MASSACHUSETTS

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Medical Policy Updates
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CARDIOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Transcatheter Tricuspid Valve Repair or Replacement	036	**New medical policy** describing medically necessary and investigational indications.	October 1, 2025	Commercial	No action required. This procedure is performed in the inpatient setting.
Transcatheter Mitral Valve Repair or Replacement	692	**Policy revised.** New indication for transseptal valve-in-valve replacement added.	July 1, 2025	Commercial	No action required. This procedure is performed in the

					inpatient setting.
Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease	283	**Policy clarified.** CPT 82172 is considered investigational and not a covered service. 82172 Apolipoprotein, each	August 1, 2025	Commercial	No action required. This is not a covered service.

BEHAVIORAL HEALTH

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Applied Behavior Analysis (ABA)	091	**Policy revised** to include medically necessary indications for Down Syndrome.	October 1, 2025	Commercial	Prior authorization is required.

ENDOCRINOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Automated Insulin Delivery Systems	107	**Policy revised.** Automated Insulin Delivery Systems updated with new evidence, following FDA approval of the t:slim X2 insulin pump with Control-IQ+ technology for adults with type 2 diabetes. Medically necessary policy statement with criteria revised for individuals with type 2 diabetes. Artificial Pancreas Device Systems title changed to Automated Insulin Delivery Systems.	October 1, 2025	Commercial	Prior authorization is not required.

GASTROENTEROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical and Surgical Management of Obesity including Anorexiants	379	**Policy revised** to include additional investigational endoscopic procedures.	October 1, 2025	Commercial	Prior authorization is required for surgical services.

PULMONOLOGY SLEEP DISORDER MANAGEMENT

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical Technology Assessment Non-Covered Services List	400	**Policy revised.** HCPCS code K1027 **removed** from the noncovered list MP 400. Prior authorization is required through Carelon for K1027, effective October 1, 2025.	October 1, 2025	Commercial Medicare	Prior authorization is required through Carelon for K1027.
Sleep Disorder Management CPT and HCPCS Codes	970	**Policy revised.** The following codes were added: 0966T, 0964T, 0965T. These codes require prior authorization through Carelon effective October 1, 2025.	October 1, 2025	Commercial Medicare	Prior authorization is required through Carelon.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Gene Therapies for Hemophilia A or B	169	**Policy clarified** to remove Beqvez from the policy. Beqvez was discontinued by the manufacturer.	June 2, 2025	Commercial Medicare	No action required.
Non-Opioid	040	**New pharmacy**	August 1,	Commercial	Prior

Medications for Pain Management		**medical policy** containing prior authorization criteria for **Journavx**.	2025		authorization is required.
Oncology Drugs (Oral and Subcutaneous)	409	**Policy revised.** Added new drugs **Itovebi** and **Lazcluze** to the policy.	August 1, 2025	Commercial	Prior authorization is required.
Medical Utilization Management (MED UM) & Pharmacy Prior Authorization Policy	033	**Policy revised.** Added Chronic Spontaneous Urticaria, Chronic Rhinosinusitis indication for **Dupixent**, added ATTR-CM indication for **Amvuttra**, added new drugs **Jubbonti, Wyost, Osenvelt, Stobclo**,and **Niktimvo**, and removed **Jetrea**, as product is discontinued.	August 1, 2025	Commercial	Prior authorization is required.
Glucagon-like Peptide (GLP-1) Receptor Agonists and Related Drugs for the Treatment of Type 2 Diabetes	056	**Policy revised.** Added indication for chronic kidney disease (CKD) to **Ozempic**.	August 1, 2025	Commercial	Prior authorization is required.
Drug Management & Retail Pharmacy Prior Authorization Policy	049	**Policy revised.** Updated **Attruby** criteria to align with other AATR-CM agents.	August 1, 2025	Commercial	Prior authorization is required.
Sublingual Immunotherapy with Allergen-specific Extracts (SLIT)	681	**Policy revised.** Updated age for **Odactra** indication to align with FDA label.	August 1, 2025	Commercial	Prior authorization is required.
Engineered T-Cell Therapy for Leukemia and Lymphoma (formerly *Chimeric Antigen Receptor Therapy for*	066	**Policy revised.** Updated policy name to streamline CAR-T medical policy titles. Added new drug **Aucatzyl**.	August 1, 2025	Commercial	Prior authorization is required.

Leukemia and Lymphoma)					
Engineered T-Cell Therapy Services for B-cell Acute Lymphoblastic Leukemia Prior Authorization Request Form (formerly *CAR T-Cell Therapy Services for B-cell Acute Lymphoblastic Leukemia Prior Authorization Request Form*)	945	**Policy revised.** Updated Request Form title and added new section for **Aucatzyl**.	August 1, 2025	Commercial	Prior authorization is required.
Immune Modulating Drugs	004	**Policy revised.** Added Stelara biosimilars to the policy: **Selarsdi** and **Yesintek**.	August 2025	Commercial	Prior authorization is required.
Immune Modulating Drugs	004	**Policy revised.** Added criteria for Giant Cell Arteritis and Alopecia Areata. Added Stelara biosimilars to the policy as Non-Formulary: **Otulfi, Pyzchiva, Stegeyma,** and **Wezlana**. **Stelara** is also moving to non-formulary.	October 1, 2025	Commercial	Prior authorization is required.

UROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Nerve Graft in Association with Radical Prostatectomy	590	**Policy retired.** This procedure is generally performed in the inpatient setting. There is no specific code.	July 1, 2025	Commercial Medicare	No action required.
Tibial Nerve Stimulation	583	**Policy revised.** Transcutaneous	October 1, 2025	Commercial Medicare	No action required.

		tibial nerve stimulation (e.g., Vivally System) is considered **investigational** for individuals with bladder conditions of urinary incontinence and urinary urgency Title changed to "Tibial Nerve Stimulation."			

Genetic Testing Guidelines

Legend	Text color	Indicates…
Guideline Change Summary	**Blue**	Change to guideline wording (*red for restrictive change)
	Black	Preservation of existing guideline wording
		Changes expected to be…
Explanation of Change	**Green**	More expansive on appropriateness
	Red	More restrictive on appropriateness
	Black	Have minimal if any impact on appropriateness review and exists primarily to clarify intent

The following updates will apply to the Carelon Clinical Appropriateness **Guidelines for Genetic Testing.** You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

Policy Change Summary	Effective Date
Prenatal Screening using Cell-free DNA	
cfDNA screening **Not Medically Necessary:** The use of cfDNA screening is considered **not medically necessary** when screening for the following: • Sex only (without family history of an X-linked disorder) • Single genes (e.g., CFTR, HBB, SMN1, RhD and/or other fetal red blood cell antigens) • Microdeletions (e.g., DiGeorge syndrome, Cri-du-chat syndrome) • Twin zygosity (monozygotic versus dizygotic) • Genome-wide copy number variants • Aneuploidies of other autosomal chromosomes (e.g., trisomy 7, trisomy 15, trisomy 16, trisomy 22, etc.) • Polygenic risk assessment *Note: Some of the tests listed above have a role in care under certain circumstances, but they should not be routinely offered.* **Explanation of change** **Clarified** cfDNA screening for fetal red blood cell antigens is considered not medically necessary	September 20, 2025

Carrier Screening in the Reproductive Setting	
Cystic fibrosis and spinal muscular atrophy Standard screening for cystic fibrosis (CFTR testing) and spinal muscular atrophy (SMN1	September 20, 2025

testing) using accepted gene variant sets is considered **medically necessary** in the following scenarios: • All pregnant individuals • An individual considering reproduction **Explanation of change:** Clarification	
Hemoglobinopathies Standard screening for hemoglobinopathies (HBA1/HBA2 and HBB testing) using hemoglobin electrophoresis or molecular genetic testing is considered **medically necessary** in the following scenarios IF no prior testing results (hemoglobin electrophoresis and/or HBA1/HBA2 and HBB gene analysis) are available for interpretation: • All pregnant individuals • An individual considering reproduction **Explanation of change:** Clarification	September 20, 2025
Expanded carrier screening **Multigene or single gene carrier screening** is considered **medically necessary** when ALL of the following criteria are met: • ONE or more of the following apply: ○ One or both individuals have ancestry (e.g., Ashkenazi Jewish, Finnish, French Canadian, among others) known to be at increased risk for certain conditions, other than cystic fibrosis, spinal muscular atrophy, and hemoglobinopathies ○ One or both individuals do not have access to a biological family history due to reasons such as adoption or use of a reproductive donor as documented in the member's medical record ○ The individual and their reproductive partner are known or suspected to be consanguineous as documented in the member's medical record • The condition(s) included in the screening test have at least a 1 in 100 carrier frequency* • The genetic disorder(s) being evaluated have gene-disease clinical validity AND pathogenic variants in the gene(s) are associated with significant morbidity and/or mortality in affected individuals • The test has sufficiently high sensitivity and specificity to guide clinical decision making • Knowledge of the pathogenic variant(s) may be used for management of either the pregnancy or the potentially affected fetus or child, or for family planning **Note: Conditions on multigene panels can have carrier frequencies less than 1 in 100 for a consanguineous partnership.* **Explanation of change: Clarified** that carrier screening for a single gene condition can also be medically necessary when criteria are met	September 20, 2025
Carrier testing based on family history Condition-specific carrier testing is considered **medically necessary** when **ANY** of the following criteria are met: • The individual has a previously affected child with the genetic condition being evaluated • Either partner has a first-, second-, or third-degree relative who is affected with or is a documented carrier of the genetic condition being evaluated • The reproductive partner of the individual being tested has a pathogenic variant or likely pathogenic in the gene associated with the condition being evaluated	September 20, 2025

Explanation of change: Expanded medical necessity criteria to include having a relative who is a documented carrier of a genetic condition. Clarification	
Fragile X syndrome carrier testing Fragile X premutation carrier testing is considered **medically necessary** in **EITHER** of the following scenarios: • Individuals assigned female sex at birth with a family history of fragile X-related disorders or intellectual disability suggestive of fragile X syndrome who are pregnant or considering pregnancy • Individuals assigned female sex at birth with unexplained ovarian insufficiency or failure, or an elevated follicle-stimulating hormone (FSH) level prior to age 40 **Explanation of change:** Clarifications	September 20, 2025

Genetic Testing for Inherited Conditions	
Cardiac conditions **Hereditary arrhythmia syndromes** Genetic testing for pathogenic variants associated with long QT syndrome, catecholamine polymorphic ventricular tachycardia (CPVT), or Brugada syndrome is considered **medically necessary** when A**NY** of the following are present: • The individual to be tested is symptomatic with supporting clinical and ECG features for long QT syndrome, or catecholamine polymorphic ventricular tachycardia (CPVT), or Brugada syndrome • The individual to be tested is presymptomatic with characteristic ECG features (at rest or with exercise) suggestive of an inherited cardiac arrhythmia syndrome AND the individual to be tested has a first-degree relative with ANY of the following: ○ Sudden cardiac death ○ Unexplained syncope ○ Unexplained cardiac arrest • There is a known familial pathogenic variant associated with long QT syndrome, catecholamine polymorphic ventricular tachycardia (CPVT), or Brugada syndrome in a first- or second-degree relative **AND** • The genetic testing is focused on pathogenic variants relevant to the individual's suspected clinical diagnosis and known familial genetics **Explanation of change**: Clarification	September 20, 2025
Primary mitochondrial diseases Genetic testing for primary mitochondrial disease is considered **medically necessary** when the following criteria are met (simplified modified Nijmegen criteria). An individual has an unexplained, progressive, multi-system disorder usually involving the central nervous system and/or neuromuscular system with findings, such as: • Brain MRI pathology associated with mitochondrial disease • Organic acid level pattern suggestive of a mitochondrial disease • Evidence of mitochondrial dysfunction in tissue **Order of testing when above criteria have been met** 1. Common mtDNA variant(s) testing or testing of nuclear gene(s) associated with the disease IF a specific primary mitochondrial disease is suspected (see Table 1) 2. Whole mtDNA genomic sequence and large-deletion analysis IF the individual's clinical presentation does **NOT** fit with a specific primary mitochondrial disorder (see Table 1) **OR** if the condition-specific test results are negative/uninformative 3. Targeted nuclear gene panel (<25 genes) testing IF whole mtDNA genomic sequence and large-deletion analysis does **NOT** yield a diagnosis	September 20, 2025

Note: Whole exome sequencing is considered medically necessary in some individuals. Please refer to the Whole Exome Sequencing and Whole Genome Sequencing guidelines. **Explanation of change:** Developed new guideline section for primary mitochondrial diseases Expanded medically necessary testing for primary mitochondrial diseases to include mtDNA genomic sequence, large-deletion, and targeted nuclear mitochondrial gene panel analysis when clinical medical necessity criteria are met	
Retinal disorders **Genetic** testing for pathogenic variants associated with inherited retinal disorders may be **medically necessary** when the **general requirements OR multi-gene panel criteria** listed above are met. Genetic testing for a known familial variant associated with an inherited retinal condition is medically necessary when BOTH of the following are met: • The individual to be tested has a first- or second-degree relative with a pathogenic or likely pathogenic variant associated with an inherited retinal condition • The testing is targeted to the gene of the known familial pathogenic or likely pathogenic variant **Explanation of change**: Specific call out for genetic testing for retinal disorders as medically necessary when the guideline general requirements or multi-gene panel criteria are met	September 20, 2025
Thrombophilia testing Thrombophilia genetic testing for common pathogenic variants associated with Factor V Leiden and/or the prothrombin (Factor II) gene G20210A is considered **medically necessary** to inform anticoagulation decision-making when **ANY** of the following criteria are met: • An individual with an unprovoked or weakly provoked venous thromboembolism (VTE) at or before age 50 (weakly provoking factors include immobility or minor injury, illness, or infection) • An individual with recurrent VTE • An individual with VTE **AND EITHER** of the following: ○ Two or more family members with a history of VTE ○ One first-degree relative with VTE at or before age 40 • An individual with VTE involving the cerebral or splanchnic veins • An individual contemplating pregnancy who has a first-degree relative with VTE **AND** a confirmed hereditary thrombophilia • An individual with an unprovoked VTE is planning to stop anticoagulation and a positive test for thrombophilia would change this decision **Explanation of change**: **Clarified** what is meant by weakly provoking factors for venous thromboembolism with added examples Clarified that testing for FV Leiden and F2 testing is medically necessary when a positive FV Leiden or F2 test result would change plans for anticoagulation treatment in an individual with an unprovoked VTE	September 20, 2025

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Genetic Liquid Biopsy in the Management of Cancer and Cancer Surveillance (note revised title)	
Cell-free DNA Testing (Liquid Biopsy) for the Management of Cancer Genetic Liquid Biopsy in the Management of Cancer and Cancer Surveillance **Explanation of change:** Guideline renamed to encompass RNA based liquid biopsy tests	November 15, 2025
General Requirements The genomic testing must have established analytical and clinical validity and be performed in an appropriately certified laboratory. Repeated testing of the same individual for the same indication should be limited to evaluation following an intervention, or when there is a change in clinical status such that additional testing is required to determine next steps in management. At times, it may be necessary to repeat a test using different techniques or protocols to clarify a finding or result of the original study. Repeated testing for the same indication using the same or similar technology may be subject to additional review or require peer-to-peer conversation in the following scenarios: • Repeated diagnostic testing of the same tumor site with no clinical change, treatment, or intervention since the previous study • Repeated diagnostic testing of the same individual and the same tumor by different providers over a short period of time **Explanation of change:** Clarification	November 15, 2025
Liquid Biopsy Testing **Definitions** **Genetic liquid biopsy** refers to the analysis of genetic material obtained from bodily fluids, primarily blood, to detect and monitor genetic changes associated with cancer. This technique focuses on identifying specific genetic pathogenic variants/likely pathogenic variants, alterations, or aberrations **in circulating tumor DNA (ctDNA) or other genetic components like RNA.** **Key applications of genetic liquid biopsy include:** • **Pathogenic variant/likely pathogenic variant detection** – Identifying specific pathogenic variants/likely pathogenic variants in genes that are associated with certain types of cancer, which can guide targeted therapies	November 15, 2025

• **Tumor profiling** – Understanding the genetic landscape of a tumor to identify potential treatment strategies and assess prognosis • **Monitoring treatment response** – Tracking changes in ctDNA levels over time to evaluate how well a cancer is responding to treatment • **Early detection and recurrence monitoring** – Detecting genetic changes that may indicate the presence of cancer at an early stage or the recurrence of a previously treated cancer **Explanation of change:** Include general information on genetic liquid biopsy testing	
General Criteria for Genetic Liquid Biopsy Testing If Cancer-site Specific Criteria (e.g., lung carcinoma, biliary tract carcinoma, breast carcinoma, prostate carcinoma) are described in this guideline, apply those criteria prior to use of the General Criteria for Genetic Liquid Biopsy Testing. The use of an FDA approved companion diagnostic test or an appropriately validated lab developed test (LDT) performed in a certified laboratory may be considered **medically necessary** when the following criteria are met. Liquid (ctDNA) based testing is considered **medically necessary** for individuals with invasive malignancy for whom the liquid biopsy test is necessary for treatment selection, and ALL the following criteria are met: • Specific cancer treatment is currently being considered which corresponds with an FDA companion diagnostic indication • There is insufficient tumor tissue available for NGS-based somatic profiling or for whom tissue biopsy is unsafe or considered infeasible due to the individual's clinical condition • The individual has not had prior testing for the targeted gene(s) of interest in the relevant clinical scenario • Other somatic tumor testing results or clinical criteria do not already provide support for the specific cancer therapy being considered that correspond to the FDA companion diagnostic indication and **ALL** the following criteria are met: ○ Clinical decision making incorporates the known or predicted impact of a specific genomic alteration on protein expression or function and published clinical data on the efficacy of targeting that genomic alteration with a particular agent ○ The genetic test is reasonably targeted in the scope of genetic testing applied ○ The genetic test has established clinical utility such that a positive or negative result will meaningfully impact the clinical management of the individual and will likely result in improvement in net health outcomes, AND ONE or more of these additional criteria must also be met: ▪ The genomic biomarker-linked therapies are approved by the US Food and Drug Administration (FDA) or recommended by NCCN as a Category 2A **for the individual's specific cancer scenario and such** therapies are being considered in the near term ▪ Treatment is being considered for which there are specific genomic biomarker-based contraindications or exclusions related to cancer treatment being considered in the near term aligned with the FDA label or NCCN 2A recommendations ▪ Treatment is being considered for which the member's health plan has a drug-specific policy requiring additional, appropriately focused genetic biomarker testing otherwise not specified by the FDA label or NCCN 2A recommendation **Explanation of change:** Split liquid (ctDNA) based testing into **General Criteria** and **Cancer-site Specific Criteria** Lab developed tests added (expansive)	November 15, 2025

Additional criteria added to meet medical necessity (restrictive)	

Cancer-site Specific Criteria	
Lung carcinoma **Individuals with locally advanced (stage IIIb), recurrent, or metastatic non-small cell lung cancer** Liquid (ctDNA) based testing is considered **medically necessary** for individuals with pathologically confirmed locally advanced (stage IIIb), recurrent, or metastatic non-small cell lung cancer (NSCLC), and ALL the following criteria are met: • There is insufficient tumor tissue available for NGS-based somatic profiling or for whom tissue biopsy is unsafe or considered infeasible due to the individual's clinical condition • No prior NGS-based somatic profiling test has previously been performed for this pathological diagnosis of NSCLC • The test is being used to provide genetic information related to the current set of actionable pathogenic variants/likely pathogenic variants (ESMO Scale for Clinical Actionability of Targets category 1A or 1B) to inform management at diagnosis or treatment progression on or after chemotherapy or immunotherapy **Explanation of change**: Clarification. ASCO and ESMO are comparable sets. ESMO Scale of Clinical Actionability for molecular Targets (ESCAT) status is easier to locate and updated more frequently.	November 15, 2025
Biliary tract carcinoma Individuals with locally advanced, recurrent, or metastatic biliary tract carcinoma Liquid (ctDNA) based testing is considered **medically necessary** for individuals with pathologically confirmed locally advanced, recurrent, or metastatic biliary tract carcinomas when **ALL** the following criteria are met: • There is insufficient tumor tissue available for NGS-based somatic profiling or for whom tissue biopsy is unsafe or considered infeasible due to the individual's clinical condition • No prior NGS-based somatic profiling test has previously been performed for this pathological diagnosis of biliary tract cancer • The test is being used to provide genetic information related to the current set of actionable pathogenic variants/likely pathogenic variants (ESMO Scale for Clinical Actionability of Targets Category 1A or 1B) to inform management at diagnosis or treatment progression on or after chemotherapy or immunotherapy **Explanation of change:** New criteria added for biliary tract carcinoma (expansive)	November 15, 2025
Breast carcinoma **Individuals with metastatic breast cancer who may benefit from PIK3CA/AKT1/PTEN or ESR1-targeted therapy** Liquid (ctDNA) based testing, to include PIK3CA, AKT1, PTEN and/or ESR1 somatic tumor testing, is considered **medically necessary** to identify individuals who may benefit from the use of alpelisib, capivasertib plus fulvestrant or elacestrant (or other FDA approved agents targeting these same pathways) when **ALL** the following criteria are met: • The individual has ER-positive and HER2-negative metastatic breast cancer • The individual is a candidate for drug treatment in the near term aligned with the FDA label or NCCN 2A recommendations • The individual has not had prior testing for the targeted gene(s) of interest in the metastatic setting • There is insufficient tumor tissue available for NGS-based somatic profiling or tissue biopsy is unsafe or considered infeasible due to the individual's clinical condition **Explanation of change:** Removed restriction of individual needing to be an adult male or postmenopausal female (expansive)	November 15, 2025

NCCN 2A recommendation added as positive criteria (expansive)	
Prostate carcinoma **Individuals with metastatic adenocarcinoma of the prostate who may benefit from a PARP inhibitor or PD-1 inhibitor** Liquid (ctDNA) based testing is considered medically necessary for individuals with metastatic adenocarcinoma when ALL the following criteria are met: • The individual has biopsy-proven adenocarcinoma of the prostate • The individual has not had prior NGS testing in the metastatic setting • The individual is a candidate for ONE of the following therapies: ○ FDA approved PARP inhibitor (olaparib, rucaparib, or other PARP inhibitor with NCCN 2A recommendation) ○ FDA approved PD-1 inhibitor (pembrolizumab or other checkpoint inhibitor with NCCN 2A recommendation) • There is insufficient tumor tissue available for NGS-based somatic profiling or tissue biopsy is unsafe or considered infeasible due to the individual's clinical condition **Explanation of change:** NCCN 2A recommendation added as positive criteria (expansive)	November 15, 2025

Individuals without malignancy for whom liquid biopsy is used for screening	
Individuals without malignancy for whom liquid biopsy is used for screening Liquid (ctDNA) based testing including multi-cancer early detection tests (MCED) is considered not medically necessary for individuals without invasive malignancy for whom the liquid biopsy test is being used for early initial cancer diagnosis or cancer screening. • The following **test examples are not medically necessary:** ○ Guardant Shield™ (Guardant Health) ○ Galleri® (GRAIL) **Explanation of change:** Test name examples added (clarifications)	November 15, 2025

ctDNA and Minimal Residual Disease (MRD)	
ctDNA and Minimal Residual Disease (MRD) Liquid (ctDNA) based testing is considered **not medically necessary** for individuals with invasive solid tumor malignancy for whom the liquid biopsy test is being used to assess for MRD during and after treatment. • The following test examples are **not medically necessary** ○ Guardant Response™ (Guardant Health) ○ Guardant Reveal™ (Guardant Health) ○ Signatera™ (Natera) **Explanation of change**: Test name examples added (clarifications)	November 15, 2025

