranial Electrotherapy Stimulation and Auricular Electrostimulation	08/04/2025	This policy is an annual review. There are no recommended changes for criteria.
S-152 – Transcatheter Closure Devices for Septal Defects	08/04/2025	This policy is an annual review. There are no recommended criteria changes.
A-0171 – Sclerotherapy Plus Ligation, Saphenofemoral Junction	08/11/2025	This is an annual review. This is a customized MCG guideline. This version will be based on MCG's 29th edition guideline. There is no change in coverage.
A-0172 – Saphenous Vein Stripping	08/11/2025	This is an annual review. This is a customized MCG guideline. This version will be based on MCG's 29th edition guideline. There is no change in coverage.
A-0425 – Saphenous Vein Ablation, Laser	08/11/2025	This is an annual review. This is a customized MCG guideline. This version will be based on MCG's 29th edition guideline. There is no change in coverage.
A-0735 – Stab Phlebectomy	08/11/2025	This is an annual review. This is a customized MCG guideline. This version will be based on MCG's 29th edition guideline. There is no change in coverage.
A-1024 – Saphenous Vein Ablation, Adhesive Injection	08/11/2025	This is an annual review. This is a customized MCG guideline. This version will be based on MCG's 29th edition guideline. There is no change in coverage.
A-1025 – Saphenous Vein Ablation, Mechanical Occlusion Chemical Ablation (MOCA)	08/11/2025	This is an annual review. This is a customized MCG guideline. This version will be based on MCG's 29th edition guideline. There is no change in coverage.
S-556 – Ligation or Ablation, Incompetent Perforator Veins	08/11/2025	This is an annual review. Administrative updates were made with no change to criteria.
S-553 – Subfascial endoscopic perforator surgery (SEPS)	08/11/2025	This is an annual review. Administrative updates were made with no change to criteria.
S-558 – Ligation, Division, and/or Excision of Varicose Vein Cluster(s)	08/11/2025	This is an annual review. Administrative updates were made with no change to criteria.

S-554 – Endovenous Cryoablation	08/11/2025	This is an annual review. Administrative updates were made with no change to criteria.
S-555 – Laser Treatment, Non-Invasive	08/11/2025	This is an annual review. Administrative updates were made with no change to criteria.
S-551 – Echosclerotherapy	08/11/2025	This is an annual review. Administrative updates were made with no change to criteria.
M-82 – Electroretinography	08/11/2025	Policy is due for an annual review. No change in coverage.
M-86 – Digital Diagnostics	08/18/2025	Policy is due for an annual review. Minor administrative changes. No change in coverage.
S-179 – Treatment of Abnormal Uterine Bleeding and Uterine Fibroids	08/04/2025	Policy is due for an annual review. Administrative changes made. No change in coverage.
S-163 – Prophylactic Mastectomy	08/11/2025	This is an annual review. There are no changes to policy criteria.
S-129 – Mastectomy and Reconstructive Surgery	08/11/2025	This is an annual review. Language updates but no change to criteria.
S-178 – Treatment of Hyperhidrosis	08/11/2025	This policy is scheduled for annual review. There is no change in coverage. Minor administrative edits for clarity.
S-310 – Cervical Diskectomy or Microdiscectomy, Foraminotomy, Laminotomy	08/11/2025	This is an annual review. This is a customized MCG guideline. This version will be based on MCG's 29th edition guideline. There is no change in coverage.
M-157 – Cardioverter-Defibrillator Insertion	08/11/2025	This is an annual review. This version will be based on MCG's 29th edition guideline. MCG has changed the title of the guideline from Electrophysiologic Study and Implantable Cardioverter Defibrillator (ICD) Insertion to Cardioverter-Defibrillator Insertion.
S-194 – Subtalar Arthroereisis	08/11/2025	This is an annual review. There is no change in coverage.
I-279 – Motixafortide (Aphexda)	08/11/2025	This policy is up for annual review with no indication for a change in coverage.
MA I-288 – Motixafortide (Aphexda)	08/11/2025	This policy is up for annual review with no indication for a change in coverage.
MA I-124 – Azacitidine (Vidaza)	08/11/2025	This policy is up for annual review with no indication for a change in coverage.
MA I-158 –Pegaspargase (Oncaspar), Asparaginase Erwinia Chrysanthemi	08/11/2025	This policy is up for annual review with no indication for a change in coverage.

(Rylaze), and Calaspargase Pegol-mknl (Asparlas)		
I-166 Elotuzumab (Empliciti)	08/11/2025	This policy is up for annual review with no indication for a change in coverage.
MA I-166 – Elotuzumab (Empliciti)	08/11/2025	This policy is up for annual review with no indication for a change in coverage.
MA I-272 – Teclistamab (Tecvayli)	08/11/2025	This policy is up for annual review with no indication for a change in coverage.
I-262 – Teclistamab (Tecvayli)	08/11/2025	This policy is up for annual review with no indication for a change in coverage.
I-150 – Daratumumab (Darzalex) and Daratumumab and Hyaluronidase-fihj (Darzalex Faspro)	08/11/2025	This policy is up for annual review. Coding was updated to current NCCN recommendations.
MA I-212 – Esketamine (Spravato)	08/18/2025	This policy is up for annual review. There are no indications for a change in coverage at this time.
I-248 – Tebentafusp-tebn (Kimmtrak)	08/25/2025	This policy is up for annual review. There are no indications for a change in coverage at this time. Minor administrative changes were made to the policy.
I-277 – Intra-arterial Melphalan (Hepzato)	08/25/2025	This policy is up for annual review. There are no indications for a change in coverage at this time.
MA I-286 – Intra-arterial Melphalan (Hepzato)	08/25/2025	This policy is up for annual review. There are no indications for a change in coverage at this time.
I-291 – Donanemab (Kisunla)	09/01/2025	This policy is up for annual review. DE version has been updated with revised Site of Care Language. The PA,WV, NY version was revised to remove all of the Site of Care criteria from the policy as it is considered experimental/investigational.
S-342 – Symplicity	08/11/2025	This is a new policy for Renal Denervation System.
S-345 – VistaSeal	08/11/2025	This is a new policy for Fibrin Sealant.
S-559 – Vascularized Composite Allotransplantation	09/01/2025	This is a new policy to address Vascular Composite Allotransplantation.
S-561 – Histotripsy	07/07/2025	This is a new policy created to address histotripsy for recurrent and metastatic liver tumors.

I-302 – Nipocalimab-aahu (Imaavy)	06/30/2025	Criteria is being established for new to market FDA approved Imaavy.
MA I-312 – Nipocalimab-aahu (Imaavy)	06/30/2025	Criteria established for new to market, FDA approved Imaavy.
I-301 – Telisotuzumab vedotin-tllv (Emrelis)	06/30/2025	This is a new policy for the recently FDA approved medication telisotuzumab vedoti-tllv (Emrelis). Telisotuzumab vedotin-tllv (Emrelis) is indicated for the treatment of adult individuals with locally advanced or metastatic NSCLC with high c-Met protein overexpression who have received prior systemic therapy.
MA I-311 – Telisotuzumab vendotin-tllv (Emrelis)	06/30/2025	This is a new policy for the recently FDA approved medication telisotuzumab vedoti-tllv (Emrelis). Telisotuzumab vedotin-tllv (Emrelis) is indicated for the treatment of adult individuals with locally advanced or metastatic NSCLC with high c-Met protein overexpression who have received prior systemic therapy.
E-52 – Home Cervical Traction Therapy	08/11/2025	This policy is scheduled for annual review. There were diagnosis codes removed.
S-32 – Implantable Hormone Replacement Pellets	08/11/2025	This is an annual review. Administrative updates were made and additional criteria have been added.
L-260 – Prostate Specific Antigen	08/18/2025	Policy is scheduled for annual review. Additional criteria added for coverage. Coding updated. Minor administrative changes made. No change to the mandates for DE and NY. Updated professional guidelines.
E-9 – Non-Custom/Custom-Made Gradient Compression Garments/Stockings/Sleeves – NY	10/13/2025	Policy is due for an annual review. Not medically necessary statement added for non-pneumatic active compression devices.
L-306 – Transplant Rejection Testing	10/06/2025	This policy underwent annual review. Two additional covered procedure codes were added to the policy in addition to quantity level limits. Language added to delineate between covered and non-covered transplant rejection testing.
I-37 – Ustekinumab (Stelara) and Ustekinumab Biosimilars	06/30/2025	This policy is up for annual review. Administrative language changes made along with adding new to market biosimilar Starjemza as a non-preferred product.
MA I-139 – Ustekinumab (Stelara) and Ustekinumab Biosimilars	06/30/2025	This policy is up for annual review. New to market biosimilar Starjemza added as a non-preferred.
I-227 – Inebilizumab-cdon (Uplizna)	06/30/2025	Policy criteria has been updated for the expanded indication of immunoglobulin G4-related disease.