Somatic Tumor Testing **<u>General Requirements</u> (apply to both Somatic Tumor Testing and Genetic Liquid Biopsy guidelines)**	
The genomic testing must have established analytical and clinical validity and be performed in an appropriately certified laboratory. Repeated testing of the same individual for the same indication should be limited to evaluation following an intervention, or when there is a change in clinical status such that additional testing is required to determine next steps in management. At times, it may be necessary to repeat a test using different techniques or protocols to clarify a finding or result of the original study. Repeated testing for the same indication using the same or similar technology may be	November 15, 2025

subject to additional review or require peer-to-peer conversation in the following scenarios: • Repeated diagnostic testing of the same tumor site with no clinical change, treatment, or intervention since the previous study • Repeated diagnostic testing of the same individual and the same tumor by different providers over a short period of time **Explanation of change**: Clarification	

Somatic Testing of Solid Tumors General Criteria (previously Umbrella Criteria)	
If Cancer-site Specific Criteria (e.g., breast cancer, colorectal cancer, prostate cancer, etc.) are described in this guideline, apply those criteria prior to use of the General Criteria. The use of an FDA approved companion diagnostic test or an appropriately validated lab developed test (LDT) performed in a certified laboratory may be considered **medically necessary** when the following criteria are met. **Explanation of change:** Clarifying information Lab developed tests added as medically necessary (expansive)	November 15, 2025
Somatic Genomic Testing (solid tumor biomarker testing) Somatic genomic testing is considered **medically necessary** in individuals with cancer when **ALL** the following criteria are met: • Clinical decision making incorporates the known or predicted impact of a specific genomic alteration on protein expression or function and published clinical data on the efficacy of targeting that genomic alteration with a particular agent • The genetic test is reasonably targeted in scope and has established clinical utility such that a positive or negative result will meaningfully impact the clinical management of the individual and will likely result in improvement in net health outcomes (i.e., the health benefits of the interventions outweigh any medical or psychological harmful effects of the testing intervention) • When the clinical utility is based on potential impact on clinical management based on genomic biomarker-linked therapies, one or more of these additional criteria must also be met: ○ The genomic biomarker-linked therapies are approved by the US Food and Drug Administration (FDA) or recommended by NCCN as a Category 2A for the individual's specific cancer scenario and such therapies are being considered in the near term ○ Treatment is being considered for which there are specific genomic biomarker-based contraindications or exclusions related to cancer treatment being considered in the near term aligned with the FDA label or NCCN 2A recommendations ○ Treatment is being considered for which the member's health plan has a drug-specific policy requiring additional, appropriately focused genetic biomarker testing otherwise not specified by the FDA label or NCCN 2A recommendation **Explanation of change:** See last bullet: Allow genetic biomarker testing per member's health plan drug-specific policy requirements (expansive)	November 15, 2025

Metastatic or Advanced Cancer (Tissue Agnostic Testing)	
Tissue-agnostic testing for patients with advanced solid tumors Multi-gene panel testing is considered **medically necessary** when **ALL** the following are	November 15, 2025

true: • The individual has a metastatic or advanced solid tumor and adequate performance status for cancer treatment • There are no satisfactory tumor-specific standard therapies available • Tumor testing falls into one or more of the following categories: ○ Mismatch-repair (MMR) deficiency ▪ MLH1, MSH2, MSH6, PMS2 or EPCAM genes by PCR or NGS testing ▪ Microsatellite testing (MSI) and/or dMMR testing ▪ MLH-1 promoter methylation and/or BRAF V600E testing with nuclear expression loss of MLH1 and PMS2 by immunohistochemistry ○ Tumor mutational burden (TMB) testing as determined by an FDA-approved test with reporting using the threshold of ≥10 mutations/megabase (mut/Mb) ○ NTRK1/2/3 and RET fusion testing ○ BRAF V600E testing ○ FGFR1/2/3 fusions or pathogenic variants/likely pathogenic variants **Explanation of change:** Removal of restrictive criteria (expansive) Added FGFR biomarkers as medically necessary tumor testing (expansive)	

Cancer-specific Criteria Bladder Cancer (Urothelial Carcinoma, including the Upper Tract)	
Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR) is considered **medically necessary** when **BOTH** of the following criteria are met: • The individual has biopsy-proven urothelial carcinoma of the bladder or upper urinary tract. • The individual has not had prior MSI or dMMR testing **Explanation of change**: IHC is out of scope for genetic testing	November 15, 2025
Targeted (i.e., 50 or fewer genes) tissue-based somatic tumor testing for FGFR pathogenic/likely pathogenic variants is considered medically necessary for individuals with urothelial tumors of the bladder or upper urinary tract when ALL the following criteria are met: • The individual has biopsy-proven urothelial malignancy • The urothelial malignancy is locally advanced (stage IIIB), recurrent, or metastatic (stage IV) • The individual is a potential candidate for an FDA-approved (or NCCN 2A) targeted therapy prescribed on the basis of this testing • The individual has not had prior FGFR testing in the locally advanced, recurrent, or metastatic setting **Explanation of change:** Clarifications NCCN 2A recommendation added to positive criteria (expansive) Removed restriction to a specific genetic biomarker (expansive)	November 15, 2025

Brain Cancer (Malignant Glioma)	
Targeted (i.e., 50 or fewer genes) tissue-based somatic tumor testing is considered **medically necessary** for individuals with malignant gliomas of the brain when **ALL** the following criteria are met: • The individual has biopsy-proven, primary malignant glioma of the brain • Genetic testing includes at least the following: ○ BRAF V600E ○ IDH1 and IDH2	November 15, 2025

• The individual has not had prior testing for these genes Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR) is considered **medically necessary** when **ALL** the following criteria are met: • The individual has biopsy-proven, malignant glioma of the brain • The individual is under age 50 years and IDH wild type • The individual has not had prior MSI or dMMR testing *Note: Tumor agnostic genetic testing indications may also apply, depending on the clinical scenario (e.g., there are no satisfactory tumor-specific standard therapies available, there are no indications for planned therapy that would apply independent of the results of genetic testing [such as immune checkpoint inhibitor indications], and progression of disease). See the Tissue Agnostic Testing guideline for details.* **Explanation of change:** Clarifications IHC is out of scope for genetic testing	

Breast Cancer, localized; early adjuvant setting	
Gene expression profiling is considered **medically necessary** to guide adjuvant therapy* treatment-decision making for individuals with localized breast cancer using Oncotype DX, MammaPrint, EndoPredict, Prosigna, or the Breast Cancer Prognostic Gene Signature Assay when **ALL** the following criteria are met: • Surgery has been performed, and a full pathological evaluation of the specimen has been completed • Histology is invasive ductal, lobular, mixed, or metaplastic • Receptor status is estrogen receptor positive (ER+), progesterone receptor positive (PR+), or both; AND HER2-negative • Lymph node status is node-negative (pN0) or axillary lymph node micro-metastasis (pN1mi) less than or equal to 2 mm • Tumor features include **ANY** of the following: ○ Tumor size greater than 1.0 cm and less than or equal to 5.0 cm ○ Tumor size 0.6–1.0 cm and moderately (histologic grade 2) or poorly-differentiated (histologic grade 3) ○ Tumor size 0.6–1.0 cm and well-differentiated (histologic grade 1) with **EITHER** of the following: ▪ angiolymphatic invasion ▪ high nuclear grade (nuclear grade 3) • Chemotherapy is being considered by the individual and their provider • No other breast cancer gene expression profiling assay has been conducted for this tumor (this includes testing on any metastatic foci or on other sites when the tumor is multifocal) [moved ****Note*** with others to follow all Breast Cancer criteria] Gene expression profiling is considered not **medically necessary** to guide adjuvant therapy treatment decision-making for individuals with ductal carcinoma in situ (DCIS) when DCIS is the sole breast cancer histology. **Explanation of change:** Clarifying. The Breast Cancer Index (BCI) was removed from early adjuvant setting. The BCI report provides information on use of EET at 5 years post-surgery. The report does not mention use of BCI test for purposes of adjuvant chemotherapy despite approval of the test for this indication by ASCO. NCCN mentions BCI in the context of EET only. This edit is done to provide clarity for reviewers who review BCI cases nearly exclusively for use of EET. A new section has been added allowing for the BCI test in the EET setting provided certain criteria are met.	November 15, 2025

Breast Cancer, localized; extended adjuvant setting	
Gene expression profiling using the Breast Cancer Index (BCI) is considered **medically necessary** to assist with extended adjuvant therapy treatment-decision making for individuals with localized breast cancer when ALL the following criteria are met: • Receptor status is estrogen receptor positive (ER+), progesterone receptor positive (PR+), or both; AND HER2-negative • The individual is premenopausal at the time of the extended adjuvant decision-making • The individual has not been treated with ovarian suppression, an aromatase inhibitor, a CDK 4/6 inhibitor, or a PARP inhibitor **Explanation of change:** Added criteria for the Breast Cancer Index in extended adjuvant setting (expansive)	November 15, 2025

Breast Cancer, metastatic and/or locally advanced** breast cancer	
Targeted (i.e., 50 or fewer genes) tissue-based somatic tumor testing for pathogenic/likely pathogenic variants of PIK3CA, AKT1, PTEN, and ESR1 is considered **medically necessary** for postmenopausal females and adult males when **ALL** the following criteria are met: • The individual has ER-positive and HER2-negative metastatic breast cancer • The individual is a candidate for treatment per FDA label (or NCCN 2A) with alpelisib, capivasertib plus fulvestrant, or inavolisib with palbociclib and fulvestrant **AND/OR** the individual is a candidate for treatment per FDA label (or NCCN 2A) with elacestrant • The individual has not had prior tissue-based testing for the targeted gene(s) of interest in the metastatic setting ***Notes*** **Adjuvant therapy refers to treatments early in the trajectory of treatment for localized breast cancer (e.g., within 12 weeks of surgery) to reduce risk of breast cancer recurrence; this is distinct from extended-adjuvant therapy decision-making that takes places years after initiation of adjuvant treatment and involves a decision about the duration of treatment. [**moved** from early adjuvant]* ***Locally advanced breast cancer refers to AJCC stages IIIA, IIIB, or IIIC disease or stage IIB disease considered inoperable and requiring systemic therapy.* *Genetic Liquid Biopsy guideline criteria may apply; see Carelon Guidelines for Genetic Liquid Biopsy in the Management of Cancer and Cancer Surveillance. Tumor agnostic genetic testing indications may also apply, depending on the clinical scenario (e.g., there are no satisfactory tumor-specific standard therapies available, there are no indications for planned therapy that would apply independent of the results of genetic testing [such as immune checkpoint inhibitor indications], and progression of disease). See the Tissue Agnostic Testing guideline for details.* **Explanation of change:** Expanded genetic marker testing from 4 genes to 50 or fewer (expansive) NCCN 2A recommendation added to positive criteria (expansive) Clarifications	November 15, 2025

Cholangiocarcinoma (Biliary Tract Cancers)	
Tissue-based somatic tumor testing for pathogenic/likely pathogenic variants in individuals with cholangiocarcinoma is considered **medically necessary** when **ALL** the following criteria are met: • The individual has biopsy-proven cholangiocarcinoma • The cholangiocarcinoma is locally advanced, unresectable, or metastatic	November 15, 2025

• The panel testing to include analysis of the following genes: IDH1, FGFR, HER2/ERBB2, and BRAF • The individual is a potential candidate for targeted therapy that is FDA approved (or NCCN 2A), prescribed on the basis of the panel test results • The individual has not had prior somatic tumor testing for IDH1, FGFR, HER2/ERBB2, and BRAF in the metastatic setting **Explanation of change:** Clarifications Added another required genetic marker (restrictive) NCCN 2A recommendation added to positive criteria (expansive)	

Colorectal Cancer	
Universal testing for all patients with newly diagnosed localized or metastatic colorectal cancer Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR) is considered **medically necessary** when **BOTH** of the following criteria are met: • The individual has biopsy-proven adenocarcinoma of the colon or rectum • The individual has not had prior MSI or dMMR testing **Explanation of change** IHC is out of scope for genetic testing	November 15, 2025
Localized colorectal cancer Targeted (i.e., 50 or fewer genes) tissue-based somatic tumor testing is considered **medically necessary** for individuals with localized (stage II-III) colorectal cancer when **BOTH** of the following criteria are met: • The individual has biopsy-proven adenocarcinoma of the colon or rectum • Includes **ANY** or **ALL** of the following, with no prior testing ○ MSI testing by PCR ○ BRAF V600E ○ KRAS ○ MLH-1 promoter methylation (applicable when there is nuclear expression loss of MLH1 and PMS2 by IHC) **Explanation of change** Clarification IHC is out of scope for genetic testing	November 15, 2025
Metastatic colorectal cancer Targeted (i.e., 50 or fewer genes) tissue-based somatic tumor testing is considered **medically necessary** for individuals with recurrent or metastatic colorectal cancer and may be performed on the primary tumor or a metastatic site when **ALL** the following criteria are met: • The individual has biopsy-proven adenocarcinoma of the colon or rectum • Assessment includes **ANY** or **ALL** of the following: ○ POLE pathogenic variants/likely pathogenic variants ○ POLD pathogenic variants/likely pathogenic variants ○ Extended RAS testing (KRAS and NRAS exons 2,3, and 4) ○ BRAF V600E ○ HER2 amplification testing ○ MLH-1 promoter methylation (applicable when there is nuclear expression loss of MLH1 and PMS2 by IHC) • There has been no prior testing for these molecular aberrations **Explanation of change:** Clarifications	

Endometrial Carcinoma	
Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR) is considered **medically necessary** when **BOTH** of the following criteria are met: • The individual has biopsy-proven endometrial carcinoma • The individual has not had prior MSI or dMMR testing Targeted (i.e., 50 or fewer genes) tissue-based somatic tumor testing is considered **medically necessary** for individuals with endometrial carcinoma and may be performed on the primary tumor or a metastatic site when **ALL** the following criteria are met: • The individual has biopsy-proven endometrial carcinoma • Assessment includes the following, as applicable: ○ MLH-1 promoter methylation (applicable when there is nuclear expression loss of MLH1 and PMS2 by IHC) ○ POLE gene testing (NGS) ○ P53 gene testing (NGS) • There has been no prior testing for these molecular aberrations **Explanation of change:** IHC is out of scope for genetic testing. Clarifications	November 15, 2025

Melanoma	
Prognostic testing in melanoma Gene expression profiling of indeterminate melanocytic skin lesions or of established cutaneous, mucosal, or uveal melanoma for prognostication is considered **not medically necessary**. *For multianalyte assays used for screening and diagnosis (often combined with algorithmic analyses), see the Carelon Guidelines for Predictive and Prognostic Polygenic Testing.* **Somatic tumor testing in advanced melanoma** Tissue-based somatic tumor testing for **BRAF V600E** pathogenic variant by validated PCR or NGS methods for individuals with resectable or unresectable high-risk stage IIC, stage III or stage IV cutaneous melanoma is considered **medically necessary** when **BOTH** of the following criteria are met: • The individual has biopsy-proven cutaneous malignant melanoma • Prior testing has not been performed **Additional testing in high-risk stage II-IV cutaneous melanoma or mucosal melanoma** Tissue-based somatic tumor testing (50 genes or fewer) for individuals with resectable or unresectable high-risk stage IIC, stage III or stage IV melanoma or mucosal melanoma is considered **medically necessary** when **ALL** the following criteria are met: • The individual has biopsy-proven malignant melanoma • Prior testing has not been performed • Testing includes **ANY** or **ALL** the following: [No criteria changes] **Additional somatic tumor testing in metastatic uveal melanoma** Testing of individuals with **metastatic uveal melanoma** for **HLA-A*0201** is considered **medically necessary** when **ALL** the following criteria are met: [No criteria changes] **Explanation of change:** Removed restriction requiring previous BRAF V600E testing	November 15, 2025

(expansive) IHC is out of scope for genetic testing; Clarifications	

Non-Small Cell Lung Cancer, localized (stage IB-IIIA)	
Tissue-based somatic testing is considered **medically necessary** to identify EGFR and/or ALK pathogenic variant in individuals with localized NSCLC when **BOTH** of the following criteria are met: • Biopsy-proven, stage IB-IIIA NSCLC • Test results will determine candidacy for treatment with targeted agents used per FDA label (or NCCN 2A) **Explanation of change:** Testing for squamous cell histology is now allowed without the requirements of being age ≤50, non-smoker, or light former smoker (expansive) Added FDA label and NCCN 2A recommended treatments as allowed (expanded beyond two specific treatments)	November 15, 2025

Non-Small Cell Lung Cancer, advanced (previously metastatic)	
Tissue-based NGS panel testing is considered **medically necessary** to identify pathogenic/likely pathogenic variants in individuals with stage IIIB, IIIC, or IV (metastatic) NSCLC when **ALL** the following criteria are met: • Biopsy-proven NSCLC • The multi-gene NGS panel testing contains, at minimum*, testing of appropriate molecular aberrations (pathogenic variants/likely pathogenic variants, rearrangements, fusions, or amplifications) in **ALL** the following genes: EGFR, ALK, ROS1, BRAF, ERBB2 (HER2), KRAS, MET exon 14 skipping, NTRK, and RET • The multi-gene NGS panel contains NRG1 for fusion analysis **IF** use of zenocutuzumab-zbco therapy is being considered • The individual has not had prior tissue-based NGS testing in the metastatic setting, unless **BOTH** of the following are met: ○ There is evidence of disease progression while on EGFR-targeted therapy ○ Tissue biopsy of a progressing lesion is being used for additional testing **Testing may be more focused if other techniques (such as IHC or FISH) are simultaneously (or previously) used for specific genes listed in the criteria that are not also included on the multi-gene panel.* **Explanation of change**: Testing for squamous cell histology is now allowed without the requirements of being age ≤50, non-smoker, or light former smoker (expansive) Added a marker for additional treatment option (expansive) Simplified criteria (expansive)	November 15, 2025

Ovarian Cancer (Epithelial)	
Targeted (i.e., 50 or fewer genes) tissue-based somatic tumor testing to determine HRD status by testing for pathogenic/likely pathogenic variants of BRCA1, BRCA2 with concomitant evaluation for genomic instability is considered **medically necessary** when **ALL** the following criteria are met: • The individual has biopsy-proven locally advanced (stage III), metastatic (stage IV), or recurrent epithelial ovarian cancer • The individual has not had prior testing that establishes the presence of actionable germline or somatic pathogenic variants/likely pathogenic variants in BRCA1 or BRCA2 genes or eligibility for PARP-inhibitor treatment based on HRD status • The individual is a candidate for treatment with a PARP inhibitor per FDA label (or NCCN 2A) Germline testing for pathogenic/likely pathogenic variants is considered **medically necessary** for all individuals with epithelial ovarian carcinoma. *See Hereditary Cancer Testing guideline for further details.*	November 15, 2025

Explanation of change Removed requirement for an FDA approved test (expansive) NCCN 2A recommendation added to positive criteria (expansive) Clarifications	

Pancreatic Adenocarcinoma	
Germline testing for pathogenic/likely pathogenic variants is considered **medically necessary** for all individuals with pancreatic adenocarcinoma. *See Hereditary Cancer Testing guideline for further details.* Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR) is considered **medically necessary** when **BOTH** of the following criteria are met: • The individual has biopsy-proven pancreatic adenocarcinoma • The individual has not had prior MSI or dMMR testing Targeted (i.e., 50 or fewer genes) tissue-based somatic tumor testing is considered **medically necessary** when **ALL** the following criteria are met: • The individual has biopsy-proven locally advanced (stage III), metastatic (stage IV), or recurrent pancreatic adenocarcinoma • The NGS panel includes BRCA1, BRCA2, PALB2, KRAS, and NRG1 as applicable • The individual has not had prior tissue-based NGS testing in the locally advanced, metastatic, or recurrent setting **Explanation of change:** IHC is out of scope for genetic testing NRG1 added as an additional biomarker based on FDA approval (expansive) Specify prior tissue-based NGS testing Clarifications	November 15, 2025

Prostate Cancer, metastatic Current	
Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR) is considered **medically necessary** when **BOTH** of the following criteria are met: • The individual has biopsy-proven adenocarcinoma of the prostate • The individual has not had prior MSI or dMMR testing Tissue-based NGS panel testing is considered **medically necessary** to identify pathogenic/likely pathogenic variants in individuals with metastatic prostate cancer when **ALL** the following criteria are met: • The individual has biopsy-proven metastatic castration-sensitive adenocarcinoma of the prostate (mCSPC) with high burden of disease* or metastatic castration-resistant adenocarcinoma of the prostate (mCRPC) • The individual is a current or likely future candidate for **ONE** of the following therapies: ○ PARP inhibitor (olaparib, rucaparib, or another PARP inhibitor FDA approved or per NCCN 2A use in this setting) ○ PD-1 inhibitor (pembrolizumab or another checkpoint inhibitor FDA approved or per NCCN 2A for use in this setting) • The NGS panel includes BRCA2, BRCA1, and may also include other genes encoding molecules involved in homologous recombination DNA damage repair (DDR), such as ATM, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, RAD51B, RAD51C, RAD51D, and RAD54L • The individual has not had prior tissue-based NGS testing in the metastatic setting Germline testing for pathogenic/likely pathogenic variants is considered **medically necessary** for all individuals with metastatic prostate adenocarcinoma. *See Hereditary Cancer Testing guideline for further details.* **High burden of disease is defined per the STAMPEDE trial as the presence of visceral metastases or 4 or more bone metastases*	November 15, 2025

Explanation of change: IHC is out of scope for genetic testing mCSPC and mCRPC specified as necessary types of prostate adenocarcinoma (restrictive) NCCN 2A recommendation added to positive criteria (expansive) Clarifications	

Sarcoma (including soft tissue sarcoma, bone sarcoma, gastrointestinal stromal tumor, uterine sarcoma)	
Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR) is considered **medically necessary** when **BOTH** of the following criteria are met: • The individual has biopsy or resection-proven sarcoma • The individual has not had prior MSI or dMMR testing Targeted (i.e., 50 or fewer genes) tissue-based somatic tumor testing by PCR or NGS* is considered **medically necessary** for individuals when **ANY** of the following criteria are met: • The individual has biopsy or resection proven sarcoma **or** a soft tissue neoplasm where molecular testing will establish the diagnosis • The individual is a potential candidate for an FDA-approved targeted therapy or ESMO Scale for Clinical Actionability of molecular Targets (ESCAT) level I gene alteration associated with drug therapy • The individual is a candidate for **ONE or more** of the following therapies: ○ FDA-approved kinase inhibitor (entrectinib, larotrectinib) approved for use with *NTRK1, NTRK2*, and *NTRK3* fusions without a known acquired resistance pathogenic variant/likely pathogenic variant ○ FDA-approved kinase inhibitor (selpercatinib) for adult and pediatric patients 2 years of age and older with locally advanced or metastatic solid tumors with a *RET* gene fusion that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options ○ FDA-approved kinase inhibitor (avapritininb) with *PDGFRA (D842V)* pathogenic variants for GIST • The individual has not had prior testing for the same indication **SARCOMA SPECIFIC TESTING**: Whole blood **SYNOVIAL SARCOMA**: Whole blood DNA HLA-A locus sequencing for eligible alleles: HLA-A*02:01, HLA-A*02:02, HLA-A*02:03 or HLA-A*02:06 and their P-group alleles and exclusion alleles: HLA-A*02:05 and its P-group alleles in adults with unresectable or metastatic synovial sarcoma is considered **medically necessary** when **ALL** the following criteria are met: • The individual is a candidate for FDA-approved autologous T-cell immunotherapy (afamitresgene autoleucel) indicated for the treatment of adults with unresectable or metastatic synovial sarcoma who have received prior chemotherapy **AND** • The tumor expresses the MAGE-A4 antigen as determined by FDA-approved or cleared companion diagnostic devices Table 1 lists genomic alterations recognized as either diagnostic, level 1 ESCAT changes associated with therapy (ESMO Scale for Clinical Actionability of molecular Targets), or Level 2A tests recommended in NCCN sarcoma guidelines. This list is a representative sample of some of the most common genomic alterations in sarcomas for which somatic molecular testing is medically necessary for diagnosis and/or treatment. Diagnostic targeted molecular or NGS panel testing for specific sarcoma types is listed below. The list is not exhaustive, and all listed genes are not required as to be included in an NGS test panel. [Table not shown here]	November 15, 2025