MA I-234 – Inebilizumab-cdon (Uplizna)	06/30/2025	This policy is being updated to include the diagnosis code for the expanded indication of immunoglobulin G4-related disease.
I-32 – Intravenous Anesthetics for Off-Label Indications	08/18/2025	Policy language is being revised to clarify all use anesthetics for the management of chronic pain, chronic neuropathic pain, chronic daily headache, and fibromyalgia is considered experimental/investigational.
I-88 – Granulocyte Colony-Stimulating Factors	06/30/2025	This policy is being updated to include the recent FDA approved expanded indications for Relueko and Fylnetra. Releuko is now indicated for the mobilization of autologous hematopoietic progenitor cells and to increase survival in patients exposed to myelosuppressive doses of radiation. Flynetra is now indicated to increase survival in patients exposed to myelosuppressive doses of radiation.
I-120 – Programmed Death Receptor (PD-1)/ Programmed Death-Ligand (PD-L1) Blocking Antibodies	07/01/2025	This policy is being updated to include criteria for the recent FDA approved indication for Zynyz. Zynyz received an FDA approved expanded indication on May 15, 2025 for the treatment of adult individuals with inoperable locally recurrent or metastatic squamous cell carcinoma of the anal canal.
I-281 – Exagamglogene autotemcel	06/30/2025	This policy is up for annual review. The policy was revised to include updated Beta Thalassemia genotypes. Administration CPT codes were also added to the policy. Policy will publish on June 30, 2025.
I-283 Lifileucel (Amtagvi)	07/14/2025	This policy is up for annual review. Policy is being revised to include the statement regarding out of specification product administration is considered e/i. Coding was updated per NCCN recommendations.
MA I-290 – Exagamglogene autotemcel	06/30/2025	This policy is up for annual review. Administration CPT codes were added to the policy.
I-146 – Monoclonal Antibodies for the Treatment of Eosinophilic Conditions	06/30/2025	This policy is up for annual review. The Nucala coverage criteria for Eosinophilic Granulomatosis with Polyangiitis (EGPA) has been updated to also allow for refractory disease. Policy is also being updated to add criteria for Nucala to capture the recently FDA approved expanded indication. Nucala is now indicated for the add-on maintenance treatment of Chronic Obstructive Pulmonary Disease in adult patients who also have an eosinophilic phenotype.
I-210 – IL-1 and IL-1b Blockers	08/04/2025	This policy is up for annual review. Coverage criteria for Ilaris was updated to include criteria for gout flares. Additional administrative

		changes were made including clarifying the authorization periods and adding language regarding self-administration.
MA I-256 – Efgartigmod alfa-fcab (Vyvgart) and Efgartigmod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)	10/13/2025	This policy is up for annual review. Step criteria established for Vyvgart Hytrulo for the diagnosis of chronic inflammatory demyelinating polyneuropathy.
I-247 – Efgartigmod alfa-fcab (Vyvgart) and Efgartigmod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)	10/13/2025	This policy is up for annual review. Step criteria established for Vyvgart Hytrulo for the diagnosis of chronic inflammatory demyelinating polyneuropathy.
MA I-150 – Daratumumab (Darzalex) and Daratumumab and Hyaluronidase-fihj (Darzalex Faspro)	8/11/2025	This policy is up for annual review. Coding was updated to current NCCN recommendations.
I-124- Azacitidine (Vidaza)	8/11/2025	This policy is up for annual review. Criteria language was updated to be more consistent with FDA label.
I-158- Pegaspargase (Oncaspar), Asparaginase Erwinia Chrysanthemi (Erwinaze), and Calaspargase Pegol-mknl (Asparlas)	8/11/2025	This policy is up for annual review with no indication for a change in coverage at this time.

Policy

Coverage Guidelines Established for Ustekinumab-hmny (Starjemza)

NEWS FOR ALL PROVIDER TYPES

Highmark Blue Shield has established new guidelines for I-37, Ustekinumab (Stelara) and Ustekinumab Biosimilars. New to market, FDA approved biosimilar ustekinumab-hmny (Starjemza) has been added to the policy as a non-preferred product.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is June 30, 2025.

Place of Service: Outpatient

Please refer to Medical Policy I-37, Ustekinumab (Stelara) and Ustekinumab Biosimilars, for additional information.