Explanation of change: Expansive	

Thyroid Cancer	
Testing of indeterminate thyroid nodules (ITN) Use of next-generation gene expression classifier testing from fine needle aspirate sampling of a thyroid nodule is considered **medically necessary** when **ALL** the following criteria are met: • There has been no prior testing of the same thyroid nodule • Initial cytopathology is reported as **ANY** of the following (Bethesda III or IV) categories: ○ Atypia of undetermined significance (AUS) ○ Follicular neoplasm (FN) • The ITN is **≤** 4 cm • **ONE** of the following gene expression classifiers may be used when performed as a stand-alone classifier test: ○ ThyGeNEXT/ThyraMIR multiplatform test ○ ThyroSeq Genomic Classifier ○ Afirma GSC **Somatic genetic testing of thyroid malignancy** Tissue-based somatic tumor testing (50 genes or fewer) is considered **medically necessary** for individuals with advanced thyroid carcinoma that is not amenable to radioactive iodine therapy when the following criteria* are met: • The individual has biopsy proven unresectable, locally advanced, recurrent, or metastatic thyroid carcinoma or anaplastic thyroid carcinoma (any stage) • The testing includes assessment for pathogenic/likely pathogenic variants of BRAF V600E and RET • The individual is considered a potential candidate for FDA-approved oral targeted therapy based on the results of this testing **See additional guidelines concerning tissue agnostic somatic testing or hereditary cancer risk testing depending on the clinical scenario.* **Explanation of change:** Removed restrictive ITN ultrasound criteria (expansive); Allow up to ITNs 4 cm in size (expansive). Clarifications	November 15, 2025

Somatic Testing of Hematologic Malignancies **General Criteria (was Umbrella Criteria)**	
If hematologic malignancy specific criteria (e.g., acute myelogenous leukemia, chronic myeloid leukemia, multiple myeloma, etc.) are described in this guideline, apply those blood cancer criteria prior to use of the General Criteria. **Somatic Genomic Testing (blood cancer biomarker testing)** Somatic genomic testing is considered **medically necessary** in individuals with cancer when **ALL** the following criteria are met: • Clinical decision making incorporates the known or predicted impact of a specific genomic alteration on protein expression or function and published clinical data on the efficacy of targeting that genomic alteration with a particular agent • The genetic test is reasonably targeted in scope and has established clinical utility such that a positive or negative result will meaningfully impact the clinical management of the individual and will likely result in improvement in net health outcomes (i.e., the health benefits of the interventions outweigh any medical or psychological harmful effects of the testing intervention) • When the clinical utility is based on potential impact on clinical management based on genomic biomarker-linked therapies, one or more of these additional criteria must also be met:	November 15, 2025

○ The genomic biomarker-linked therapies are approved by the US Food and Drug Administration (FDA) or recommended by NCCN as a Category 2A for the individual's specific cancer scenario and such therapies are being considered in the near term ○ Treatment is being considered for which there are specific genomic biomarker-based contraindications or exclusions related to cancer treatment being considered in the near term aligned with the FDA label or NCCN 2A recommendations ○ Treatment is being considered for which the member's health plan has a drug-specific policy requiring additional, appropriately focused genetic biomarker testing otherwise not specified by the FDA label or NCCN 2A recommendation **Explanation of change**: NCCN 2A recommendation added to positive criteria; Allow for member's health plan drug-specific policy requirements to positive criteria (expansive)	

Blood Cancer-specific Criteria **Acute Lymphoblastic Leukemia and Pediatric B-cell Precursor Lymphoblastic Lymphoma**	
Initial Diagnosis Tissue- (**OR** bone marrow-) based (**OR** alternatively, peripheral blood if morphologically detectable circulating blasts) somatic genetic testing (50 or fewer genes) is considered **medically necessary** for children or adults with acute lymphoblastic leukemia (ALL) or pediatric B-cell precursor lymphoblastic lymphoma (BCP-LBL) when **BOTH** of the following criteria are met: • Testing is for the purpose of establishing the diagnosis, to stratify risk, or to identify actionable therapeutic targets • A multi-gene panel contains genes that are identified with B-ALL, T-ALL or BCP-LBL, such as ABL1, ABL2, CRLF2, CSF1R, FLT3, FGFR, NTRK, LYN, PTK2Br, IL7R, JAK1, JAK2, JAK3, ETV6, RUNX1, TCF3, TCF4, PBX1, DUX4, PAX5, KMT2A, HLF, ZNF384, MEF2D, ZNF384, MYC, PDGFRB, SH2B3, TP53, IKZF1, NUTM1, MEF2D, ZNF384, RAS, PTEN, NOTCH1, and FBXW7 **Measurable Residual Disease (MRD)** The use of NGS testing on bone marrow specimen is considered **medically necessary** in children or adults with ALL to measure minimal residual disease (MRD) at the end of initial treatment induction and end of initial consolidation and at similar defined points over the course of sequential therapies. BCR-ABL kinase domain point pathogenic variant analysis is considered **medically necessary** in the evaluation of individuals with BCR-ABL (Philadelphia chromosome) positive ALL to evaluate treated individuals who manifest suboptimal response to initial tyrosine kinase inhibitor therapy or loss of response to tyrosine kinase inhibitor therapy. PCR testing for BCR-ABL1 quantification on bone marrow specimen is considered **medically necessary** in the monitoring of Philadelphia chromosome-positive ALL. **Explanation of change:** Added another cancer type (pediatric BCP-LBL) (expansive) Chromosomal testing is out of scope for genetic testing (clarifying)	November 15, 2025

Acute Myelogenous Leukemia	
Initial Diagnosis Tissue-based (**OR** alternatively, peripheral blood if morphologically detectable circulating blasts) somatic genetic testing (50 or fewer genes) is considered **medically necessary** for individuals with acute myelogenous leukemia (AML) when **BOTH** of the following criteria are met: • Testing is for the purpose of establishing the diagnosis, to stratify risk, or to identify	November 15, 2025

actionable therapeutic targets • A multi-gene panel contains genes that are identified with AML, such as FLT3 (including FLT3-ITD), IDH1, IDH2, NPM1, CBFB, MYH1, CEBPA, MLLT3, KMT2A, DEK, NUP214, KAT6A, CREBBP, GATA2, EVI1, DDX41, TP53, ASXL1, BCOR, EZH2, RUNX1, SF3B1, SRSF2, STAG2, U2AF1, and ZRSR2 **Measurable Residual Disease (MRD)** The use of multi-gene panel NGS testing on peripheral blood or bone marrow specimens is considered **not medically necessary** in members with AML to measure minimal residual disease (MRD). The use of focused testing of peripheral blood or bone marrow using RT-qPCR is considered **medically necessary** when used at appropriate defined points over the course of therapy, such as at the end of initial treatment induction, at the end of initial consolidation, or at the completion of other sequential therapies, to measure minimal residual disease (MRD) in individuals with AML involving **ONE** of the following disease molecular subtypes: • Acute promyelocytic leukemia (APL) • NPM1 • Core binding factor • Internal tandem duplication of FLT3 (FLT3-ITD) **Explanation of change**: Added FLT3-ITD as medically necessary (expansive) Chromosomal testing is out of scope for genetic testing (clarifying) Clarifications	

B-cell Lymphomas	
The use of focused multi-gene panel NGS testing (20 genes or fewer) on bone marrow specimens is **medically necessary** when **ALL** of the following criteria are met: • Individuals have high-grade B-cell lymphoma or diffuse large B-cell lymphoma (DLBCL) • Testing is for the purpose of establishing the diagnosis, to stratify risk, or to identify actionable therapeutic targets The use of multi-gene panel NGS testing on peripheral blood or bone marrow specimens is considered **not medically necessary** for individuals with B-cell lymphomas for the purpose of evaluating minimal residual disease (MRD). **Explanation of change:** New criteria for B-cell lymphomas (expansive)	November 15, 2025

Chronic Lymphocytic Leukemia	
Bone marrow tissue-based **OR** peripheral blood somatic genetic testing using a focused multi-gene panel NGS testing (20 genes or fewer) is **medically necessary** when **ALL** the following criteria are met: • Individuals have been diagnosed with chronic lymphocytic leukemia (CLL) • Testing is for the purpose of initial risk stratification and treatment selection • A multi-gene panel includes testing of TP53, SF3B1, NOTCH1, BIRC3, and ATM The use of multi-gene panel NGS testing on peripheral blood or bone marrow specimens is considered **not medically necessary** in members with CLL for initial workup or to measure minimal residual disease (MRD). **Explanation of change**: Criteria added for focused NGS panel for risk stratification (expansive)	November 15, 2025

Chronic Myeloid Leukemia	
Focused bone marrow tissue-based **OR** peripheral blood somatic genetic testing is	November

considered **medically necessary** for establishing the diagnosis of suspected chronic myelogenous leukemia (CML) when the following criterion is met: • PCR or FISH testing includes the evaluation of the BCR-ABL1 fusion gene BCR-ABL kinase domain point pathogenic variant/likely pathogenic variant analysis is considered **medically necessary** in the monitoring of CML in the following circumstance: • Evaluation of individuals with CML to evaluate treated individuals who manifest suboptimal response to tyrosine kinase inhibitor therapy indicated by **ANY** of the following: ○ Lack of a partial hematologic or cytogenetic response at 3 months or greater after treatment onset ○ Less than a complete hematologic and cytogenetic response at 12 months ○ Disease progression to accelerated or blast phase **Measurable Residual Disease (MRD) testing** PCR testing for BCR-ABL1 quantification is considered **medically necessary** for response assessment every 3 months during active treatment with tyrosine kinase inhibitor therapy. PCR testing for BCR-ABL1 quantification is considered **medically necessary** for monitoring patients who have undergone discontinuation of tyrosine kinase inhibitor therapy with assessment not more frequent than the following schedule: monthly for the first 6 months after discontinuation, bimonthly for months 7 to 12, and every 3 months thereafter. **Explanation of change** Focused testing (clarifying) Chromosomal testing is out of scope for genetic testing (clarifying)	15, 2025

Myelodysplastic Syndrome	
Somatic testing (i.e., 50 or fewer genes) of bone marrow tissue **OR** peripheral blood is considered **medically necessary** for individuals with clinically diagnosed or suspected myelodysplastic syndrome when **BOTH** of the following criteria are met: • Testing is for the purpose of establishing the diagnosis, to stratify risk, or to identify actionable therapeutic targets • A multi-gene panel contains genes that are identified with MDS, such as ASXL1, DNMT3A, EZH2, NRAS, RUNX1, SF3B1, SETBP1, SRSF2, STAG2, TET2, TP53, U2AF1, ZRSR2, and UBA1 **Explanation of change:** Added genetic marker to examples (clarifying) Chromosomal testing is out of scope for genetic testing (clarifying)	November 15, 2025

Multiple Myeloma	
Gene expression profile tests Gene expression profile tests for diagnostic evaluation, risk stratification, or management of multiple myeloma are considered **not medically necessary**. *For multianalyte assays used for prognostication (often combined with algorithmic analyses), see the Carelon Guidelines for Predictive and Prognostic Polygenic Testing.* **Measurable Residual Disease Testing** The use of NGS testing of tumor DNA from bone marrow specimens to detect or quantify minimal residual disease (MRD) in individuals with myeloma is considered **medically necessary** under **EITHER** of the following circumstances: • MRD testing used prior to initiating new treatment intended to induce myeloma remission	November 15, 2025

• MRD testing used to assess depth of response after a cycle of treatment intended to induce myeloma remission **Explanation of change**: Chromosomal testing is out of scope for genetic testing (clarifying)	

Advanced Imaging/Radiology Guidelines

Legend	Text color	Indicates…
Guideline Change Summary	**Blue**	Change to guideline wording (*red for restrictive change)
	Black	Preservation of existing guideline wording
		Changes expected to be…
Explanation of Change	**Green**	More expansive on appropriateness
	Red	More restrictive on appropriateness
	Black	Have minimal if any impact on appropriateness review and exists primarily to clarify intent

The following updates will apply to the Carelon Clinical Appropriateness **Guidelines for Advanced Imaging/Radiology.** You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

Imaging of the Brain	
Neurodegenerative Conditions **Neurocognitive disorders (Adult only)** *Includes mild cognitive impairment, dementia, and variants (e.g., vascular, Alzheimer's disease, frontotemporal degeneration spectrum, diffuse Lewy body).* Advanced imaging is considered medically necessary to direct management in **ANY** of the following scenarios: • Initial evaluation of documented cognitive abnormality when unexplained by clinical evaluation • Evaluation of rapidly progressive symptoms • In patients being treated with amyloid therapy (MRI brain only) **IMAGING STUDY** • CT brain • MRI brain (preferred) PET Brain is considered medically necessary to differentiate between frontotemporal dementia and Alzheimer's disease when substantial diagnostic uncertainty remains after **ALL** of the following: • Neuropsychological testing • Evaluation by a physician experienced in neurodegenerative disease • Structural imaging (CT or MRI) **IMAGING STUDY** • FDG PET or PET/CT • Amyloid Brain PET or PET/CT when amyloid therapy is being considered **Explanation of change:** Specification of MRI for amyloid therapy monitoring; expansion to remove intervals and include other amyloid therapies. Other formatting changes (no content change).	November 15, 2025
Trauma ***ADULT*** Advanced imaging is considered medically necessary in **EITHER** of the following scenarios: • Acute head trauma when **ANY** of the following risk factors are present: ○ Age 65 years or older	November 15, 2025

○ Retrograde amnesia ○ At least 2 episodes of emesis ○ Evidence of open, depressed, or basilar skull fracture ○ Focal neurologic findings ○ Glasgow coma scale less than 15 or altered mental status ○ High-risk mechanism of injury ○ Seizure ○ Bleeding diathesis/coagulopathy ○ Intracranial shunt • Subacute or chronic head trauma in **EITHER** of the following scenarios: ○ Cognitive or focal neurologic deficits ○ Nonfocal neurologic signs or symptoms (including post-concussive syndrome) refractory to therapy ***PEDIATRIC*** Advanced imaging is considered medically necessary in **EITHER** of the following scenarios: • Acute head trauma when **ANY** of the following risk factors are present: Altered mental status ○ Change in behavior ○ Vomiting ○ Loss of consciousness ○ History of high-risk motor vehicle accident or other mechanism of injury ○ Scalp hematoma when younger than age 2 years ○ Evidence of basilar skull fracture ○ Non-accidental injury • Subacute or chronic head trauma in **ANY** of the following scenarios: ○ A follow-up study 3-6 weeks after head trauma in patients age 6 years or younger, when the neurologic exam is stable or inconclusive ○ Cognitive or focal neurologic deficits ○ Nonfocal neurologic signs or symptoms (including post-concussive syndrome) refractory to therapy **Explanation of change:** Updated for non-acute trauma to align with ACR AUC recommendations, terminology clarifications	
Tumor or Neoplasm **Pituitary mass (including pituitary adenoma, incidentaloma)** Advanced imaging is considered medically necessary in **ANY** of the following scenarios: • Incidental pituitary lesion detected on CT or MRI, when at least 10 mm in size and not a simple cyst • Suspected pituitary adenoma when supported by signs or symptoms as well as laboratory findings • Management (including perioperative evaluation) of known adenoma • Surveillance of clinically stable adenoma in **EITHER** of the following: ○ Unresected adenoma ▪ Macroadenoma (size greater than 10 mm) ▪ Microadenoma (size 10 mm or less): Annual surveillance imaging ○ Resected adenoma ▪ At least 3 months following resection **Explanation of change** Combined pituitary tumor sections; incidentaloma size threshold aligned with cited ACR white paper.	November 15, 2025
Seizure disorder and epilepsy ***ADULT***	November 15, 2025

Advanced imaging is considered medically necessary in **ANY** of the following scenarios: • Initial evaluation of new or changing seizure, to rule out a structural brain lesion • Seizures increasing in frequency or severity despite optimal medical management • Prior to discontinuation of anticonvulsant therapy in patients who have not been previously imaged • Epilepsy refractory to optimal medical management in surgical candidates ***PEDIATRIC*** Advanced imaging is considered medically necessary in **ANY** of the following scenarios: • Neonatal/infantile seizure (age 2 years or younger) when **EITHER** of the following is present: ○ Initial evaluation of seizure not associated with fever ○ Periodic follow up at 6-month intervals up to 30 months, if initial imaging study is nondiagnostic • Childhood/adolescent seizure (over age 2) when **ANY** of the following is present: ○ Focal neurologic findings at the time of the seizure ○ Persistent neurologic deficit in the postictal period ○ Idiopathic generalized epilepsy with atypical clinical course ○ Partial or absence seizures ○ Nondiagnostic EEG ○ Seizures increasing in frequency or severity despite optimal medical management ○ Prior to discontinuation of anticonvulsant therapy in patients who have not been previously imaged ○ Epilepsy refractory to optimal medical management in surgical candidates • Complex febrile seizure (age 6 months to 5 years) when **EITHER** of the following is present: ○ More than one seizure during a febrile period ○ Seizure lasting longer than 15 minutes *Note: Imaging is not generally indicated for simple febrile seizures.* **IMAGING STUDY** • CT brain • MRI brain • Functional MRI (fMRI) in epilepsy refractory to optimal medical management in surgical candidates when done as a replacement for a Wada test or direct electrical stimulation mapping • PET brain imaging in epilepsy refractory to optimal medical management in surgical candidates **Explanation of change:** Added allowance for absence seizure, other clarifications aligned with operational intent	
Procedural Imaging (Previously Perioperative/Periprocedural Imaging) **Magnetoencephalography and magnetic source imaging** Advanced imaging is considered medically necessary in **ANY** of the following scenarios: • Preoperative seizure localization for intractable epilepsy, when MRI is nondiagnostic • Preoperative mapping of eloquent cortex **IMAGING STUDY** • Magnetoencephalography (MEG) or magnetic source imaging (MSI) **Explanation of change:** New guideline content (codes already managed for Elevance plans)	November 15, 2025

Signs and Symptoms **Dizziness or vertigo** *Also see Head and Neck Imaging guidelines* Advanced imaging is considered **medically necessary** for dizziness associated with **ANY** of the following: • Abnormal neurologic exam, audiogram or vestibular function testing suggestive of an intracranial or vestibulocochlear mass lesion • Unilateral hearing loss or tinnitus • Tullio's phenomenon (noise-induced dizziness) **Explanation of change** Specification of objective findings aligned with ACR AUC; including current Hearing loss/Tinnitus allowances.	November 15, 2025
Headache Advanced imaging is considered **medically necessary** to evaluate headache not previously imaged by MRI in **ANY** of the following scenarios: • Thunderclap or sentinel headache (sudden onset and severe, or worst headache of life, reaching maximal intensity within minutes) • Headache triggered by or occurring primarily in association with exertion or Valsalva (including cough, exercise, or sexual activity) • Positional or orthostatic headache • New headache onset after age 50 • Change in headache pattern • Abnormal neurological exam • Unexplained and unexpected increase in frequency and/or severity of headaches • Trigeminal autonomic cephalgia (TAC), including cluster headaches • Comorbid conditions that increase the likelihood of an intracranial lesion, including malignancy, immunosuppression, sarcoidosis, neurocutaneous disorders (phakomatoses), or pregnancy *Note: For headache related to trauma, infection, aneurysm, venous sinus thrombosis or other specific diagnoses, please refer to those indications in the Brain Imaging or Vascular Imaging guidelines* *For typical migraine or tension-type headache, without red flags and without a change in pattern, advanced imaging is not indicated.* **Explanation of change** Specification of prior imaging to allow MRI evaluation, additional clarifications (no operational change)	November 15, 2025

Imaging of the Extremities	
Infection **Septic arthritis** Advanced imaging is considered **medically necessary** for diagnosis and management when radiograph, ultrasound, or arthrocentesis is nondiagnostic or not sufficient to guide treatment. IMAGING STUDY • MRI upper or lower extremity (joint) **Explanation of change:** Removal of non-joint modality for joint indication	November 15, 2025

Inflammatory Conditions **Myositis** Advanced imaging is considered medically necessary in **EITHER** of the following scenarios: • Clinically suspected myositis, for imaging confirmation or localization for biopsy • Monitor response to therapy **Explanation of change:** Clarification/expansion to allow imaging confirmation	November 15, 2025
Trauma **Fracture** Advanced imaging is considered **medically necessary** in **ANY** of the following scenarios: • Detection of occult fracture following nondiagnostic radiographs at high-risk/weight bearing sites: ○ Upper extremity: ▪ Scaphoid ▪ Lunate ○ Lower extremity: ▪ Femoral neck, proximal femur ▪ Tibia (anterior tibial cortex; tibial plateau; medial malleolus) ▪ Patella ▪ Talus ▪ Navicular ▪ Metatarsal base (second and fifth digits) ▪ Great toe sesamoid ▪ Calcaneus (in individuals when imaging will direct the timing of return to vigorous athletic activity) • Following radiographs demonstrating supracondylar, intra-articular, or Salter-Harris (growth plate) fractures (including tibial plateau fracture) • To assess fracture healing for delayed union or nonunion when radiographs are nondiagnostic **IMAGING STUDY** • MRI upper extremity (joint or non-joint); MRI lower extremity • CT upper or lower extremity for evaluation of supracondylar, intra-articular, or Salter-Harris fractures • CT upper or lower extremity for detection of occult fracture when MRI cannot be performed • CT upper extremity (joint or non-joint) for delayed union or nonunion of the scaphoid as an alternative to MRI **Explanation of change:** Addition of high-risk site (medial malleolus) Clarification for intra-articular fracture (no operational change)	November 15, 2025
Tumor/Neoplasm **Soft tissue mass – not otherwise specified** Advanced imaging is considered **medically necessary** in **ANY** of the following scenarios: • Superficial or palpable non-popliteal mass, following nondiagnostic radiograph or ultrasound • Superficial or palpable popliteal (posterior knee) mass, following nondiagnostic radiographs and ultrasound • Soft tissue evaluation when prominent or unexplained calcifications are seen on radiograph	November 15, 2025

Explanation of change: Removal of unsupported content; other clarification (no operational change)	
Conditions of the Upper Extremity (previously Ligament and Tendon Derangement of the Upper Extremity) **Labral tear – shoulder** Advanced imaging is considered **medically necessary** for suspected labral tear in ANY of the following scenarios: • History of shoulder dislocation or recurrent subluxation, with persistent pain and/or instability • Acute trauma with either evidence of suprascapular nerve entrapment or radiographic suspicion of a bony Bankart lesion (anteroinferior glenoid fracture) • Pain with at least one physical exam finding of SLAP tear, nondiagnostic radiograph and failure of at least 6 weeks of conservative management **Explanation of change:** Expanded/simplified criteria aligned with Carelon MSK guidelines. Added XR per ACR AUC for chronic shoulder pain, alignment with joint imaging thresholds.	November 15, 2025
Ligament and tendon injuries – wrist Advanced imaging is considered **medically necessary** following nondiagnostic radiographs in **ANY** of the following scenarios: • Suspected scapholunate ligament tear • Acute triangular fibrocartilage complex (TFCC) tear • Chronic TFCC tear with failure of at least 6 weeks conservative management **IMAGING STUDY** • MRI upper extremity (joint) • CT when MRI cannot be performed or is nondiagnostic **Explanation of change:** Removal of operationally vague scenario now addressed under UE Pain NOS; section combined with TFCC tear (no content change)	November 15, 2025
Conditions of the Lower Extremity (previously Ligament and Tendon Derangement of the Lower Extremity) **Labral tear and femoral acetabular impingement – hip** Advanced imaging is considered **medically necessary** in **EITHER** of the following scenarios: • Suspected labral tear with **ALL** of the following: • Hip pain, **OR** positive impingement on exam • Nondiagnostic radiograph (without advanced osteoarthritis, or normal) • Failure of at least 6 weeks of conservative management **Explanation of change:** Simplification of pain description, XR requirement aligned with MSK guideline	November 15, 2025
Meniscal tear/injury Advanced imaging is considered **medically necessary** following nondiagnostic radiographs in **EITHER** of the following scenarios: • Knee pain with symptoms of locking, catching, or instability **AND** at least **TWO** of the following physical exam findings of meniscal tear: • Joint swelling or effusion • Positive McMurray or Apley test • Joint line tenderness • Reduced range of motion	November 15, 2025