Coverage Criteria Established for Nipocalimab-aahu (Imaavy)

Highmark Blue Shield has established new criteria for the new to market therapy for treatment of generalized myasthenia gravis, Nipocalimab-aahu (Imaavy). Imaavy will be considered non-preferred for antiacetylcholine receptor (AchR) antibody positive, generalized myasthenia gravis.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is June 30, 2025.

Place of Service: Outpatient

Please refer to Medical Policy I-302, Nipocalimab-aahu (Imaavy), for additional information.

Preferred Product Update for Vyvgart Hytrulo

Highmark Blue Shield has revised criteria for I-247, Efgartigimod alfa-fcab (Vyvgart) and Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo). The criteria requires an individual to experience therapeutic failure, intolerance, or contraindication to treatment with systemic corticosteroids or an immune globulin therapy before the non-preferred product, Vyvgart Hytrulo, is received for the treatment of chronic inflammatory demyelinating polyneuropathy (CIDP).

This revised Medical Policy will apply to professional providers and facility claims. The effective date is October 13, 2025.

Place of Service: Outpatient

Please refer to Medical Policy I-247, Efgartigimod alfa-fcab (Vyvgart) and Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo), for additional information.

New Criteria: Highmark Northeastern New York and Highmark Western New York has established new criteria for Non-Custom/Custom-Made Gradient Compression Garments/Stockings/Sleeves

Highmark Northeastern New York and Highmark Western New York has established new criteria for Non-Custom/Custom-Made Gradient Compression Garments/Stockings/Sleeves. A not medically necessary statement has been added regarding non-pneumatic active compression devices for lymphedema.

This revised Medical Policy will apply to professional providers. The effective date is October 13, 2025.

Place of Service: Outpatient

Please refer to Medical Policy E-9 Non-Custom/Custom-Made Gradient Compression Garments/Stockings/Sleeves, for additional information.

Revised Coding: Highmark Blue Shield has revised the coding for Transplant Rejection Testing

Highmark Blue Shield has revised coding for Transplant Rejection Testing. Language added to delineate between covered and non-covered transplant rejection testing.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is October 6, 2025.

Place of Service:

Please refer to Medical Policy L-306-002 Transplant Rejection Testing, for additional information.

Coverage Guidelines Established for Ustekinumab-hmny (Starjemza)

NEWS FOR ALL PROVIDER TYPES

MA MEDICARE ADVANTAGE

Highmark's Medicare Advantage products have established new guidelines for I-139, Ustekinumab (Stelara) and Ustekinumab Biosimilars. New to market, FDA approved biosimilar ustekinumab-hmny (Starjemza) has been added to the policy as a non-preferred product.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is June 30, 2025.

Please refer to Medical Policy I-139, Ustekinumab (Stelara) and Ustekinumab Biosimilars, for additional information.

Coverage Criteria Established for Nipocalimab-aahu (Imaavy)

NEWS FOR ALL PROVIDER TYPES

MA MEDICARE ADVANTAGE

Highmark's Medicare Advantage products have established new criteria for the new to market therapy for treatment of generalized myasthenia gravis, Nipocalimab-aahu (Imaavy). Imaavy will be considered non-preferred for antiacetylcholine receptor (AchR) antibody positive, generalized myasthenia gravis.

This revised Medical Policy will apply to professional providers and facility claims. The effective date is June 30, 2025.

Please refer to Medical Policy I-312, Nipocalimab-aahu (Imaavy), for additional information.

Preferred Product Update for Vyvgart Hytrulo

NEWS FOR ALL PROVIDER TYPES

MA MEDICARE ADVANTAGE

Highmark's Medicare Advantage products have revised criteria for I-256, Efgartigimod alfa-fcab (Vyvgart) and Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo). The criteria requires an individual initiating therapy to experience therapeutic failure, intolerance, or contraindication to treatment with systemic corticosteroids or an immune globulin therapy before the non-preferred product, Vyvgart Hytrulo, is received for the treatment of chronic inflammatory demyelinating polyneuropathy (CIDP).

This revised Medical Policy will apply to professional providers and facility claims. The effective date is October 13, 2025.

Please refer to Medical Policy I-256, Efgartigimod alfa-fcab (Vyvgart) and Efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo), for additional information.

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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Medical Policy Update is a monthly newsletter for the health care providers who participate in our networks and submit claims to Highmark using the appropriate HIPAA transactions or claim forms as required by Highmark. This publication focuses only on medical policy and claims administration updates, including coding guidelines and procedure code revisions, and is the sole source for this information. For all other news, information, and updates, be sure to read *Provider News*, available on the Provider Resource Center.

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