• Knee pain with at least **ONE** physical exam finding of meniscal tear and failure of at least 6 weeks of conservative management **Explanation of change:** Alignment with Carelon MSK Joint surgery guideline thresholds	
Pain, unspecified **Lower extremity pain, not otherwise specified** *Applies when focused history and physical exam have not provided a likely diagnosis.* Advanced imaging is considered **medically necessary** for persistent pain when **BOTH** of the following criteria are met: • Radiographs are nondiagnostic (and without severe osteoarthritis) • Failure of at least 6 weeks of conservative management **IMAGING STUDY** • MRI lower extremity • CT lower extremity when MRI cannot be performed or is nondiagnostic **Upper extremity pain, not otherwise specified** *Applies when focused history and physical exam have not provided a likely diagnosis.* Advanced imaging is considered **medically necessary** for persistent pain when **BOTH** of the following criteria are met: • Radiographs are nondiagnostic (and without severe osteoarthritis) • Failure of at least 6 weeks of conservative management **Explanation of change** Removal of site-specific exclusions for Pain NOS with aligned thresholds for conservative management; updated OA grading	November 15, 2025

Imaging of the Spine	
Infectious and Inflammatory Conditions **Axial spondyloarthropathy** *Includes ankylosing spondylitis, reactive arthritis, psoriatic arthritis, spondyloarthropathy associated with inflammatory bowel disease, and juvenile-onset spondyloarthritis* Advanced imaging of the spine is considered medically necessary in **ANY** of the following scenarios: • Diagnosis of spondyloarthritis (SpA) when **ALL** of the following are present: ○ Inflammatory back pain* for at least 3 months ○ Radiographs and MRI of the sacroiliac joints are negative or equivocal for sacroiliitis • Management for **EITHER** of the following: ○ On biologic therapy for treatment spondyloarthritis (nrSpA), with unclear disease activity after full clinical and laboratory evaluation, when progression on MRI will lead to an alteration of management ○ Suspected fracture in setting of known spinal ankylosis **IMAGING STUDY** • CT cervical, thoracic, or lumbar spine • MRI cervical, thoracic, or lumbar spine (preferred) **Inflammatory back pain characteristically includes the following features: insidious onset, improvement with exercise, no improvement with rest, occurring at night, and age of onset <40 years of age.*	November 15, 2025

Explanation of change: Expanded and simplified allowances aligned with cited diagnostic thresholds	
Miscellaneous Conditions of the Spine **Vertebral compression fracture** Advanced imaging is considered medically necessary in **ANY** of the following scenarios: • New symptomatic vertebral compression fracture by radiograph, when vertebroplasty or kyphoplasty is being considered • Vertebral compression fracture with history of malignancy • Previously treated compression fracture(s) with new back pain • Suspected fracture in setting of known spinal ankylosis **Explanation of change:** Changes in alignment with ACR AUC recommendations	November 15, 2025
Pain, Radiculopathy and Spinal stenosis (Previously Pain Indications) **Neck pain or cervical radiculopathy** Advanced imaging is considered **medically necessary** in **EITHER** of the following scenarios: • Neurologic exam findings suggesting cervical nerve root or cord compression that has not previously been imaged, or is new since last imaging was performed • Pain or radiculopathy following at least 6 weeks of conservative management **Mid-back pain or thoracic radiculopathy** Advanced imaging is considered **medically necessary** in **EITHER** of the following scenarios: • Neurologic exam findings suggesting thoracic nerve root or cord compression that has not previously been imaged or is new since last imaging was performed • Pain or radiculopathy following at least 6 weeks of conservative management **Low back pain or lumbar radiculopathy** ***ADULT*** Advanced imaging is considered **medically necessary** in **EITHER** of the following scenarios: • Neurologic exam findings suggesting lumbar nerve root or cord compression that has not previously been imaged or is new since last imaging was performed • Pain or radiculopathy following at least 6 weeks of conservative management ***PEDIATRIC*** Advanced imaging is considered **medically necessary** in **ANY** of the following scenarios: • Pain with nondiagnostic radiographs and **ANY** of the following characteristics: ○ Constant ○ Occurs at night ○ Radicular ○ Duration greater than 4 weeks and not responsive to conservative management • Neurologic exam findings suggesting lumbar nerve root or cord compression that has not previously been imaged or is new since last imaging was performed **Explanation of change** Added specification for new neurologic findings Removed intervention candidacy requirement Removed cervical x-ray requirements aligned with ACR AUC. Condensed Radiculopathy and Adult/Peds (no content change)	November 15, 2025
Spinal stenosis and spondylolisthesis Advanced imaging is considered **medically necessary** in **ANY** of the following scenarios:	November 15, 2025

• Acute onset of neurogenic claudication in patients who are not candidates for conservative management due to intractable pain • Chronic neurogenic claudication that has not responded to at least 6 weeks of conservative management • Spondylolisthesis, with evidence of instability on lumbar spine radiographs **Explanation of change:** Removed intervention candidacy requirement. Title clarification; removed scenario addressed in other sections (not content change)	

Imaging of the Heart	
Coronary CT Angiography/ MRI Cardiac/ PET Perfusion Imaging/ Myocardial Perfusion Imaging/ Stress Echocardiography **Imaging Considerations** • …. • For purposes of this guideline, a patient is considered to have had preceding evaluation of coronary artery disease if any of the following have been performed: Stress testing with adjunctive imaging (nuclear, echo, PET, MRI) or coronary angiography (CCTA or invasive). **Explanation of change:** In several guidelines the appropriateness of imaging is based on whether the patient has had a preceding evaluation for CAD. Reviewers had requested that the term "preceding evaluation for CAD" be defined	November 15, 2025
Established or suspected CAD **Patients with abnormal or inconclusive exercise treadmill test (performed without imaging) who have not undergone evaluation for CAD since the treadmill test** • Abnormal findings on an exercise treadmill test include chest pain, ST segment change, abnormal blood pressure response, or complex ventricular arrhythmias • Provided that criteria for positivity (as outlined above) are not present, an exercise EKG test is deemed to be inconclusive when target heart rate was not reached or when the protocol could not be completed for other reasons (e.g. non-cardiac symptoms, inability to walk on a treadmill, other safety concerns). **Explanation of change** Addition of inconclusive exercise treadmill test as an indication for additional CAD testing	November 15, 2025
Established or suspected CAD **Preoperative cardiac evaluation of patients undergoing non-emergency non-cardiac surgery** *Note: It is assumed that those who require emergency surgery will undergo inpatient preoperative evaluation.* Stress testing with adjunctive imaging or CCTA/Cardiac MRI/Perfusion PET/MPI/SE is considered medically necessary when **ALL** of the following (A-C) apply A. At least two (2) of the following • Age ≥ 75 years • History of heart disease (myocardial infarction [MI], PCI, cardiac surgery, heart failure, atrial fibrillation, or moderate/severe valvular disease confirmed by echocardiography) • Angina or dyspnea • Hemoglobin <12 g/dl • The proposed surgery is vascular B. Poor or unknown functional capacity C. The proposed surgery is an elevated risk procedure* *All surgical procedures **EXCEPT** those listed below are considered elevated risk: • ophthalmologic • dental • endoscopic (including arthroscopic) • endocrine • breast	November 15, 2025

• obstetric /gynecological • dermatological Prior to considering elective surgery, patients with active cardiac conditions such as unstable coronary syndromes (unstable angina), decompensated heart failure (NYHA class IV, worsening or new onset heart failure), significant arrhythmias (third degree AV block Mobitz II AV block, uncontrolled supraventricular arrhythmia, symptomatic ventricular arrhythmias, ventricular tachycardia), symptomatic bradycardia or severe stenotic valvular lesions should be evaluated and managed per ACC/AHA guidelines. **That evaluation may include CCTA/Cardiac MRI/Perfusion PET/MPI/SE**. • **Low-risk surgery** (endoscopic procedures, superficial procedures, cataract surgery, breast surgery, ambulatory surgery) **Explanation of change** Include preoperative stress testing in alignment with 2024 AHA/ACC/ACS/ASNC/HRS/SCA/SCCT/SCMR/SVM guideline for perioperative cardiovascular management for noncardiac surgery: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. JACC. 2024;84(19):1869–1969.	

Vascular Imaging	
Procedure-related Imaging **Vascular evaluation prior to transcatheter aortic valve implantation/replacement (TAVI/TAVR) or cardiac surgery** **Explanation of change** Cardiac surgery added to Procedure-related imaging (allows CT or CTA chest).	November 15, 2025
Brain, Head and Neck **Stenosis or occlusion, extracranial carotid arteries** *See separate indication for acute stroke or transient ischemic attack.* Vascular imaging is considered **medically necessary** in patients who are candidates for carotid revascularization in **ANY** of the following scenarios: • Screening ○ Starting 5 years post-neck irradiation and every 3 years thereafter • Diagnosis of suspected carotid stenosis ○ Hollenhorst plaques (cholesterol emboli) or retinal neovascularity on retinal examination • Management of known carotid stenosis ○ Worsening neurologic symptoms or signs attributable to the anterior circulation • Surveillance of established carotid disease in asymptomatic persons with no prior revascularization: ○ Moderate (50%-69%) stenosis: every 12 months ○ Severe (70% or greater) stenosis: every 6 months • Post-revascularization: baseline evaluation, then every 6 months for 2 years, then annually **Explanation of change** Combined post-revascularization imaging and updated alignment with SVS guidelines. Cardiac surgery item moved to Procedure related imaging.	November 15, 2025
Stroke or transient ischemic attack (TIA), intracranial evaluation *Also see Brain Imaging guidelines.* Vascular imaging is considered **medically necessary** in **ANY** of the following scenarios,	November 15, 2025

when no prior intracranial imaging since the stroke/TIA event: • Acute or subacute stroke/TIA (within 30 days of signs or symptoms other than syncope) • Chronic (30 days or more) stroke/TIA with signs or symptoms other than syncope attributable to the posterior circulation **Explanation of change:** Simplification for acute/subacute stroke/TIA by timing, specification for same-episode imaging	
Stroke or transient ischemic attack (TIA), extracranial evaluation Vascular imaging is considered **medically necessary** in **ANY** of the following scenarios, when no carotid imaging since the stroke/TIA event: • Acute or subacute stroke/TIA (within 30 days of signs or symptoms other than syncope) • Chronic (30 days or more) stroke/TIA in **EITHER** of the following scenarios: ○ Signs or symptoms attributable to the anterior (carotid) circulation, in patients who are candidates for carotid revascularization ○ Signs or symptoms other than syncope attributable to the posterior circulation **IMAGING STUDY** • Duplex arterial ultrasound (any indication) • CTA or MRA neck for acute/subacute stroke/TIA and chronic posterior circulation stroke/TIA • CTA or MRA neck for chronic anterior circulation stroke/TIA when duplex arterial ultrasound cannot be performed or is nondiagnostic **Explanation of change:** Simplification for acute/subacute stroke/TIA by timing, specification for same-episode imaging	November 15, 2025
Venous thrombosis or compression, intracranial *Includes dural venous sinus thrombosis, venous sinus thrombosis, and cerebral vein thrombosis* Advanced imaging is considered **medically necessary** in **ANY** of the following: • Suspected venous sinus thrombosis in setting of headache, visual changes, eye pain or other neurologic symptoms, with **ANY** of the following: ○ Papilledema, cranial nerve palsy, or focal neurologic deficit on exam ○ Risk factor for venous thrombosis ○ Elevated D-dimer ○ Suspicious or nondiagnostic CT head or MRI brain • History of venous sinus thrombosis, with current signs or symptoms of recurrent thrombosis • Follow-up of known venous sinus thrombosis • To exclude venous compression by an adjacent intracranial mass **IMAGING STUDY** • CTA or MRA head • CT brain or MRI Brain **Explanation of change:** Simplification of content by common presentation, allowance of CT/MRI in lieu of CTA/MRA, other clarifications.	November 15, 2025
Chest **Acute aortic syndrome** *Includes aortic dissection, rupture, intramural hematoma, penetrating ulcer, and pseudoaneurysm* Advanced imaging is considered **medically necessary** in **ANY** of the following scenarios:	November 15, 2025

• Initial diagnosis of suspected disease • Management of known disease • Annual surveillance of clinically stable disease **IMAGING STUDY** • CT or CTA chest • MRA chest **Explanation of change:** Added CT allowance (contrast CT may be sufficient for eval)	
Upper Extremity Physiologic testing for peripheral arterial disease Physiologic testing is considered **medically necessary** for diagnosis and management in **ANY** of the following scenarios: • New or worsening signs or symptoms (**ANY** of the following): ○ Claudication ○ Unilateral cold painful hand (including resting ischemic pain) ○ Finger discoloration or ulcer ○ Non healing arm ulcers or gangrene ○ Absent pulses of the arm or hand associated with infection • Arterial entrapment syndrome or positional arterial obstruction • Arm or hand trauma and a suspicion of vascular injury • Preoperative evaluation in EITHER of the following: ○ Evaluation of native arteries prior to arteriovenous fistula or graft for dialysis access ○ Prior to planned harvest of the arterial harvesting (e.g., for CABG) • Suspected complication of upper extremity arterial access (including suspected arterial steal) • Post procedure baseline and initial 6 month follow up after revascularization with a vein bypass graft • Annual surveillance starting 1 year after revascularization with a vein or prosthetic bypass graft **Explanation of change:** Alignment of preop indications with Duplex US criteria; other clarifications	November 15, 2025
Lower Extremity **Physiologic testing for peripheral arterial disease** Physiologic testing is considered **medically necessary** for diagnosis and management in **ANY** of the following scenarios: • New or worsening signs or symptoms (**ANY** of the following): ○ Claudication ○ Resting limb pain with diminished or absent pulses ○ Non healing ulcers or gangrene ○ Absent pulses of the leg or foot • Acute limb ischemia • Baseline in newly diagnosed peripheral arterial disease (ABI) or prior to revascularization (segmental pressure measurements) • Post-revascularization: ○ Post procedure baseline evaluation ○ After surgical revascularization: At 3-month intervals within the first 2 years, and annually thereafter ○ After endovascular revascularization*: At 4-month intervals within the first	November 15, 2025

year, and annually thereafter **IMAGING STUDY** Limited, complete, or noninvasive physiologic studies *Endovascular revascularization may include angioplasty, thrombectomy, atherectomy, or stent placement **Explanation of change:** Alignment of post-revascularization indications with Duplex US criteria	

Sleep Disorder Management Guidelines

Legend	Text color	Indicates…
Guideline Change Summary	**Blue**	Change to guideline wording (*red for restrictive change)
	Black	Preservation of existing guideline wording
		Changes expected to be…
Explanation of Change	**Green**	More expansive on appropriateness
	Red	More restrictive on appropriateness
	Black	Have minimal if any impact on appropriateness review and exists primarily to clarify intent

The following updates will apply to the Carelon Clinical Appropriateness **Guidelines for Sleep Disorder Management.** You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

Polysomnography and Home Sleep Apnea Testing	
Overview Portable testing units that provide respiratory analysis through measurement of peripheral arterial tone (which do not fit neatly into the above classification) are an alternative approach to HSAT. Home sleep apnea studies offer an alternative to PSG for some patients with suspected OSA. This option is more comfortable and convenient for the patient, is less costly and more readily available in regions where the demand for PSG is high. Multiple night home sleep apnea studies may be indicated in some situations. Patients who are age 17 years or younger, have severe chronic obstructive pulmonary disease, advanced congestive heart failure, neuromuscular diseases, or cognitive impairment, are not suitable candidates for home sleep apnea studies **Explanation of change:** Inclusion of devices using peripheral arterial tone as an alternative approach to HSAT	November 15, 2025
Home (Unattended) Sleep Studies **Suspected OSA** Home sleep apnea studies are considered **medically necessary** if the patient meets **ANY** of the following criteria: • Observed apneas during sleep • A combination of **at least TWO of 5 criteria listed below**: ○ Excessive daytime sleepiness evidenced by an Epworth sleepiness scale score greater than 10, inappropriate daytime napping (e.g., during driving, conversation, or eating), or sleepiness that interferes with daily activities and is not explained by other conditions ○ Habitual snoring or gasping/choking episodes associated with awakenings ○ Treatment-resistant hypertension (persistent hypertension in a patient taking three or more antihypertensive medications) ○ Obesity, defined as a body mass index (BMI) greater than 30 kg/m2 or neck circumference greater than 17 inches in men or greater than 16 inches in women ○ Craniofacial or upper airway soft tissue abnormalities, including adenotonsillar hypertrophy, or neuromuscular disease • History of stroke (more than 30 days previously), transient ischemic attack, coronary artery disease, or sustained supraventricular tachycardic or bradycardic arrhythmias in patients who meet **ONE of 5 criteria listed above** • Any of the following conditions which may suggest OSA when the etiology is unclear: right heart failure, polycythemia, sustained supraventricular or ventricular tachyarrhythmia occurring solely during sleep, or pulmonary hypertension	November 15, 2025

Explanation of change: Removed contraindication phrasing Expansion of criteria for when etiology is unclear	
Established OSA – follow-up home sleep apnea studies A follow-up home sleep apnea study is considered **medically necessary** for a patient with an established diagnosis of OSA when **ANY** of the following apply: • On one occasion following: ○ Upper airway surgery performed to treat OSA and/or improve compliance with PAP therapy ○ Initiation of use of an oral appliance • To reevaluate the diagnosis of OSA and need for continued CPAP if there is a significant weight loss (defined as 10% of body weight) since the most recent sleep study • Prior to implantation of a hypoglossal nerve stimulator in a patient who has not had a diagnostic study (home or lab) within the preceding 18 months **Explanation of change:** Removed contraindication phrasing	November 15, 2025
In-Lab (Attended) Sleep Studies in Adult Patients (Age 18 Years or Older) **Suspected OSA (in patients with unspecified sleep apnea and nocturnal desaturation, OSA should be suspected and excluded if clinically appropriate)** ***The following criteria apply to individuals with a contraindication to a home sleep apnea study****. See list of contraindications to home sleep apnea studies.* An in-lab sleep (attended) study is considered **medically necessary** if the patient meets **ANY** of the following criteria and has a contraindication to a home sleep apnea study: • Observed apneas during sleep • A combination of **at least TWO of 5 criteria listed below**: ○ Excessive daytime sleepiness evidenced by an Epworth sleepiness scale score greater than 10, inappropriate daytime napping (e.g., during driving, conversation, or eating), or sleepiness that interferes with daily activities and is not explained by other conditions ○ Habitual snoring or gasping/choking episodes associated with awakenings ○ Treatment-resistant hypertension (persistent hypertension in a patient taking three or more antihypertensive medications) ○ Obesity, defined as a body mass index (BMI) greater than 30 kg/m2 or neck circumference greater than 17 inches in men or greater than 16 inches in women ○ Craniofacial or upper airway soft tissue abnormalities, including adenotonsillar hypertrophy, or neuromuscular disease • History of stroke (more than 30 days previously), transient ischemic attack, coronary artery disease, or sustained tachycardic or bradycardic arrhythmias in patients who meet **ONE of 5 criteria listed above** • Any of the following conditions which may suggest OSA when the etiology is unclear: right heart failure, polycythemia, sustained supraventricular or ventricular tachyarrhythmia occurring solely during sleep, or pulmonary hypertension **Explanation of change:** Expansion of criteria for when etiology is unclear	November 15, 2025
Suspected sleep disorder other than OSA An in-lab supervised sleep study is considered **medically necessary** when there is suspicion of **ANY** of the following: • Central sleep apnea (CSA) – to support the suspicion of CSA in this context, **ONE** of	November 15, 2025

the following must be documented: heart failure, stroke within the preceding 90 days, chronic opiate or narcotic use or Chiari malformation. OSA should be excluded before considering CSA in patients who snore. • Narcolepsy • Nocturnal Seizures • Parasomnia which is likely to result in harm to the patient or others • Idiopathic hypersomnia • Periodic limb movement disorder (PLMD)—to support a suspicion of PLMD in this context, **ONE** of the following must be documented: pregnancy, renal failure, iron deficiency anemia, peripheral neuropathy, use of antidepressant or antipsychotic medications. A diagnosis of PLMD requires that the patient have ongoing hypersomnia or insomnia. Patients with OSA and/or RLS should have these conditions treated before evaluation for PLMD. • Nocturnal desaturation (due to severe COPD or certain restrictive thoracic disorders) **Explanation of change:** Clarifications provided for CSA and PLMD	
In-Lab (Attended) Sleep Studies in Non-Adult Patients (Age 17 Years or Younger) **Explanation of change:** Age change to clarify non-adult patients	November 15, 2025
Contraindications to Home Sleep Apnea Studies • Age **17** years or younger [no other changes] **Explanation of change:** Age change to clarify non-adult patients	November 15, 2025
Contraindications to APAP [no other changes] **Explanation of change:** Removed age restriction	November 15, 2025
Multiple Sleep Latency Testing and Maintenance of Wakefulness Testing	
Overview **Idiopathic hypersomnia** Daytime sleepiness following adequate (or even prolonged) nocturnal sleep duration and non-refreshing daytime naps are characteristic of idiopathic hypersomnia. Patients with idiopathic hypersomnia may have sleep paralysis and hallucination but cataplexy is absent. Despite prolonged sleep duration, patients with idiopathic hypersomnia display difficult morning awakening, sleep drunkenness and constant somnolence. Idiopathic hypersomnia is rarer than narcolepsy and tends to be more resistant to treatment. A diagnosis of idiopathic hypersomnia requires exclusion of other causes of fatigue and excessive daytime sleepiness including hypothyroidism, depression, obstructive sleep apnea, etc. Patients who have undergone diagnostic testing for OSA and whose AHI is >5 should be adequately treated for OSA before undergoing evaluation for other causes of hypersomnia. **Explanation of change:** Clarification of idiopathic hypersomnia	November 15, 2025
Management of OSA using Auto-Titrating and Continuous Positive Airway Pressure Devices	
Treatment with CPAP is considered medically necessary for a patient aged 18 years or older when BOTH of the following criteria are met: • Home- or lab-based sleep study demonstrates **ONE** of the following: • AHI 15 or higher • AHI 5–14 with any of the following: excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease, history of stroke • Appropriate CPAP level has been determined	November 15, 2025

Explanation of change: Removal of extraneous criteria	
Treatment with CPAP is considered medically necessary for a patient aged 17 years or younger when BOTH of the following criteria are met: **Explanation of change:** Age change to clarify non-adult patients	November 15, 2025
Treatment with APAP is considered medically necessary for a patient aged 18 years or older when BOTH of the following criteria are met: • Home or lab-based sleep study demonstrates **ONE** of the following: ○ AHI 15 or higher ○ AHI 5–14 with any of the following: excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease, history of stroke • The patient has no contraindication to the use of APAP (see *APAP contraindications*) **Explanation of change:** Age change to clarify non-adult patients	November 15, 2025
Treatment with APAP is considered medically necessary for a patient aged 17 years or younger when ALL of the following criteria are met: • A lab-based sleep study demonstrating AHI of at least 1 (one) **Explanation of change:** Eliminated titration requirement	November 15, 2025
Ongoing treatment with APAP or CPAP Ongoing treatment with APAP* or CPAP* is considered medically necessary for patients who demonstrate compliance with therapy. Demonstration of compliance is required every 90 days for the first year of therapy and annually thereafter. Compliance is defined as **EITHER** of the following: • Use of the PAP device for at least 4 hours per night on 70% of nights during a consecutive 30-day period within the preceding 90 days • The treating provider (as distinct from the DME provider) attests that the patient is accruing clinical benefit from PAP therapy at current usage levels *Demonstration of compliance is not required for non-adult patients. **Explanation of change:** Clarification that clinical benefit attestation must come from the treating provider	November 15, 2025
Contraindications to APAP • Congestive heart failure • Moderate or severe chronic obstructive pulmonary disease (COPD): FEV1/FVC less than or equal to 0.7 and FEV1 less than 80% of predicted **Explanation of change:** Removal of age restriction	November 15, 2025
Bi-Level Positive Airway Pressure Devices	
Ongoing treatment with BPAP Ongoing treatment with BPAP for obstructive sleep apnea* is considered medically necessary for adult patients who demonstrate compliance with therapy. Demonstration of compliance is required for adult patients every 90 days for the first year of treatment and annually thereafter. Compliance is defined as **EITHER** of the following: • Use of the BPAP device for at least 4 hours per night on 70% of nights during a consecutive 30-day period within the preceding 90 days • The treating provider (as distinct from the DME provider) attests that the patient is accruing clinical benefit from PAP therapy at current usage levels	November 15, 2025

*Demonstration of compliance is not required for non-adult patients or when BPAP is used for disorders other than OSA and CSA. **Explanation of change:** Clarification that clinical benefit attestation must come from the treating provider	
Management of OSA using Oral Appliances	
Overview …It is highly recommended that the decision to use an oral appliance in the management of OSA should follow consultation with a sleep medicine specialist. Custom made oral appliances require a prescription from a medical provider. Oral appliances should be used with caution when there is comorbid temporomandibular joint disease and should be avoided in patients with periodontal disease. **Explanation of change:** Clarification for patients with periodontal disease or temporomandibular joint dysfunction [**TMJ should not be considered an absolute contraindication to oral appliance leading to modification of the blue text as shown above]**	November 15, 2025
Treatment with an Oral Appliance is considered medically necessary for patients aged 16 years or older with severe/ mild or moderate OSA (apnea/hypopnea index [AHI] greater than 30) when ALL of the following criteria are met: • The appliance is a TRD or a Medicare-compliant MRA • The patient does not have periodontal disease or temporomandibular joint dysfunction • **ONE** of the following… **Explanation of change** Use of an oral appliance should be avoided in patients with periodontal disease, or used with caution in those with temporomandibular joint dysfunction	November 15, 2025
Miscellaneous Devices in the Management of OSA and Restless Legs Syndrome	
Guideline Scope This guideline addresses two approaches to the management of obstructive sleep apnea: electronic positional therapy and neuromuscular electrical training of the tongue musculature. In addition, the guideline addresses the use of peroneal nerve stimulation for treatment of restless legs syndrome. **Overview** …To date, no high-quality evidence of benefit has been provided for neuromuscular electrical training as a treatment for OSA. Restless legs syndrome (RLS) is a poorly understood sleep-related disorder in which patients report an urge to move their legs during periods of immobility. The symptoms occur predominantly in the evening or at night and are relieved by movement. Although the pathophysiological mechanisms are not clearly defined, iron deficiency and pregnancy are associated. Treatment consists of avoidance of exacerbating factors, pharmacological intervention (gabapentin enacarbil, gabapentin, pregabalin, extended-release oxycodone), and iron supplementation. Recently, bilateral high-frequency peroneal nerve stimulation has been proposed as a treatment option for patients with refractory RLS. To date, studies supporting this therapy have been small, mostly industry sponsored, and non-blinded (making interpretation of subjective endpoints challenging). **Exclusions** Electronic positional therapy is considered **not medically necessary** in all clinical scenarios. Neuromuscular electrical training of the tongue musculature is considered **not medically**	November 15, 2025

necessary in all clinical scenarios. Peroneal nerve stimulation for management of RLS is considered not medically necessary in all clinical scenarios. **Explanation of change:** Added criteria for restless legs syndrome (RLS). Peroneal nerve stimulation for management of RLS is considered not medically necessary.	

June 2025

BEHAVIORAL HEALTH NEUROLOGY NEUROSURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Deep Brain Stimulation	473	Investigational policy statements on psychiatric disorders **clarified.**	June 1, 2025	Commercial	No action required.
Vagus Nerve Stimulation	474	**Policy revised** to include investigational policy statements for treatment of psychiatric conditions, including but not limited to depression, treatment resistant depression and obsessive-compulsive disorder.	September 1, 2025	Commercial	Prior authorization is not required.
Laser Interstitial Thermal Therapy	948	**Policy revised** to include investigational policy statements for the treatment of psychiatric disorders, including but not limited to depression, treatment resistant depression or obsessive-compulsive disorder. Title changed to Interstitial Thermal Therapy.	September 1, 2025	Commercial Medicare	This is not a covered service.

DERMATOLOGY PLASTIC SURGERY

POLICY TITLE	POLICY	POLICY CHANGE	EFFECTIVE	PRODUCTS	PROVIDER ACTIONS

	NO.	SUMMARY	DATE	AFFECTED	REQUIRED
Medicare Advantage Management	132	**Policy revised.** Prior authorization will **no longer be required** for breast reconstructive surgery for breast cancer-related diagnoses for Medicare Advantage. This change will take effect for dates of service on and after September 1, 2025 for Medicare Advantage (HMO, PPO) members. Codes that **no longer require authorization with a breast cancer-related diagnosis** as of September 1, 2025: 11920, 11921, 11922, 11970, 11971, 19316, 19318, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19367, 19368, 19369, 19371, 19380, 19396, S2066 S2067, S2068. **Authorization will continue to be required** for breast reconstructive surgery services not related to breast cancer and for breast reconstructive surgery services related to gender affirming services.	September 1, 2025	Medicare	Prior authorization will no longer be required for cancer-related diagnoses.
Reconstructive Breast Surgery-Management of Breast Implants	428	**Policy revised.** Prior authorization will **no longer be required** for breast reconstructive surgery for breast cancer-related diagnoses for all products.	September 1, 2025	Commercial Medicare	Prior authorization will no longer be required for cancer-related diagnoses.

		This change will take effect for dates of service on and after September 1, 2025, for commercial (HMO, PPO, POS) and Medicare Advantage (HMO, PPO) members. Codes that **no longer require authorization with a breast cancer-related diagnosis** as of September 1, 2025: 11920, 11921, 11922, 11970, 11971, 19316, 19318, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19367, 19368, 19369, 19371, 19380, 19396, S2066 S2067, S2068. **Authorization will continue to be required** for breast reconstructive surgery services not related to breast cancer and for breast reconstructive surgery services related to gender affirming services.			
Outpatient Prior Authorization Code List	072	**Policy revised.** Prior authorization will no longer be required for the following codes under MP 428 Reconstructive Breast Surgery/Management of Breast Implants. **Codes that no longer require authorization with a breast cancer-related diagnosis** as of September 1, 2025: 11920, 11921, 11922, 11970, 11971, 19316, 19318, 19325, 19328,	September 1, 2025	Commercial	Prior authorization will no longer be required for cancer-related diagnoses.

		19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19367, 19368, 19369, 19371, 19380, 19396, S2066 S2067, S2068.			
Bioengineered Skin and Soft Tissue Substitutes	663	**Policy revised.** GraftJacket and AlloMend removed from breast reconstruction policy statement as materials are not evaluated for this indication.	September 1, 2025	Commercial Medicare	Prior authorization is not required.
Amniotic Membrane and Amniotic Fluid	643	**Policy revised.** NuShield added to existing medically necessary policy statement for the treatment of nonhealing diabetic lower-extremity ulcers based on RCT evidence. Otherwise, policy statements unchanged.	September 1, 2025	Commercial	No action required. Prior authorization is not required.

ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Balloon Spacers for Treatment of Irreparable Rotator Cuffs of the Shoulder	176	**New medical policy** describing investigational indications. Subacromial balloon spacer implantation is considered **investigational** as a treatment for massive, irreparable, full-thickness rotator cuff tears.	September 1, 2025	Commercial Medicare	No action required. This is not a covered service.
InterQual Musculoskeletal Services Management CPT and HCPCS Codes	221	**Policy revised.** Codes 0440T, 0441T, 0442T will be removed from MP #221. Codes 0440T, 0441T,	September 1, 2025	Commercial Medicare	No action required.

		0442T will be considered investigational effective September 1, 2025.			

PULMONOLOGY SLEEP DISORDER MANAGEMENT

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical Technology Assessment Non-Covered Services List	400	**Policy clarified.** SleepImage Ring Device for diagnosis and management of obstructive sleep apnea added. There is no specific code for this service.	May 1, 2025	Commercial Medicare	No action required. This is not a covered service.
Medical Technology Assessment Non-Covered Services List	400	**Policy revised.** HCPCS code K1027 **removed** from the noncovered list MP 400. Prior authorization is required for K1027 through Carelon effective September 1, 2025.	September 1, 2025	Commercial Medicare	Prior authorization is required through Carelon for K1027.
Sleep Disorder Management CPT and HCPCS Codes	970	**Policy revised.** The following codes were added: 0966T, 0964T, 0965T. These codes require prior authorization through Carelon effective September 1, 2025.	September 1, 2025	Commercial Medicare	Prior authorization is required through Carelon.

May 2025

CARDIOLOGY

POLICY TITLE	POLICY	POLICY CHANGE	EFFECTIVE	PRODUCTS	PROVIDER ACTIONS

	NO.	SUMMARY	DATE	AFFECTED	REQUIRED
Catheter Ablation as Treatment for Atrial Fibrillation	141	**Policy revised.** Medically necessary policy statements added for pulsed field ablation.	August 1, 2025	Commercial Medicare	Prior authorization is not required.
Transmyocardial Revascularization	651	**Policy retired.** This is a covered service.	May 1, 2025	Commercial	No action required.

DERMATOLOGY PLASTIC SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Suction Lipectomy for Lipedema	043	**Policy clarified** to remove reference to the diagnosis of lipedema in the trunk.	April 15, 2025	Commercial Medicare	Prior authorization is still required.
Treatment of Varicose Veins/Venous Insufficiency	238	**Policy clarified** to align with the BCBS-association national policy criteria on symptomatic varicose tributaries. See Prior Authorization Request Form for Treatment of Varicose Veins/Venous Insufficiency #129.	April 1, 2025	Commercial	Prior authorization is still required.

ENDOCRINOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Artificial Pancreas Device Systems	107	**Policy revised.** New indication and medically necessary policy statement with criteria added for use of an FDA-approved hybrid closed-loop system (eg, Omnipod 5) in individuals ages 18 years and older with type 2 diabetes.	August 1, 2025	Commercial	Prior authorization is not required.

GASTROENTEROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Esophagogastroduodenoscopy (EGD)/Upper Gastrointestinal Endoscopy	202	**New policy** describing medically necessary and investigational indications.	August 1, 2025	Commercial Medicare	No action required.
Adjunctive Techniques for Screening and Surveillance and Risk Classification of Barrett Esophagus and Esophageal Dysplasia	841	**Policy clarified** to remove EsoGuard and BarreGen. These tests are managed by Carelon.	April 10, 2025	Commercial Medicare	Prior authorization is not required.

LABORATORY INFECTIOUS DISEASES

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Pathogen Panel Testing	045	**Policy clarified** to include reference to tick-borne illnesses.	May 1, 2025	Commercial	Prior authorization is not required.

NEUROLOGY NEUROSURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Peripheral Nerve Injury Repair Using Synthetic Conduits or Processed Nerve Allografts	214	**New medical policy** describing medically necessary and investigational indications.	August 1, 2025	Commercial Medicare	Prior authorization is not required.
Surgical Left Atrial Appendage Occlusion Devices for Stroke Prevention in Atrial Fibrillation	176	**Policy retired.** This is a covered service. This procedure is performed in the inpatient setting.	April 9, 2025	Commercial Medicare	No action required.

OPHTHALMOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Retinal Telescreening for Diabetic Retinopathy	065	**Policy retired.** This is a covered service.	May 1, 2025	Commercial	No action required.
Endothelial Keratoplasty	180	**Policy retired.** This is a covered service.	May 1, 2025	Commercial Medicare	No action required.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Factor and Non-Factor Anti-Hemophilic Drugs	360	**Policy revised. Alhemo** and **Hympavzi** will be added to the policy. Name of policy updated.	May 1, 2025	Commercial	Prior authorization is required.
Chimeric Antigen Receptor Therapy for Multiple Myeloma	942	**Policy revised.** Updated **Idecabtagene** criteria.	June 1, 2025	Commercial	Prior authorization is required.
Monoclonal Antibodies for Treatment of Alzheimer's Disease	946	**Policy revised.** Updated renewal length from 12 to 6 months.	June 1, 2025	Commercial	Prior authorization is required.
Anti-hyperlipidemics	013	**Policy revised. Tryngolza** will be added to the policy.	June 1, 2025	Commercial	Prior authorization is required.
Drugs for Cystic Fibrosis	408	**Policy revised. Alyftrek** will be added to the policy.	June 1, 2025	Commercial	Prior authorization is required.
Immuno-modulators for Skin Conditions	010	**Policy revised** to further clarify criteria differences between Zoryve Cream and Zoryve Foam.	June 1, 2025	Commercial	Prior authorization is required.
Engineered T-Cell Therapy for Synovial	213	**New pharmacy** policy describing medically necessary and	June 1, 2025	Commercial	Prior authorization is required.

Sarcoma (Tecelra®)		investigational indications. Prior authorization request form for Engineered T-Cell Therapy for Synovial Sarcoma (Tecelra®) #222.			

April 2025

BEHAVIORAL HEALTH

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Behavioral Health Continuum of Care	194	**New medical policy** describing medically necessary and investigational indications.	July 1, 2025	Commercial Medicare	Prior authorization is required.

ORAL AND MAXILLOFACIAL SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Temporo-mandibular Joint Disorder	035	**Policy clarified.** CPT codes 21073 and 21116 removed. Prior authorization is no longer required on codes 21073 and 21116.	April 1, 2025	Commercial Medicare	No action required.
Outpatient Prior Authorization Code List	072	**Policy clarified.** CPT codes 21073 and 21116 removed. Prior authorization is no longer required on codes 21073 and 21116.	April 1, 2025	Commercial	No action required.
Medicare Advantage Management	132	**Policy clarified**. CPT codes 21073 and 21116 removed. Prior authorization is no longer required on codes 21073 and	April 1, 2025	Medicare	No action required.

		21116.			

21073 Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care)
21116 Injection procedure for temporomandibular joint arthrography

ORTHOPEDICS NEUROSURGERY MUSCULOSKELETAL

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Musculoskeletal Services Management CPT and HCPCS Codes	221	**Policy clarified** to remove the following codes. 23107; 27202; 27226; 27227; 27228; 27253 27254; 27269; 27310; 27381; 29904; 63271; 63272; 63275; 63276 63277; 63281; 63286; 63287; 63290. Prior authorization is no longer required on effective date.	April 1, 2025	Commercial Medicare	Prior authorization is no longer required in these codes.

23107 Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body
27202 Open treatment of coccygeal fracture
27226 Open treatment of posterior or anterior acetabular wall fracture, with internal fixation
27227 Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation
27228 Open treatment of acetabular fracture(s) involving anterior and posterior (two) columns, includes T-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture, with internal fixation
27253 Open treatment of hip dislocation, traumatic, without internal fixation
27254 Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation
27269 Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed
27310 Arthrotomy, knee, with exploration, drainage, or removal of foreign body (e.g., infection)
27381 Suture of infrapatellar tendon; secondary reconstruction, including fascial or tendon graft
29904 Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body
63271 Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic
63272 Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar
63275 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical
63276 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic
63277 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar
63281 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, thoracic
63286 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic
63287 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar
63290 Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level

OTOLARYNGOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Radiofrequency Volumetric	140	**New medical policy** describing ***ongoing***	April 1, 2025	Commercial Medicare	No action required.

Tissue Reduction for Nasal Obstruction (VivAer)		investigational indications. Code 30469 removed from MP 400 Medical Technology Assessment Noncovered Services List and transferred to new MP 140.			This is not a covered service.

30469 Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
CNS Stimulants and Psycho-therapeutic Agents	019	**Policy revised** to list Wakix and Xywav as preferred brands. We're also adding Sodium Oxybate, Lumryz, and Xywav to the policy. Prior authorization will apply to new starts.	July 1, 2025	Commercial	Prior authorization is required.
Drug Management & Retail Pharmacy Prior Authorization	049	**Policy revised** to add Xdemvy to the policy.	July 1, 2025	Commercial	Prior authorization is required.
Drugs for Weight Loss and Cardiovascular Risk Reduction in Overweight and Obesity	572	**Policy revised** to add a dispensing limit of 30 days to GLP-1s listed in the policy to help reduce waste. Block access to weight loss GLP-1's through mail order pharmacy.	July 1, 2025	Commercial	Prior authorization is required.
Immune Modulating Drugs	004	**Policy revised.** As previously communicated, we are updating to move Humira to non-covered on the Blue Cross Blue Shield of Massachusetts formulary. We'll prefer biosimilars Hadlima and Simlandi. Authorization is required for new prescriptions of	July 1, 2025	Commercial	Prior authorization is required.

		the biosimilar and the prescription should be filled through an in-network specialty pharmacy. We are also moving the following agents to non-covered, in addition to Humira, on July 1, 2025: • Adalimumab-AATY • Adalimumab-ADBM • Adalimumab-AACF • Adalimumab-RYVK • Adalimumab-ADAZ • Adalimumab-FKJP For existing Humira and adalimumab prescriptions, if a provider changes the member's prescription to Hadlima or Simlandi, a new authorization request is not required. The member's existing authorization will be transferred, and the biosimilar will be covered through their original authorization approval date. Providers can request a clinical exception if a member has circumstances that require continued coverage for Humira. Blue Cross will reach out to prescribers of Humira (for existing members) by the end of April with additional information.			
Immuno-globulins	310	**Policy revised** to move Hyqvia as non-preferred.	July 1, 2025	Commercial	Prior authorization is required.
Medical Utilization Management (MED UM) & Pharmacy Prior Authorization	033	**Policy revised** to reduce approval length of Takhzyro from 1 year to six (6) months and add continuation criteria.	July 1, 2025	Commercial	Prior authorization is required.

Quality Care Cancer Program (Medical Oncology)	099	**Policy revised** to add the following medications to our Medical Oncology policy. Authorization through Carelon Medical Benefits Management, is ***required for new and existing prescriptions***: Alimta, Bendeka, Nplate, Polivy, pemetrexed disodium. To request prior authorization with Carelon see MP 099-page 6.	July 1, 2025	Commercial	Prior authorization is required through Carelon.
Quality Care Dosing (QCD) Guidelines	621-B	**Policy revised** to add quantity limits for the following: Lumryz, Sodium Oxybate, Xdemvy, and Xywav.	July 1, 2025	Commercial	Prior authorization is required.
Medicare Advantage Part B Step Therapy	020	**Policy clarified.** Pavblu added to Step 3 medication (prior authorization will be required).	April 1, 2025	Medicare	Providers will be required to use Avastin (Step 1) and Beovu, Byooviz, Cimerli, Lucentis, Susvimo, or Vabysmo (Step 2) prior to use of Pavblu.

March 2025

ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions	111	**Policy retired.** Codes 27415, 27416, 29866 29867 from retired MP 111 added to MP 221 Musculoskeletal Services Management CPT and HCPCS Codes. Code 28446 will no longer require prior authorization effective 3.1.25. This is a	March 1, 2025	Commercial Medicare	No action required.

		covered service.			
Musculoskeletal Services Management CPT and HCPCS Codes	221	**Policy clarified.** Codes 27415, 27416, 29866 29867 from retired MP 111 added to MP 221.	March 1, 2025	Commercial Medicare	PA is required for codes 27415, 27416, 29866 29867 through InterQual.
Musculoskeletal Services Management	220	**Policy clarified.** MP 111 Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions noted as retired. Codes 27415, 27416, 29866 29867 from retired MP 111 added to MP 221 Musculoskeletal Services Management CPT and HCPCS Codes.	March 1, 2025	Commercial Medicare	PA is required for codes 27415, 27416, 29866 29867 through InterQual.
Meniscal Allografts and Other Meniscal Implants	110	**Policy retired.** Code 29868 from retired MP 110 added to MP 221 Musculoskeletal Services Management CPT and HCPCS Codes. Ongoing investigational code G0428 transferred to MP 400 Non-covered Services List.	March 1, 2025	Commercial Medicare	No action required.
Musculoskeletal Services Management CPT and HCPCS Codes	221	**Policy clarified.** Code 29868 from retired MP 110 added to MP 221.	March 1, 2025	Commercial Medicare	PA is required for code 29868 through InterQual.
Musculoskeletal Services Management	220	**Policy clarified.** MP 110 Meniscal Allografts and Other Meniscal Implants noted as retired. Codes 29868 from retired MP 110 added to MP 221 Musculoskeletal Services Management CPT and HCPCS	March 1, 2025	Commercial Medicare	PA is required for code 29868 through InterQual.

		Codes.			

PLASTIC SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Plastic Surgery	068	**Policy revised.** Clinical criteria on panniculectomy updated.	June 1, 2025	Commercial	Prior authorization is required.

Genetic Testing Guidelines

Legend	Text color	Indicates…
Guideline Change Summary	**Blue**	Change to guideline wording
	Black	Preservation of existing guideline wording
		Changes expected to be…
Explanation of Change	**Green**	More expansive on appropriateness
	Red	More restrictive on appropriateness
	Black	Have minimal if any impact on appropriateness review and exists primarily to clarify intent

The following updates will apply to the Carelon Clinical Appropriateness **Guidelines for Genetic Testing.** You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

Clinical Appropriateness Framework
Added this statement that will appear in all Carelon guidelines:
Genetic tests not specifically mentioned in the guidelines are considered not medically necessary.

Carelon Guideline	Policy Change Summary	Effective Date
	Chromosomal Microarray Analysis	
Postnatal/ Pediatric evaluation	**Postnatal/Pediatric evaluation** Chromosomal microarray analysis is considered **medically necessary** as a first-line test in the initial postnatal evaluation of individuals with **ANY** of the following: • Multiple congenital anomalies without an established diagnosis • Congenital or early onset epilepsy (before age 3 years) without suspected environmental causes • Autism spectrum disorder with no identifiable cause (idiopathic) • Developmental delay or intellectual disability with no identifiable cause (idiopathic) • Early neonatal death up to 7 days after birth ○ Note: If chromosomal microarray has been performed prenatally, it is not medically necessary to repeat it postnatally. **Explanation of change** Expansive edit to include neonatal death to the list of indications considered medically necessary for chromosomal	June 15, 2025

	microarray analysis.	
Optical Genome Mapping	**Optical Genome Mapping** Optical Genome Mapping is considered **not medically necessary** in prenatal and postnatal evaluation. **Explanation of change** New section for Optical Genome Mapping clarifies current position as not medically necessary. OGM may be an alternative methodology for structural variant analysis, but more studies are required before considering this technique as medically necessary.	June 15, 2025

Carelon Guideline	Policy Change Summary	Effective Date
Whole Exome and Whole Genome Sequencing		
Whole Exome Sequencing	**Whole Exome Sequencing** Whole exome sequencing (WES) is considered **medically necessary** in the following scenarios. **GENERAL CRITERIA** **ALL** of the following general criteria must be met: • The results of testing would confirm or establish a clinical diagnosis • Counseling, which encompasses **ALL** of the following components, has been performed: ○ Interpretation of family and medical histories to provide a risk assessment for disease occurrence or recurrence ○ Education about inheritance patterns, genetic testing, disease management, prevention, and resources ○ Counseling to promote informed choices and adaptation to the risk or presence of a genetic condition ○ Counseling for the psychological aspects of genetic testing ○ Counseling should include the following details: ▪ Limitations of the testing used ▪ A negative result does not indicate heritable risk is zero or low ▪ Identification of incidental secondary findings and inconclusive results called variants of uncertain significance is possible ▪ Modifications to genetic variants' pathogenicity interpretations can occur, and patients may be recontacted with reclassified results in the future • Post-test counseling should be performed for genetic test results SPECIFIC CRITERIA REQUIRED BASED ON CLINICAL PRESENTATION: **A. Prenatal** (required): • Abnormal fetal anatomic findings which are characteristic of a genetic abnormality and no	June 15, 2025

	diagnostic findings found on karyotype and/or chromosomal microarray testing **OR** **B. Postnatal:** Whole exome sequencing (WES) is indicated if **ONE** of the following criteria is met: • Multiple anomalies (i.e., structural and/or functional) apparent before one year of age not suggestive of a specific genetic condition for which a targeted gene panel is available or chromosomal microarray is the appropriate diagnostic methodology • Developmental delay, autism spectrum disorders, or intellectual disability with onset prior to 18 years of age with no identifiable cause (idiopathic) • Congenital or early onset epilepsy (before age 3 years) without suspected environmental etiology Whole exome sequencing (WES) is considered **not medically necessary** in the following scenario: • Genomic autopsy for early neonatal death (up to 7 days after birth) ***Note:*** *WES may include comparator WES testing of the biologic parent(s) or sibling (duo or trio testing) of the affected individual.* **Explanation of change** Clarify and restructure the criteria for improved readability. Restrictive edit specifies that WES for early neonatal death is an exclusion.	

Carelon Guideline	Policy Change Summary	Effective Date
Pharmacogenomic Testing		
Pharmaco-genomic Testing	For each of the therapies and associated biomarkers in **Table 1**, genotyping for the appropriate biomarker is considered **medically necessary** when **ALL** the following conditions are met: • The medication for which genotyping is being done is the most appropriate treatment for the individual's underlying condition • The pharmacogenomic test has demonstrated analytical and clinical validity and clinical utility for the individual, including consideration of the frequency of relevant alleles in the individual's subgroup (when applicable) • The biomarker testing is focused on the specific genetic polymorphisms relevant to guiding treatment for the individual's condition and expected treatment **Explanation of change** Clarifications	June 15, 2025

Table 1. Therapies and associated biomarkers **considered medically necessary** for genotyping

Biomarker	Drug	Therapeutic Area
ApoE4	Lecanemab, donanemab-azbt	Neurology
CFTR	ivacaftor	Pediatrics
CYP2C19	clopidogrel	Cardiology
CYP2C9	siponimod	Neurology
CYP2C9	deuruxolitnib	Dermatology
CYP2D6	eliglustat	Hematology
CYP2D6	tetrabenazine	Neurology
G6PD	rasburicase	Hematology
G6PD	tafenoquine, primaquine	Infectious Diseases
HLA-B*1502	carbamazepine, oxcarbazepine	Neurology
HLA-B*5701	abacavir	Infectious Diseases
HLA-B*58:01	allopurinol	Rheumatology
NAGS	carglumic acid	Gastroenterology
POLG	divalproex sodium, valproic acid	Neurology
TPMT NUDT15	mercaptopurine, thioguanine	Hematology

Explanation of change
Clarified title of Table
Expansive changes:

- **donanemab-azbt** added for association with genotyping for ApoE ε4 in the realm of Neurology for treatment of Alzheimer's disease
- **deuruxolitinib** added for association with genotyping for CYP2C9 in the realm of Dermatology for treatment of alopecia areata
- **NUDT15** risk allele added to explain the majority of thiopurine-related myelosuppression risk in Asians and Hispanics. It is reasonable to expand the table and include it in this testing

Clarification: eliglustat's therapeutic area clarified as being related to hematology rather than pediatrics

Predictive and Prognostic Polygenic Testing
Guideline reaffirmed. Edited Description/Scope and Rationale.

February 2025

GASTROENTEROLOGY ONCOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Analysis of Human DNA or RNA in Stool Samples as a	557	**Policy revised.** Cologuard Plus and Colosense added to evidence review and	May 1, 2025	Commercial	No action required.

Technique for Colorectal Cancer Screening		policy statements as medically necessary. Title expanded to include RNA tests.			

NEUROLOGY REHABILITATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Transcutaneous Electrical Nerve Stimulation and Transcutaneous Afferent Patterned Stimulation and Transcutaneous Afferent Patterned Stimulation	003	**Policy revised.** Added new policy statements to differentiate TAPS as investigational for both essential tremor and action tremor associated with Parkinson disease. Updated title to incorporate TAPS. Other policy statements unchanged.	May 1, 2025	Commercial	No action required.

NEUROSURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Intraosseous Basivertebral Nerve Ablation	485	**Policy revised** to include that treatment of 3 or more vertebral bodies during a single session is investigational.	May 1, 2025	Commercial Medicare	Prior authorization is required.

OBSTETRICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Assisted Reproductive Services	086	**Policy clarified.** Selective fetal reduction removed. Coverage is determined by the subscriber certificate.	February 1, 2025	Commercial	Prior authorization is required.

PHARMACY

POLICY TITLE	POLICY	POLICY CHANGE	EFFECTIVE	PRODUCTS	PROVIDER ACTIONS

	NO.	SUMMARY	DATE	AFFECTED	REQUIRED
Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma	066	**Policy clarified.** Policy criteria 1a under Axicabtagene ciloleucel (Yescarta): Non-Hodgkin Lymphoma statements clarified: Histologically confirmed diagnosis of large B-cell lymphoma that is considered refractory to first line chemoimmunotherapy, or relapsed within 12 months, following first-line chemoimmunotherapy that included an anti-CD20 monoclonal antibody and anthracycline-containing regimen. Axicabtagene ciloleucel (Yescarta): Non-Hodgkin Lymphoma footnote c removed.	January 14, 2025	Commercial	Prior authorization is required.

UROLOGY LABORATORY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical Technology Assessment Noncovered List	400	**Policy revised.** CPT 82610 Cystatin C removed from the noncovered list.	May 1, 2025	Commercial Medicare	No action required.

January 2025

GENETIC TESTING FOR MEDICARE ADVANTAGE

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Carelon Genetic Testing Management Program	954	**Policy revised** to add that prior authorization is required for Medicare Advantage through Carelon. effective January 1, 2025.	January 1, 2025	Medicare	Prior authorization is required through Carelon.

		Note: Prior to 1/2025, prior authorization through Carelon was not required for Medicare Advantage.			
Carelon Genetic Testing Management Program CPT and HCPCS Codes	957	**Policy revised** to add that prior authorization is required for Medicare Advantage through Carelon. Effective January 1, 2025. Note: Prior to January 1, 2025, prior authorization through Carelon was not required for Medicare Advantage.	January 1, 2025	Medicare	Prior authorization is required through Carelon.

ONCOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Irreversible Electroporation of Tumors Located in the Liver, Pancreas, Kidney, or Lung	188	**New medical policy** describing investigational indications. Irreversible electroporation is investigational for treatment of liver, pancreatic, kidney and lung cancer.	April 1, 2025	Commercial Medicare	No action required. This is not a covered service.

ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical Technology Assessment Non-Covered Services List	400	**Policy clarified.** Percutaneous ultrasonic tenotomy added.	April 1, 2025	Commercial Medicare	No action required. This is not a covered service.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medicare Advantage Part B Step Therapy	020	**Policy revised**. A new drug class, Interleukin-6 Receptor Antagonist, has been added to the policy. Tyenne is a Step 1 medication. Actemra and Tofidence are Step 2 medications, which will now require prior authorization (prior authorization will be required for members new to therapy; existing users within the past 365 days will be grandfathered).	January 1, 2025	Medicare	Providers will be required to use Tyenne prior to the use of Actemra and Tofidence.
Medicare Advantage Part B Step Therapy	020	**Policy revised.** A new drug class, Myasthenia Gravis, has been added to the policy. Soliris, Ultomiris, Vyvgart, and Vyvgart Hytrulo are Step 1 medications. Rystiggo is a Step 2 medication, which will now require prior authorization (prior authorization will be required for members new to therapy; existing users within the past 365 days will be grandfathered).	January 1, 2025	Medicare	Providers will be required to use Soliris, Ultomiris, Vyvgart, and Vyvgart Hytrulo prior to using Rystiggo.
Medicare Advantage Part B Step Therapy	020	**Policy clarified.** Eylea and Eylea HD will be moving to Step 3 medications, which will require the prior use of a Step 1 and Step 2 medication (prior authorization will be required for members new to therapy; existing users within the past 365 days will be	January 1, 2025	Medicare	Providers will be required to use Avastin (Step 1) and Beovu, Byooviz, Cimerli, Lucentis, Macugen, Susvimo, or Vabysmo (Step 2) prior to using Eylea and Eylea HD.

		grandfathered).			
Medicare Advantage Part B Medical Utilization Management	125	**Policy revised.** Briumvi and Tysabri have been added to the policy.	January 1, 2025	Medicare	Providers will need to submit a Prior Authorization for Briumvi and Tysabri.
Medicare Advantage Part B Medical Utilization Management	125	**Policy clarified.** The preferred devices/supplies table with quantity limits for Diabetes Glucose Monitors and Supplies has been added to the policy.	January 1, 2025	Medicare	Providers will need to submit a Prior Authorization for Non-preferred Devices/Supplies

December 2024

CARDIOLOGY INTERVENTIONAL RADIOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Percutaneous Revas-cularization Procedures for Lower Extremity Peripheral Arterial Disease	161	**New medical policy** describing medically necessary and investigational indications.	March 1, 2025	Commercial Medicare	No action required. Prior authorization is not required.

ENDOCRINOLOGY INTERNAL MEDICINE

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Vertebral Fracture Assessment with Densitometry or Biomechanical Computed Tomography	449	**Policy revised.** New investigational indications for biomechanical computed tomography added. Screening for vertebral fractures using DEXA dual-energy x-ray absorptiometry or biomechanical computed tomography	March 1, 2025	Commercial Medicare	No action required. This is not a covered service.

		is considered investigational.			

GASTROENTEROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Adjunctive Techniques for Screening, Surveillance, and Risk Classification of Barrett Esophagus and Esophageal Dysplasia	841	**Policy revised.** Three new investigational indications were added: **EsoCheck and Esoguard** screening and surveillance of Barrett esophagus and esophageal dysplasia. **TissueCypher** for assessing the risk of progression to high-grade dysplasia or esophageal adenocarcinoma in individuals with Barrett esophagus. **BarreGen** for the risk stratification of Barrett esophagus and esophageal dysplasia.	March 1, 2025	Commercial Medicare	No action required. This is not a covered service.

MULTISPECIALTY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Thermography	342	**Policy #342 retired.** Narrative transferred to MP 400 Non-covered Services List. There is no specific CPT code for this test.	December 1, 2024	Commercial	No action required.
Complemen-tary Medicine	178	**Policy clarified.** Gua Sha therapy added to not medically necessary and investigational services.	December 1, 2024	Commercial Medicare	No action required.

NEUROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Evaluation of Biomarkers for Alzheimer Disease	581	**Policy revised.** Policy statements changed to medically necessary specifically for indication related to use of CSF biomarkers to select individuals for treatment with FDA-approved amyloid targeting therapies. Other policy statements remain investigational.	March 1, 2025	Commercial Medicare	No action required. Prior authorization is not required.

ORTHOPEDICS DERMATOLOGY RADIATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Low-Dose Radiotherapy for Non-Oncologic Indications	177	**New medical policy** describing medically necessary and investigational indications.	March 1, 2025	Commercial Medicare	No action required. Prior authorization is not required.

PEDIATRICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Quantitative Electro-Encephalo-graphy as a Diagnostic Aid for Attention-Deficit/Hyperac tivity Disorder, Cognitive Impairment or Autism Spectrum Disorder	554	**Policy revised.** New investigational indications added for the use of quantitative EEG as a diagnostic aid for cognitive impairment and autism spectrum disorder. Existing policy statement unchanged.	March 1, 2025	Commercial Medicare	No action required. This is not a covered service.

PHARMACY GENE THERAPIES: NEUROLOGY HEMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Gene Therapies for Metachromatic Leuko-dystrophy	106	**New medical policy** describing medically necessary and investigational indications. Prior Authorization Request Form for Gene Therapies for for Metachromatic Leukodystrophy **Lenmeldy** (atidarsagene autotemcel), #109	December 1, 2024	Commercial Medicare	Prior authorization is required.
Gene Therapies for Hemophilia A or B	168	**Policy revised** to include medically necessary and investigational indications for Beqvez (Fidanacogene eleparvovec-dzkt). Prior Authorization Request Form for Gene Therapies for Hemophilia B **Beqvez**® (Fidanacogene eleparvovec-dzkt), #126 C9172 Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose	October 30, 2024	Commercial Medicare	Prior authorization is required.

PHYSICAL MEDICINE REHABILITATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Iontophoresis and Phonophoresis as a Transdermal Technique for Drug Delivery	095	**Policy retired.** This is a covered service.	December 1, 2024	Commercial	No action required.

UROLOGY

POLICY TITLE	POLICY	POLICY CHANGE	EFFECTIVE	PRODUCTS	PROVIDER ACTIONS

	NO.	SUMMARY	DATE	AFFECTED	REQUIRED
Sexual Dysfunction Diagnosis and Therapy	078	**Policy retired.** This is a covered service.	December 1, 2024	Commercial	No action required.

November 2024

BEHAVIORAL HEALTH

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Zulresso (Brexanolone) for the Treatment of Post-Partum Depression	147	**Policy clarified.** Coverage for Zurzuvae added. This oral drug is covered through the pharmacy benefits.	November 1, 2024	Commercial Medicare	Prior authorization is required.

GENERAL SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Treatment of Varicose Veins/Venous Insufficiency	238	**Policy clarified.** The first policy statement under symptomatic varicose tributaries section was edited for clarity.	November 1, 2024	Commercial Medicare	Prior authorization is required.

MULTISPECIALTY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Hyperbaric Oxygen Therapy	653	**Policy revised** to include medically necessary treatment of: • necrotizing soft tissue infections • Idiopathic sudden sensorineural hearing loss • Central retinal artery occlusion.	February 1, 2025	Commercial	No action required. Prior authorization is not required.

		Added to investigational indications: acute peripheral artery insufficiency (outside of other listed medically necessary indications involving arterial insufficiency).			

NEUROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Remote Electrical Neuromodu-lation for Migraines	140	**New medical policy** describing medically necessary indications for remote electrical neuromodulation using Nerivio™.	February 1, 2025	Commercial Medicare	No action required. Prior authorization is not required.

PEDIATRICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Treatment of Congenital Athymia	**108**	**New medical policy** describing medically necessary and investigational indications.	February 1, 2025	Commercial Medicare	No action required. Prior authorization is not required.

PHARMACY - NEUROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Monoclonal Antibodies for Treatment of Alzheimer's Disease	946	**Policy clarified** to include that per label, Donanemab is administered every four weeks as an intravenous infusion over approximately 30 minutes. Product label of donanemab recommends obtaining an MRI prior to the second, third, fourth,	October 3, 2024	Commercial	Prior authorization is required for Lecanemab and Donanemab.

		and seventh infusions.			

Carelon Guidelines. Effective March 23, 2025

Advanced Imaging/Radiology Guidelines

Legend	Text color	Indicates…
Guideline Change Summary	**Blue**	Change to guideline wording
	Black	Preservation of existing guideline wording
		Changes expected to be…
Explanation of Change	**Green**	More expansive on appropriateness
	Red	More restrictive on appropriateness
	Black	Have minimal if any impact on appropriateness review and exists primarily to clarify intent

The following updates will apply to the Carelon Clinical Appropriateness **Guidelines for Advanced Imaging/Radiology.** You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

Carelon Guideline	Policy Change Summary	Effective Date
General Abdominal and Pelvic Indications		
Tumor or Neoplasm – not otherwise specified	**Tumor or Neoplasm – not otherwise specified** **IMAGING STUDY** ***ADULT*** • Ultrasound required for initial evaluation of a palpable pelvic mass in patients assigned female at birth, or for testicular masses in patients assigned male at birth • CT abdomen and/or pelvis for all other scenarios, or following nondiagnostic pelvic ultrasound • MRI abdomen for further characterization of abdominal mass seen on prior imaging, including CT scan **Explanation of change** Added requirement for initial evaluation of testicular masses with ultrasound prior to advanced imaging	March 23, 2025
Female Reproductive System and Obstetric Indications		
Endometriosis	**Endometriosis** Advanced imaging is considered **medically necessary** in EITHER of the following scenarios: • Diagnosis of clinically suspected endometriosis following nondiagnostic pelvic ultrasound • Management of established endometriosis **Explanation of change** Removed requirement for initial ultrasound in patients with established endometriosis	March 23, 2025
Obstetric Indications	**Obstetric Indications** **IMAGING STUDY** • Ultrasound is required for initial evaluation of fetal and placental conditions • Fetal MRI in the second or third trimester of pregnancy, for indications involving the fetus or placenta, following nondiagnostic ultrasound • MRI pelvis for pelvimetry or other obstetrical complications	March 23, 2025

	Explanation of change Specified that fetal MRI should be done in the second or third trimester	
	Hepatobiliary Indications	
Diffuse liver disease	**Diffuse liver disease** **IMAGING STUDY** • CT abdomen for **EITHER** of the following: ○ Suspected liver disease ○ Iron overload in hemochromatosis when MRI cannot be performed or is nondiagnostic • MRI abdomen for evaluation of hemochromatosis • MR elastography for diagnosis and management of advanced hepatic fibrosis/cirrhosis **Explanation of change** Removed the criteria for LiverMultiScan as an alternative to MR elastography due to lack of data indicating a change in management.	March 23, 2025
	Pancreatic Indications	
Pancreatic mass, indeterminate cystic (including suspected IPMN/IPMT)	**Pancreatic mass, indeterminate cystic (including suspected IPMN/IPMT)** **Explanation of change** Clarified that this indication is meant to apply only to indeterminate cystic lesions, including when IPMN is suspected. Known IPMN should be reviewed using the Tumor or Neoplasm NOS indication.	March 23, 2025
	Nonspecific Signs and Symptoms	
Abdominal and/or pelvic pain, undifferentiated	**Abdominal and/or pelvic pain, undifferentiated** ***ADULT*** Advanced imaging is considered medically necessary in **EITHER** of the following scenarios: • Acute abdominal pain associated with clinical findings of a surgical abdomen, including severe undifferentiated abdominal pain or guarding or that remains unexplained after ALL of the following: ○ History ○ Physical exam ○ Relevant lab results* ○ Ultrasound if the pain localizes to the right upper quadrant (abdominal ultrasound) or female pelvis (pelvic ultrasound) • Nonacute abdominal pain that remains unexplained after ALL of the following: ○ History ○ Physical exam ○ Relevant lab results* ○ Ultrasound if the pain is localized to the right upper quadrant (abdominal ultrasound) or female pelvis (pelvic ultrasound) ○ Upper endoscopy if the pain is epigastric unless associated with elevated inflammatory markers (leukocytosis, C-reactive protein [CRP]) ○ Colonoscopy if the pain is associated with defecation and a change in the form and frequency of stools (i.e.,	March 23, 2025

	irritable bowel syndrome) ***PEDIATRIC*** Advanced imaging is considered medically necessary for diagnosis in **ANY** of the following scenarios: • Acute abdominal pain associated with clinical findings of a surgical abdomen, including severe undifferentiated abdominal pain or guarding or that remains unexplained after ALL of the following: ○ History ○ Physical exam ○ Relevant lab results* ○ Abdominal or pelvic ultrasound • Chronic or recurrent pelvic pain following nondiagnostic ultrasound • Chronic or recurrent abdominal pain following nondiagnostic ultrasound when **ANY** of the following red flag signs are present: ○ Chronic severe diarrhea (at least 3 watery stools per day for more than 2 weeks) ○ Deceleration of linear growth ○ Fever of unknown origin ○ Gastrointestinal bleeding ○ History of a genetic or congenital syndrome ○ Immunocompromised ○ Involuntary weight loss ○ Persistent focal abdominal pain, especially right upper or right lower quadrant ○ Persistent vomiting ○ Elevated inflammatory markers (leukocytosis, C-reactive protein [CRP]) *Preliminary lab tests may include metabolic profile, complete blood count (CBC), C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), and/or urinalysis. **Explanation of change** Removed general prerequisite for "prior imaging where available," as the intent is already addressed by the more specific requirements for US depending on pain location. Clarified language around lab (intent is that some preliminary lab testing is always appropriate).	

	Imaging of the Chest Guidelines	
	Tumor or Neoplasm	
Lymphadenopathy	**Lymphadenopathy** See *Oncologic Imaging for patients with documented malignancy.* *Thoracic lymphadenopathy is defined as at least one lymph node greater than 1 cm in short axis diameter.* Advanced imaging is considered **medically necessary** for diagnosis, management, or surveillance in **ANY** of the following scenarios: • Palpable thoracic or supraclavicular lymph nodes, when not amenable to percutaneous biopsy • Associated clinical or lab findings suggestive of malignancy, especially lymphoma or testicular carcinoma	March 23, 2025

	• Mediastinal or hilar lymph nodes when **ANY** of the following is present: ○ Suspected by non-advanced imaging (i.e. chest radiography) ○ Single follow up at least 3 months after discovery of nodes with a short axis diameter greater than 1.4 cm without suspicious features ○ Lymphadenopathy with suspicious features: ▪ Necrosis ▪ Loss of fatty hilar morphology ▪ Heterogenous or hypervascular enhancement ▪ Irregular borders ▪ Interval enlargement ▪ Multiple enlarged nodes on the same side of the mediastinum (ipsilateral/unilateral) **Explanation of change** Moved the criterion for clinical/lab findings suggestive of malignancy as this does not apply only to mediastinal/hilar lymphadenopathy. No change in intent.	
	Signs and Symptoms	
Dyspnea	**Dyspnea** Advanced imaging is considered medically necessary when **BOTH** of the following apply: • Dyspnea is not explained by cardiac evaluation • Dyspnea is not explained by chest radiography **IMAGING STUDY** • CT chest **Rationale** The differential diagnosis for dyspnea is broad, but most etiologies are cardiovascular or pulmonary. When cardiac evaluation, generally including clinical examination and transthoracic echocardiography, has not revealed a cause for the dyspnea, pulmonary causes including asthma, bronchitis, chronic obstructive pulmonary disease, and interstitial lung disease are often considered in the differential diagnosis. Chest radiography is often able to guide further evaluation and can in some cases provide a specific diagnosis. When chest radiography is normal despite persistent clinical symptoms, or when chest radiography reveals an abnormality which requires further characterization, CT is a useful study. The American College of Radiology Appropriateness Criteria note that the protocol can be tailored to include adjuncts such as expiratory images or prone images, so knowledge of the clinically suspected diagnosis is helpful for planning of CT imaging. **Explanation of change** Added an indication for dyspnea to account for requests submitted without a differential diagnosis.	March 23, 2025

	Oncologic Imaging Guidelines	
	Cancer Screening	
Colorectal cancer screening (CT colonography)	**Colorectal cancer screening (CT colonography)** **Average risk:* - No personal history of colonic adenoma, serrated sessile polyp/lesion (SSP/SSL), or colorectal cancer (CRC) - No personal history of inflammatory bowel disease, high-risk CRC	March 23, 2025

	genetic syndromes, cystic fibrosis, or childhood cancer - Negative family history for CRC, confirmed advanced adenoma (i.e. highgrade dysplasia, ≥ 1 cm, villous or tubulovillous histology or an advanced SSP/SSL) **Explanation of change** NCCN alignment for definition of average risk	
Pancreatic cancer screening	**Pancreatic cancer screening** Annual CT or MRI (preferred) Abdomen is indicated as an alternative to endoscopic ultrasound in **ANY** of the following scenarios: • Family history of pancreatic cancer in ≥1 first-degree and ≥1 second-degree relatives*, starting at age 50 or 10 years earlier than the youngest affected relative *Relative(s) with exocrine pancreatic cancer, on the same side of the family as the gene mutation or history of pancreatic cancer **Explanation of change** NCCN alignment for eligibility by family history	March 23, 2025
Hepatocellular carcinoma (HCC) screening	**Hepatocellular carcinoma (HCC) screening** CT or MRI Abdomen is indicated every 6 months as an alternative to abdominal ultrasound in patients with Hepatitis B or cirrhosis (any etiology) when ultrasound cannot be performed or is nondiagnostic. **Explanation of change** NCCN alignment (interval of screening imaging)	March 23, 2025

	Anal Cancer	
CT chest, CT abdomen and pelvis	**CT chest, CT abdomen and pelvis** Surveillance: Indicated no more than annually (stage II-III) **MRI pelvis** Surveillance: Indicated no more than annually (stage II-III) **Explanation of change** CT: NCCN alignment (surveillance intervals)	March 23, 2025

	Bladder and Urothelial Cancers	
Bladder/Urothelial Cancers: Non-muscle Invasive	**Bladder/Urothelial Cancers: Non-muscle Invasive** **CT chest** Surveillance: Not indicated **CT abdomen and pelvis** Surveillance: Indicated no more than every 12 months **Bladder/Urothelial Cancers: Muscle Invasive** **CT chest, CT abdomen and pelvis** Surveillance: Indicated no more than every 6 months **FDG- /CT** Diagnostic Workup: Indicated when standard imaging cannot be performed or is nondiagnostic for metastatic disease **Explanation of change** CT - NCCN alignment (surveillance intervals, Chest imaging for NMIBC); FDG PET: NCCN 2B recommendation, aligned with standard imaging approach	March 23, 2025

	Breast Cancer	
CT chest, CT abdomen and pelvis	**CT chest, CT abdomen and pelvis** Diagnostic Workup: Indicated for at-risk* or clinically suspected metastatic disease **MRI Breast** Surveillance: Indicated annually for a personal history of breast cancer after breast conserving therapy or unilateral mastectomy in **ANY** of the following scenarios: ○ Meets criteria for MRI breast screening ○ Heterogeneously or extremely dense breasts ○ Breast cancer diagnosis before age 50 **FDG-PET/CT** Diagnostic Workup: Indicated when standard imaging cannot be performed or is nondiagnostic for metastatic disease **Tumor size >2 cm (T2), positive lymph nodes, tumor size >1 cm (T1c) and HER2+, or triple-negative disease* **Explanation of change** NCCN alignment (addition of risk subtypes for initial CT staging, MRI Breast surveillance, FDG PET staging)	March 23, 2025

	Cervical Cancer	
FDG-PET/CT	**FDG-PET/CT** Diagnostic Workup: Indicated for patients with stage IB1 or higher disease, or small cell neuroendocrine carcinoma of the cervix, as an alternative to CT chest, abdomen, and pelvis Management: Indicated in **ANY** of the following scenarios: • Single treatment response evaluation following radiation or chemoradiation when performed at least 12 weeks following completion of therapy Surveillance: Indicated for small cell neuroendocrine carcinoma of the cervix only **Explanation of change** FDG PET: NCCN alignment (small cell NECC diagnostic workup/surveillance); clarification of management (no operational change)	March 23, 2025

	Colorectal Cancer	
MRI pelvis	**MRI pelvis** Surveillance: Indicated no more than every 6 months for rectal cancer treated with transanal local excision or nonoperative management **FDG-PET/CT** Management: Indicated in **ANY** of the following scenarios: • CT/MRI is equivocal for metastatic disease and lesion(s) is/are greater than 1 cm in diameter **Explanation of change** MRI - NCCN alignments (surveillance interval, addition for nonoperative management) FDG-PET: Addition to account for lesions seen by MRI (eg post-liver directed therapy)	March 23, 2025

	Esophageal and Gastroesophageal Junction Cancers	
CT chest, CT abdomen	**CT chest, CT abdomen** Surveillance: Indicated no more than every 6 months (T1b or greater) **FDG-PET/CT** Management: Indicated in **ANY** of the following scenarios: • Radiation planning for preoperative or definitive treatment only • Single assessment of response to primary (neoadjuvant) treatment when performed at least 5 weeks after completion of therapy **Explanation of change** CT - NCCN alignment (surveillance interval) FDG PET - NCCN alignment (to account for other perioperative treatment).	March 23, 2025

	Gastric Cancer	
CT chest, CT abdomen and pelvis	**CT chest, CT abdomen and pelvis** Surveillance: Indicated no more than every 6 months **FDG-PET/CT** Management: Indicated in **ANY** of the following scenarios: • Single assessment of response to primary (neoadjuvant) treatment, when performed at least 5 weeks after completion of therapy **Explanation of change** CT - NCCN alignment (surveillance interval) FDG PET - NCCN alignment (imaging interval, removal of imaging requirement)	March 23, 2025

	Head and Neck Cancer	
FDG-PET/CT	**FDG-PET/CT** Management: Indicated in **ANY** of the following scenarios: • Single treatment response evaluation, no sooner than 12 weeks after completion of radiation therapy or chemoradiation • Follow up of equivocal post-treatment PET scan, no sooner than 12 weeks after the last study **Explanation of change** FDG PET: NCCN alignment (treatment response, f/u of equivocal post-treatment PET)	March 23, 2025

	Hepatocellular and Biliary Tract Cancers	
CT chest, CT abdomen and pelvis	**CT chest, CT abdomen and pelvis** Surveillance: Indicated no more than every 6 months **MRI abdomen with or without MRCP** Surveillance: Indicated no more than every 6 months **Explanation of change** CT/MRI - NCCN alignment (surveillance intervals)	March 23, 2025

	Histiocytic Neoplasms	
FDG-PET/CT	**FDG-PET/CT** Diagnostic Workup: Indicated in patients with LCH, ECD, or RDD **Explanation of change** FDG PET: NCCN alignment (PET threshold)	March 23, 2025

	Kidney Cancer	
CT chest	**CT chest** Surveillance: Indicated for **ANY** of the following: • Ablation: no more than annually • Partial or total nephrectomy: no more than every 6 months • Stage III or IV disease	March 23, 2025
CT abdomen +/- pelvis, MRI abdomen	**CT abdomen +/- pelvis, MRI abdomen** Management: Indicated for **EITHER** of the following: • Baseline imaging after ablation, partial or total nephrectomy • Active surveillance of stage I renal cancer: within 6 months of initiation, then annually Surveillance: Indicated for ANY of the following: • After ablation, partial or total nephrectomy: no more than every 6 months • Stage III or IV disease **Explanation of change** CT/MRI - NCCN alignment (surveillance intervals)	March 23, 2025

	Lung Cancer – Small Cell	
FDG-PET/CT	**FDG-PET/CT** Management: Indicated for **EITHER** of the following scenarios: • Prior to initiation of radiation therapy • Standard imaging cannot be performed, or is nondiagnostic for recurrent or progressive disease **Explanation of change** FDG-PET: Addition of standard imaging allowance when further characterization needed	March 23, 2025

	Lymphoma – Non-Hodgkin and Leukemia	
	Chronic lymphocytic leukemia or small lymphocytic lymphoma **CT chest, CT abdomen and pelvis** Surveillance: Not indicated **Lymphoma – Non-Hodgkin: Indolent non-Hodgkin lymphoma** **CT neck, CT chest, CT abdomen and pelvis** Surveillance: Indicated in **EITHER** of the following scenarios: • Follicular, marginal zone/MALT, or mantle cell lymphoma: Every 6 months, up to 2 years following completion of treatment and every 12 months thereafter • All other subtypes: Every 6 months, up to 2 years following completion of treatment **Lymphoma – Non-Hodgkin: Intermediate and high grade non-Hodgkin lymphoma** **CT neck, CT chest, CT abdomen and pelvis** Surveillance: Indicated in **EITHER** of the following scenarios: • Follicular, marginal zone/MALT, or mantle cell lymphoma: Every 6 months, up to 2 years following completion of treatment, and every 12 months thereafter • All other subtypes: Every 6 months, up to 2 years following completion of treatment	March 23, 2025

	Explanation of change CT - NCCN alignments (surveillance imaging)	

	Multiple Myeloma	
FDG-PET/CT	**FDG-PET/CT** Diagnostic Workup: Indicated for multiple myeloma or solitary plasmacytoma* **Explanation of change** FDG-PET: NCCN alignment (indicated for patients suspected of having multiple myeloma or solitary plasmacytoma).	March 23, 2025

	Penile, Vaginal, and Vulvar Cancers	
FDG-PET/CT	**FDG-PET/CT** Diagnostic Workup: Indicated in **ANY** of the following scenarios: • Standard imaging cannot be performed or is nondiagnostic for metastatic disease • Staging of penile cancer when pelvic lymph nodes are enlarged on CT or MRI and needle biopsy is not technically feasible • Staging of vaginal cancer Management: Indicated in **ANY** of the following scenarios: • Radiation planning for preoperative or definitive treatment only • Single treatment response assessment following radiation when performed at least 12 weeks after completion of therapy • Standard imaging cannot be performed or is nondiagnostic for recurrent or progressive disease • Restaging of local recurrence when pelvic exenteration surgery is planned **Explanation of change** FDG-PET: NCCN alignment (added initial staging vaginal cancer, RT response scenarios)	March 23, 2025

	Thyroid Cancer	
FDG-PET/CT	**FDG-PET/CT** Diagnostic Workup: Indicated for **ANY** of the following subtypes: • Anaplastic • Oncocytic carcinoma Management: Indicated in **ANY** of the following scenarios: • Follow up of anaplastic carcinoma • Suspected recurrent papillary, follicular, or oncocytic carcinoma when I-131 scan is negative (or has been negative in the past) and stimulated thyroglobulin level is > 2 ng/dL • Suspected recurrent medullary carcinoma when detectable basal calcitonin or elevated CEA, and standard imaging is negative **Somatostatin receptor (SSR) PET/CT** Diagnostic Workup: Indicated for medullary carcinoma when standard imaging cannot be performed or is nondiagnostic **Explanation of change** FDG and SSR PET - NCCN scenario alignments (initial staging/management)	March 23, 2025

Genetic Testing Guidelines

Legend	Text color	Indicates…
Guideline Change Summary	**Blue**	Change to guideline wording
	Black	Preservation of existing guideline wording
		Changes expected to be…
Explanation of Change	**Green**	More expansive on appropriateness
	Red	More restrictive on appropriateness
	Black	Have minimal if any impact on appropriateness review and exists primarily to clarify intent

The following updates will apply to the Carelon Clinical Appropriateness **Guidelines for Genetic Testing.** You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

Carelon Guideline	Policy Change Summary	Effective Date
Hereditary Cancer Testing General requirements – Germline pathogenic variants not otherwise specified*		
*To be used only when a specific indication is not available.	***To be used only when a specific indication is not available.*** Genetic testing is considered **medically necessary when ALL** the following criteria are met: • The individual to be tested is either at significant risk for a genetic disorder (for example, based on family history) or suspected to have a known genetic condition or is known to have been inadequately tested for a suspected genetic condition ○ This may include but is not limited to a personal history of a tumor (somatic) pathogenic variant in one or more of these genes: BRCA1, BRCA2, BRIP1, MLH1, MSH2, MSH6, MUTYH, PALB2, PMS2, RAD51C, RAD51D, RET, SDHAF2, SDHB, SDHC, SDHD, TMEM127, TSC2, or VHL ○ For individuals younger than age 30, this may include personal history of a pathogenic variant in one or more of these genes: APC, PTEN, RB1, or TP53 • Scientific literature has established that one or more genes have pathogenic variability associated with the genetic condition • The genetic test has established clinical utility such that a positive or negative result of the genetic test will significantly impact clinical management and will likely result in a net improvement in health outcomes **Explanation of change** Removed criteria stating that alternate biochemical tests are not available, have provided an indeterminate result, or are less accurate than genetic testing Listed specific examples of somatic test findings that, per ASCO guideline, should generate consideration of germline testing (clarification) Included examples of pathogenic variants for individuals age <30 (clarification) Confirmatory	March 23, 2025
	Confirmatory genetic testing of the identified variant(s) is	March 23, 2025

	considered **medically necessary if ALL** of the criteria above are met and **EITHER** of the following apply: • An individual identified to have a pathogenic or likely pathogenic germline variant in genes with established clinical utility based on FDA approved direct-to-consumer genetic testing • An individual identified to have a pathogenic or likely pathogenic germline variant in genes with established clinical utility based on results of IRB approved clinical research studies Germline genetic testing for known familial pathogenic or likely pathogenic variants is considered medically necessary in the following scenarios: • Any first-, second-, or third-degree relative who has a known pathogenic or likely pathogenic variant, where the results have established clinical utility **Explanation of change** Expanded criteria to include confirmatory genetic testing for individuals identified to have a pathogenic or likely pathogenic germline variant in genes with established clinical utility based on results from direct-to-consumer genetic testing and/or results from an IRB approved clinical research study	

	Adenomatous polyp syndromes	
Adenomatous polyp syndromes	Germline genetic testing of the APC gene and/or MUTYH gene variants for susceptibility to invasive cancer due to adenomatous polyp syndromes is considered **medically necessary when ANY** of the following criteria are met: • The individual has a personal history of more than 10 cumulative colorectal adenomas • The individual has multifocal or bilateral congenital hypertrophy of retinal pigment epithelium (CHRPE) • The individual has a first- or second-degree relative with a known pathogenic variant in the APC or MUTYH gene • The individual has a first-, second- or third-degree relative with clinical findings suggestive of an inherited polyposis syndrome **Explanation of change** Added criteria for individuals with multifocal or bilateral congenital hypertrophy of retinal pigment epithelium (CHRPE) Added criteria for first-, second-, or third-degree relatives with known pathogenic variant or clinical findings suggestive of an inherited polyposis syndrome	March 23, 2025

	Hamartomatous polyposis syndromes Juvenile polyposis syndrome	
Hamartoma-tous polyposis syndromes Juvenile polyposis syndrome	Genetic testing for SMAD4 and BMPR1A gene variants to evaluate for juvenile polyposis syndrome is considered **medically necessary when ANY** of the following criteria are met: • Five (5) or more juvenile polyps in the colon • Multiple juvenile polyps in other parts of the gastrointestinal tract • Any number of juvenile polyps in a person with a known family history of juvenile polyps • Individual is a first- or second-degree relative of a patient	March 23, 2025

	suspected of having or diagnosed with juvenile polyposis syndrome **Explanation of change** Increased testing requirement for number of juvenile polyps in the colon from three to five (restrictive)	

	Cowden syndrome	
Cowden syndrome	Genetic testing for PTEN pathogenic variants to evaluate for Cowden syndrome is considered medically necessary when BOTH of the following criteria are met: • **EITHER** of the following pathognomonic criteria are present: ○ Adult Lhermitte-Dulcos disease (cerebellar tumors) ○ Multiple mucocutaneous lesions including **ANY** of the following: ▪ Three or more trichilemmomas, at least one of which is biopsy-proven ▪ Three of more acral keratoses (palmoplantar keratotic pits and/or acral hyperkeratotic papules) ▪ Three or more mucocutaneous neuromas ▪ Three or more oral papillomas (particularly on tongue and gingivae) which are biopsy- proven or diagnosed by a dermatologist • **THREE** (3) or more of the following conditions are present: ○ Breast cancer ○ Fibrocystic disease of the breast ○ Non-medullary thyroid cancer ○ Thyroid adenoma or multinodular goiter ○ Endometrial cancer ○ Genitourinary tumors ○ Genitourinary malformations or testicular lipomatosis ○ Uterine fibroids ○ Any GI hamartomas or ganglioneuromas ○ Autism spectrum disorder ○ Intellectual disability with IQ ≤ 75 ○ Biopsy-proven trichilemmoma ○ Multiple palmoplantar keratoses ○ Multifocal cutaneous facial papules • **THREE** (3) or more of the following conditions are present: ○ Breast cancer ○ Fibrocystic disease of the breast ○ Non-medullary thyroid cancer ○ Thyroid adenoma or multinodular goiter ○ Endometrial cancer ○ Renal cell carcinoma ○ Colorectal cancer ○ Genitourinary malformations or testicular lipomatosis ○ Lipomas ○ Uterine fibroids ○ Any GI hamartomas or ganglioneuromas ○ Autism spectrum disorder ○ Intellectual disability with IQ ≤ 75 ○ Biopsy-proven trichilemmoma ○ Multiple palmoplantar keratoses ○ Multifocal cutaneous facial papules ○ Macular pigmentation of the glans penis ○ Vascular anomalies (including multiple intracranial	March 23, 2025

	developmental venous anomalies) ○ Macrocephaly (≥ 97th percentile: 58 cm for adult women, 60 cm for adult men) **Explanation of change** Clarified genitourinary tumors as renal cell carcinoma Added minor criteria to include colorectal cancer and lipomas to the list of conditions that may be present Removed duplicate “Macular pigmentation of the glans penis”	

	Lynch syndrome	
Lynch syndrome	Germline genetic testing of MLH1, MSH2, MSH6, PMS2 or EPCAM genes to evaluate for Lynch syndrome (a mismatch repair deficiency syndrome) is considered **medically necessary in ANY** of the following scenarios: • Known Lynch syndrome pathologic variant in a first- or second-degree relative • Personal history of a tumor with MMR deficiency based on somatic testing using PCR, NGS, or IHC • Immunohistochemistry (IHC) testing of colorectal cancer, endometrial cancer, or any other Lynch syndrome-associated cancer showing loss of expression of MSH2 or MSH6 (or both), or loss of expression of PMS2; or loss of expression of MLH1 and PMS2 without evidence of BRAF V600E pathogenic variant or MLH1 promoter methylation • Evidence of microsatellite instability (MSI-high) based on testing of colorectal cancer, endometrial cancer, or any other Lynch syndrome-associated cancer, and IHC testing showing loss of expression of MLH1 and PMS2 without evidence of BRAF V600E pathogenic variant or MLH1 promoter methylation • 5% or higher lifetime risk of Lynch syndrome based on a validated predictive model • Personal history of colorectal or endometrial cancer or any other Lynch syndrome-related cancer in **ANY** of the following scenarios: ○ Individual is age 49 years or younger at diagnosis ○ Presence of synchronous or metachronous colorectal cancer ○ Known additional Lynch syndrome-related cancer (colorectal, endometrial, gastric, ovarian, pancreatic, urothelial, CNS glioma, biliary tract, small intestine, sebaceous adenomas or carcinomas, keratoacanthomas, or breast carcinomas with medullary features) • Family history which includes **ANY** of the following: ○ At least one first-degree relative with colorectal or endometrial cancer diagnosed before age 50 ○ At least one first-degree relative with colorectal or endometrial cancer and another Lynch syndrome-related cancer ○ Two or more first- or second-degree relatives on the same side of the family with Lynch syndrome-related cancers, with at least one diagnosed before age 50 ○ Three or more first- or second-degree relatives on the same side of the family with Lynch syndrome-related	March 23, 2025

	cancers **Explanation of change** MMR deficiency (dMMR) clarified to be demonstrable by PCR, NGS, or IHC Personal history criteria expanded to include any other Lynch syndrome related cancer, and specified which cancers are associated with Lynch syndrome Breast cancer with medullary features included as a Lynch-syndrome associated cancer Family history criteria based on multiple family members with Lynch syndrome related cancers specified only those on the same side of the family Parenthetical reference to selected predictive models about germline risk removed for consistency with other parts of the guideline	

	Li-Fraumeni syndrome	
Li-Fraumeni syndrome	Testing for pathogenic or likely pathogenic variants of TP53 is considered **medically necessary** for individuals at risk based on **ANY** of the following (referencing the Chompret criteria, last updated in 2015): • Personal history of breast cancer diagnosed at or before age 30 • Personal history of breast cancer diagnosed at or before age 45 and **EITHER** of the following: ○ At least one first- or second-degree relative with a Li-Fraumeni syndrome spectrum tumor other than breast diagnosed before age 56 ○ At least one first- or second-degree relative with multiple primary cancers at any age • Personal history of a Li-Fraumeni syndrome spectrum tumor other than breast cancer (soft tissue sarcoma, osteosarcoma, CNS tumor) diagnosed at or before age 45 and **EITHER** of the following: ○ At least one first- or second-degree relative with a Li-Fraumeni syndrome spectrum tumor before age 56 ○ At least one first- or second-degree relative with multiple primary cancers at any age • Personal history of multiple tumors (other than multiple tumors of the breast), of which two belong to the Li-Fraumeni syndrome spectrum **AND** at least one was diagnosed at or before age 45 • Personal history of adrenocortical carcinoma, choroid plexus carcinoma, embryonal anaplastic rhabdomyosarcoma, or pediatric hypodiploid acute lymphoblastic leukemia • Individual has at least one first-, second-, or third-degree relative with a known TP53 pathogenic or likely pathogenic germline variant **AND** the affected family member meets at least ONE of the above personal history criteria for Li-Fraumeni syndrome • Individual has had a pathogenic or likely pathogenic variant of TP53 identified on tumor somatic testing **AND ONE** of the following applies: ○ The individual meets one or more of the personal history criteria above ○ The individual was diagnosed at or before age 29 with	March 23, 2025

	any cancer **Explanation of change** Added pediatric hypodiploid acute lymphoblastic leukemia to the personal history positive criteria Restricted testing criteria for testing as follow-up to TP53 positive somatic tumor test results Restricted testing criteria for testing of unaffected first-, second-, or third-degree relatives	

	Hereditary Breast, Ovarian, and Pancreatic Cancer (HBOP) **Hereditary breast, ovarian, and pancreatic cancers**	
	Explanation of change HBOP criteria explicitly divided into categories by disease. Distinguished personal history from family history, and when close blood relatives are included in family history criteria, specified inclusion of first-, second-, and third-degree relatives on same side of the family. Clarified the threshold for elevated risk to be ≥5% based on use of validated predictive models	March 23, 2025

	Hereditary breast cancer	
Individuals age ≤65 newly diagnosed with invasive breast carcinoma	**Individuals age ≤65 newly diagnosed with invasive breast carcinoma** Germline genetic testing using a multi-gene panel that includes BRCA1 and BRCA2 is considered **medically necessary** for individuals age ≤65 within 12 months of a new diagnosis of invasive breast cancer to aid in therapy and surgical decision-making and/or for personal and family risk assessment. See multi-gene panel testing for hereditary breast, ovarian, or pancreatic carcinoma* for details about the scope of panel testing. **Individuals age >65 newly diagnosed with invasive breast carcinoma** Germline genetic testing using a multi-gene panel that includes BRCA1 and BRCA2 is considered **medically necessary** for individuals age >65 within 12 months of a new diagnosis of invasive breast cancer to aid in therapy and surgical decision-making and/or for personal and family risk assessment with **ANY** of the following criteria: • Individuals assigned male sex at birth • Triple-negative breast cancer • Multiple primary breast cancers (synchronous or metachronous) • Lobular breast cancer concomitant with personal or family history of hereditary diffuse gastric cancer • Ashkenazi Jewish ethnicity • Currently a candidate for PARP inhibitor therapy See multi-gene panel testing for hereditary breast, ovarian, or pancreatic carcinoma* for details about the scope of panel testing. **Individuals age ≤65 previously diagnosed with invasive breast carcinoma** Germline genetic testing using a multi-gene panel that includes BRCA1 and BRCA2 is considered **medically necessary** for individuals age ≤65 with invasive breast cancer diagnosed ≥12 months prior when **BOTH** of the following criteria are met: • There is recurrence or development of a new primary breast	March 23, 2025

	cancer (ipsilateral or contralateral) • The individual is considered a candidate for treatment with a PARP inhibitor See multi-gene panel testing for hereditary breast, ovarian, or pancreatic carcinoma* for details about the scope of panel testing. **Individuals with no current or prior diagnosis of breast carcinoma** Germline genetic testing using a multi-gene panel that includes BRCA1 and BRCA2 is considered **medically necessary** for individuals without a current or prior diagnosis of invasive breast cancer with **ANY** of the following criteria: • Personal or family history suggests the possibility of a pathogenic variant with **ANY** of the following: ○ Personal history of epithelial ovarian cancer or pancreatic adenocarcinoma ○ Risk of a pathologic or likely pathologic variant in BRCA1 or BRCA2 is ≥5% based on a validated predictive model ○ At least one first-, second-, or third-degree blood relative with breast cancer diagnosed at or before age 50 ○ At least one first-, second-, or third-degree blood relative with epithelial ovarian, fallopian tube, or primary peritoneal cancer ○ At least one first- or second-degree blood relative with multiple primary breast cancers (metachronous or synchronous) ○ At least one first-, second-, or third-degree blood relative on the same side of the family with breast cancer in an individual assigned male sex at birth ○ At least one first-, second-, or third-degree blood relative on the same side of the family with metastatic prostate cancer or high or very high-risk grade group of localized or locally advanced prostate cancer ○ Three or more first-, second-, or third-degree blood relatives on the same side of the family with invasive breast and/or prostate cancer ○ Individuals with at least two first-degree blood relatives with pancreatic cancer ○ Ashkenazi Jewish descent **AND** at least one first-degree blood relative with breast cancer ○ Ashkenazi Jewish descent **AND** two or more second-degree blood relatives on the same side of the family with breast or epithelial ovarian cancer ○ Individuals requiring confirmatory testing based on findings of BRCA1 or BRCA2 pathogenic or likely pathogenic germline variants found in other testing contexts including ANY of the following: ▪ 23andMe PGS (or similar FDA approved commercial direct-to-consumer testing) ▪ somatic testing for malignancy ▪ **IRB approved clinical research** See multi-gene panel testing for hereditary breast, ovarian, or pancreatic carcinoma* for details about the scope of panel testing. **Explanation of change**	

	• All women <65 with personal history of breast cancer now included for BRCA1/2 testing • For accounting for ancestry, other high-risk populations (in addition to Ashkenazi Jewish ancestry) included in the criteria for testing newly diagnosed patients • All individuals who are candidates for PARP inhibitor therapy are included in scope for testing • Family history criteria for testing related to having a relative with multiple primary breast cancers expanded to first- or second-degree relative • Family history criteria for testing related to having a relative with epithelial ovarian, fallopian tube, or primary peritoneal cancer expanded to include first-, second-, or third-degree relatives • Family history criteria for testing related to having a relative with breast cancer who is also an individual assigned male sex at birth expanded to include first-, second-, or third-degree relatives • Family history criteria for testing related to having a relative age <50 with breast cancer expanded to be at least one relative who is a first- or second-degree blood relative • Clarified the statement about BRCA risk models, eliminating reference to tools that are not examples of validated risk models • Clarified that direct-to-consumer testing refers to those tests that are FDA approved; also clarified language to refer to pathogenic or likely pathogenic variants for consistency with other guideline criteria	

	Hereditary epithelial ovarian cancer	
Individuals with personal history of invasive epithelial ovarian carcinoma	**Individuals with personal history of invasive epithelial ovarian carcinoma** Germline genetic testing using a multi-gene panel that includes BRCA1 and BRCA2 is considered **medically necessary f**or individuals with a personal history of invasive epithelial ovarian cancer (including fallopian tube cancer or primary peritoneal cancer) at any age to aid in therapy and surgical decision-making and/or for personal and family risk assessment. See multi-gene panel testing for hereditary breast, ovarian, or pancreatic carcinoma* for details about the scope of panel testing. **Individuals with no current or prior diagnosis of epithelial ovarian carcinoma** Germline genetic testing using a multi-gene panel that includes BRCA1 and BRCA2 is considered **medically necessary** for individuals without a current or prior diagnosis of epithelial ovarian cancer with personal or family history suggests the possibility of a pathogenic variant with **ANY** of the following: • At least one first- or second-degree blood relative with epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer at any age • Risk of a pathologic or likely pathologic variant in BRCA1 or BRCA2 is ≥5% based on a validated predictive model See multi-gene panel testing for hereditary breast, ovarian, or pancreatic carcinoma* for details about the scope of panel testing. **Explanation of change**	March 23, 2025

	Clarified scope of epithelial ovarian cancer testing to include fallopian tube cancer and primary peritoneal cancer Removed use of common screening tools used for assessing who should be further evaluated for BRCA risk; specified that the criteria are focused on validated predictive models that indicate the risk of a pathologic or likely pathologic variant in BRCA1 or BRCA2 is ≥5%	

	Hereditary pancreatic ductal adenocarcinoma	
	Individuals with personal history of exocrine pancreatic cancer (pancreatic ductal adenocarcinoma) Germline genetic testing using a multi-gene panel that includes BRCA1 and BRCA2 is considered **medically necessary** for individuals with a personal history of invasive epithelial ovarian cancer at any age to aid in therapy and surgical decision-making and/or for personal and family risk assessment. See multi-gene panel testing for hereditary breast, ovarian, or pancreatic carcinoma* for details about the scope of panel testing. **Individuals with no current or prior diagnosis of exocrine pancreatic cancer (pancreatic ductal adenocarcinoma)** Germline genetic testing using a multi-gene panel that includes BRCA1 and BRCA2 is considered **medically necessary** for individuals without a current or prior diagnosis of epithelial ovarian cancer with personal or family history suggests the possibility of a pathogenic variant with **ANY** of the following: • First-degree blood relative with exocrine pancreatic cancer (pancreatic ductal adenocarcinoma) • Risk of a pathologic or likely pathologic variant in BRCA1 or BRCA2 is ≥5% based on a validated predictive model. See multi-gene panel testing for hereditary breast, ovarian, or pancreatic carcinoma* for details about the scope of panel testing. **Explanation of change** Removed use of common screening tools used for assessing who should be further evaluated for BRCA risk; specified that the criteria are focused on validated predictive models that indicate the risk of a pathologic or likely pathologic variant in BRCA1 or BRCA2 is ≥5% Clarified scope of pancreatic cancer testing to include exocrine pancreatic cancer (pancreatic ductal adenocarcinoma)	March 23, 2025

	Multi-gene panel testing for HBOP	
Multi-gene panel testing for hereditary breast, ovarian, or pancreatic carcinoma	***Multi-gene panel testing for hereditary breast, ovarian, or pancreatic carcinoma** Germline genetic testing which includes additional pathogenic variants (beyond BRCA1 or BRCA2) related to breast, ovarian, or pancreatic cancer is considered medically necessary when ALL of the following criteria are met: • Panels are targeted to the personal and family history of the individual • Genes included in the panel have known pathogenic or likely pathogenic germline variants associated with significantly increased risk for breast and/or associated cancers along with established management implications See Tables 1, 2, and 3 [not included here], for detailed examples of genes that should be tested based on the members' presentation related to one or more of breast, ovarian, and pancreatic cancers,	March 23, 2025

	respectively. *Note: Individuals meeting the criteria for single gene testing who tested negative with previous limited testing sometime in the past (e.g., single gene and/or absent deletion duplication analysis) may be considered for multi-gene panel testing in this scenario. This does not imply that single gene testing is currently necessary before proceeding to multi-gene testing.* **Explanation of change** Clarified in the HBOP multi-gene panel statement that the panel genes are related to known pathogenic or likely pathogenic germline variants and clarified that the genes in Tables 1, 2, and 3 refer to detailed examples of genes that should be tested based on the members presentation related to one or more o of these cancers (breast, ovarian, or pancreatic cancer) For pancreatic carcinoma, added CDK4 to the multi-gene panel list (in Table 3, not shown) For breast cancer, removed the following genes from the multi-gene panel list: ATM, BARD1, CHEK2, RAD51C, and RAD51D (in Table 1, not shown)	

	Melanoma	
Melanoma	Germline genetic testing of a focused set of 20 or fewer specific genes which may include CDKN2A, BAP1, and CDK4 pathogenic variants are considered medically necessary for persons at risk for familial melanoma, familial atypical multiple mole melanoma-pancreatic cancer syndromes, or familial atypical multiple mole melanoma syndrome (FAMMM) as defined by **ANY** of the following diagnostic criteria: • Personal history of three (3) or more melanomas • Personal history of melanoma and pancreatic cancer (exocrine type) • Personal history of melanoma and a personal or family history in two or more first-degree relatives with mesothelioma or clear cell renal carcinoma or basal cell carcinoma (BAP-1 associated cancers) • Personal history of melanoma and astrocytoma • Three or more first- or second-degree relatives with melanoma or pancreatic cancer • Personal history of invasive cutaneous melanoma who have a first-degree relative diagnosed with pancreatic cancer (exocrine type) • Both melanoma and astrocytoma in two or more first-degree relatives **Explanation of change** Gene list expanded to include CDK4 pathogenic variants	March 23, 2025

	Nevoid basal cell carcinoma syndrome	
Nevoid basal cell carcinoma syndrome	(also called Gorlin-Goltz syndrome; basal cell nevus syndrome) Focused genetic testing that may include testing for PTCH variants (including associated downstream gene variants, such as SMO and genes such as SUFU) is considered medically necessary for persons at risk for nevoid basal cell carcinoma syndrome based on the following diagnostic criteria.	March 23, 2025

	The individual must meet **ANY** of the following: **TWO (2) major criteria, ONE major criterion AND two minor criteria, OR THREE (3) minor criteria.** • **Major criteria** ○ Multiple basal cell carcinomas (out of proportion to prior sun exposure and skin type) or a basal cell carcinoma diagnosed before age 30 (excluding basal cell carcinomas that develop after radiotherapy) ○ Lamellar calcification of the falx cerebri ○ Odontogenic keratocyst ○ Palmar or plantar pitting ○ First-degree relative with nevoid basal cell carcinoma syndrome • **Minor criteria** ○ Childhood medulloblastoma (primitive neuroectodermal tumor) ○ Lymphomesenteric or pleural cysts ○ Macrocephaly ○ Cleft lip or cleft palate ○ Vertebral or rib anomalies observed on x-ray ○ Preaxial or postaxial polydactyly ○ Ovarian or cardiac fibromas ○ Ocular anomalies (cataract, developmental defects, and pigmentary changes of the retinal epithelium) **Explanation of change** Clarified that SMO is a PTCH gene variant and SUFU is a gene The threshold for number of basal cell carcinomas is no longer set at 5 in a lifetime and may be as low as two (multiple) if this is considered out of proportion to prior skin exposure or skin type Removed reference to the individual's age for Lamellar calcification of the falx cerebri (major criterion) Minor clarifications in the wording of major and minor criteria to improve the clarity and simplicity of applying the criteria	

	Endocrine neoplasms	
Endocrine neoplasms	Germline genetic testing for a single gene or a panel focused on the set of genes reasonably needed to assess the suspected condition is considered **medically necessary** in individuals with a personal history of **ANY** of the following: • Adrenocortical carcinoma (ACC) • Paraganglioma or pheochromocytoma • Duodenal or pancreatic neuroendocrine tumor • Type 2 gastric neuroendocrine tumor • Gastrointestinal stroma tumors (GIST) diagnosed before age 30 • Medullary thyroid cancer • Parathyroid adenoma, diffuse hyperplasia, or primary hyperparathyroidism before age 30 • Multiple parathyroid adenomas or recurrent primary hyperparathyroidism • MEN2-related features including lip mucosal neuromas resulting in thick vermilion of the upper and lower lip, mucosal neuromas of the lips and tongue, medullated corneal nerve fibers, marfanoid habitus. • Family history of neuroendocrine tumors or associated conditions (including primary hyperparathyroidism, duodenal or	March 23, 2025

	pancreatic neuroendocrine tumor, pituitary adenoma, or carcinoid tumor of bronchial, thymic, or gastric origin) in a first-, second-, or third-degree relative and clinical features in the individual suspicious of a hereditary condition See Tables 4-7 below [not included here] for scope of genes that should be tested based on the underlying type of endocrine neoplasm. **Explanation of change** Added criteria for early onset GI stromal tumors (expansive) to account for evaluation for SDHB gene-deficient GIST Clarified that focused set of genes refers to up to 20 genes Clarified that the criteria related to duodenal or pancreatic gastrinomas is more generally described as neuroendocrine tumors of those organs Clarified that family history of neuroendocrine tumors refers to first-, second-, or third-degree relatives Provided some examples of associated conditions in the criteria about family history of neuroendocrine tumors or associated conditions Added tables to refer to scope of genes that should be tested (i.e., the lower limit) according to the endocrine neoplasm	

	Kidney cancer	
Kidney cancer	Germline genetic testing for a single gene OR a targeted panel (up to 20 genes) which may include BAP1, FH, FLCN, MET, SDHA, SDHAF2, SDHB, SDHC, SDHD, PTEN, or VHL is considered medically necessary for hereditary kidney cancer syndromes in individuals with **ANY** of the following: • Personal history of renal cell carcinoma diagnosed at age 46 or younger • Personal history of renal cell carcinoma and at least one first- or second-degree relative with renal cell carcinoma • Personal history of bilateral or multifocal renal tumors • Personal history of ANY of the following characteristics: ○ Kidney tumor multifocal papillary histology ○ Kidney tumor with Birt-Hogg-Dubé syndrome histology (multiple chromophobe, oncocytoma, or oncocytic hybrid) ○ Hereditary leiomyomatosis-associated renal cell carcinoma (HLRCC) ○ Renal cell carcinoma with fumarate hydratase deficiency or succinate hydrase deficiency ○ Angiomyolipomas of the kidney and one additional tuberous sclerosis complex criterion in the same individual • Unaffected individual with a family history of renal cell carcinoma in two or more first- or second-degree relatives **Explanation of change** Expanded criteria to include individuals with a personal history of various rare kidney tumors (Birt-Hogge-Dubé syndrome, HLRCC associated renal cell carcinoma, etc.) Expanded criteria to include unaffected individuals with two or more first- or second-degree relatives with renal cell carcinoma Listed specific genes for multi-gene panel testing	March 23, 2025

	Prostate Cancer	
Prostate Cancer	Germline genetic testing of a focused set of 20 or fewer specific genes which may include BRCA2, BRCA1, ATM, HOXB13, MLH1, MSH2, MSH6, PMS2, and EPCAM to inform assessment of hereditary risk of prostate cancer is considered medically necessary for individuals with a history of ANY of the following: • Personal history of **ANY** of the following: ○ Metastatic, locally advanced, or high/very high risk localized prostate cancer ○ Prostate cancer diagnosed before age 60 **AND** at least one first-degree relative with prostate cancer diagnosed before age 60 ○ Low- or intermediate-risk localized prostate cancer concomitant with **ANY** of the following: ▪ A personal history of breast, pancreatic, gastric, brain, melanoma, intestinal (colorectal or small bowel), or upper tract urothelial cancer(s) ▪ A family history of breast cancer in relatives assigned female sex at birth and diagnosed at or before age 50 ▪ A family history of pancreatic, gastric, brain, melanoma, intestinal cancer (colorectal or small bowel), or endometrial cancer diagnosed at or before age 50 ▪ A family history of upper tract urothelial cancer(s) in first- or second-degree relatives ▪ Ashkenazi Jewish ancestry ▪ Intraductal or cribriform histology **Explanation of change** For individuals with low-risk prostate cancer, criteria expanded to include family history of breast cancer in relatives assigned female at birth and age ≤50; family history of pancreatic, gastric, brain, melanoma, intestinal (colorectal or small bowel), or endometrial cancer diagnosed at age ≤50; family history of upper tract urothelial cancer(s) in first- or second-degree relatives; Ashkenazi Jewish ancestry; intraductal or cribriform histology For individuals with intermediate risk prostate cancer, criteria expanded to include family history of breast cancer in relatives assigned female at birth and age ≤50; family history of pancreatic, gastric, brain, melanoma, intestinal (colorectal or small bowel), or endometrial cancer diagnosed at age ≤50; family history of upper tract urothelial cancer(s) in first- or second-degree relatives Removed CHEK2 or PALB2 from the multi-panel gene list for prostate cancer	March 23, 2025

Prostate Cancer	• Family history suggests the possibility of a pathogenic variant related to increased risk of prostate cancer with **ANY** of the following: ○ Two or more first-degree relatives with prostate cancer ○ One or more first- or second-degree relatives with prostate cancer diagnosed before age 60 or who died of prostate cancer ○ Risk of a pathologic or likely pathologic variant in	March 23, 2025

	BRCA1 or BRCA2 is ≥5% based on a validated predictive model ○ At least one first-, second-, or third-degree blood relative with breast cancer diagnosed at or before age 50 ○ At least one first-, second-, or third-degree blood relative with epithelial ovarian, fallopian tube, or primary peritoneal cancer ○ At least one first-degree, second-, or third-degree blood relative with multiple primary breast cancers (metachronous or synchronous) ○ At least one first-, second-, or third-degree blood relative on the same side of the family with breast cancer in an individual assigned male sex at birth ○ At least one first-, second-, or third-degree blood relative on the same side of the family with metastatic prostate cancer, or high or very high-risk grade group of localized or locally advanced prostate cancer ○ Three or more first-, second-, or third-degree blood relatives on the same side of the family with invasive breast and/or prostate cancer ○ Individuals with at least two first-degree blood relatives with pancreatic cancer ○ Ashkenazi Jewish descent **AND** at least one first-degree blood relative with breast cancer ○ Ashkenazi Jewish descent **AND** two or more second-degree blood relatives on the same side of the family with breast or epithelial ovarian cancer ○ Individuals requiring confirmatory testing of a specific gene or genes found to have pathogenic variants involving BRCA2, BRCA1, CHEK2, ATM, PALB2, HOXB13, MLH1, MSH2, MSH6, PMS2, or EPCAM from ANY of the following: ▪ 23andMe PGS (or similar FDA approved commercial direct-to-consumer testing) ▪ In the context of somatic testing for malignancy ▪ Findings discovered in the context of IRB approved clinical research **Explanation of change** Expanded criteria to first-, second-, or third-degree relatives with multiple primary breast cancers Expanded criteria for personal history of prostate cancer diagnosed before age 60 to include at least one first- or second-degree relative For individuals unaffected by prostate cancer, criteria are expanded to include family history indicators for risk of BRCA 1 or BRCA2 pathogenic variants that match the hereditary breast, ovarian, or pancreatic (HBOP) criteria based on family history Noted that confirmatory testing from direct-to-consumer or research study findings is limited to testing of the specific genes with pathogenic mutations. Also clarified that the direct-to-consumer testing is FDA approved. Removed use of common screening tools used for assessing who should be further evaluated for BRCA risk; specified that the criteria are focused on validated predictive models that indicate the risk of a pathologic or likely pathologic variant in BRCA1 or BRCA2 is ≥5%	

	Carrier Screening in the Reproductive Setting	
Description and Scope	Genetic carrier screening in the reproductive setting applies to individuals in the preconception setting, individuals who are currently pregnant, and reproductive partners of individuals who are currently pregnant. These tests are performed on asymptomatic individuals to identify future pregnancies or current pregnancies that are at increased risk for autosomal recessive or X-linked single gene disorders. This testing is generally performed on individuals who have not been diagnosed with, and do not show clinical characteristics of, the condition being evaluated. **Explanation of change** Clarified that these tests are performed on asymptomatic individuals to identify future pregnancies or current pregnancies that are at increased risk for autosomal recessive or X-linked single gene disorders	March 23, 2025

	Standard carrier screening	
Cystic fibrosis and spinal muscular atrophy	**Cystic fibrosis and spinal muscular atrophy** Standard screening for cystic fibrosis (CFTR testing) and spinal muscular atrophy (SMN1 testing) using accepted gene variant sets is considered **medically necessary** in the following scenarios: • All pregnant individuals • An individual considering pregnancy **Explanation of change** Removed CBC from the list of acceptable prior testing Removed "AND their reproductive partner" for clarity	March 23, 2025

	Expanded carrier screening	
	Multigene carrier screening (i.e., multigene testing) is considered **medically necessary** when **ALL** of the following criteria are met: • **ONE** or more of the following apply: ○ One or both individuals have ancestry (e.g., Ashkenazi Jewish, Finnish, French Canadian, among others) known to be at increased risk for certain conditions, other than cystic fibrosis, spinal muscular atrophy, and hemoglobinopathies ○ One or both individuals do not have access to a biological family history due to reasons such as adoption or use of a reproductive donor as documented in the member's medical record ○ The individual and their reproductive partner are known or suspected to be consanguineous as documented in the member's medical record • The conditions on the multigene panel have at least a 1 in 100 carrier frequency* • The genetic disorders being evaluated have gene-disease clinical validity AND pathogenic variants in the genes are associated with significant morbidity and/or mortality in affected individuals • The test has sufficiently high sensitivity and specificity to guide clinical decision making • Knowledge of the pathogenic variant(s) may be used for management of either the pregnancy or the potentially affected	March 23, 2025

	fetus or child, or for family planning ***Note:** Conditions on multigene panels can have carrier frequencies less than 1 in 100 for a consanguineous partnership.* **Explanation of change** Slightly modified the scope of ancestry examples to simplify Clarified that adoption or consanguinity are factors taken into account when documented in the member's medical record Emphasized the 1 in 100 carrier frequency for readability. For individuals in a consanguineous partnership, allow for conditions on multigene panels with less than 1 in 100 carrier frequencies. Removed criteria stating that alternate biochemical tests are not available, have provided an indeterminate result, or are less accurate than genetic testing	

	Exclusions	
Exclusions	The following tests and clinical scenarios are considered **not medically necessary**: • Carrier screening for autosomal dominant conditions • Carrier screening for conditions known to have adult-onset • Cell-free DNA screening for single gene disorders, microdeletions, or other indications not otherwise specified • Variants with high allele frequencies and low penetrance of a phenotype (e.g., methylene tetrahydrofolate reductase variants) • Whole exome or whole genome assays for the purpose of carrier screening • Molecular screening for conditions where nonmolecular screening techniques can be used (e.g., hereditary hemochromatosis has low penetrance when molecular variants are identified) **Explanation of change** Explicitly state that autosomal dominant conditions are excluded from carrier screening (clarification) Parenthetical mention of conditions known to have adult onset were removed	March 23, 2025

	Carrier testing based on family history	
Carrier testing based on family history	Condition-specific carrier testing is considered medically necessary when ANY of the following criteria are met: • The individual has a previously affected child with the genetic condition being evaluated • Either partner has a first-, second-, or third-degree relative who is affected with the genetic condition being evaluated • The reproductive partner of the individual being tested has a pathogenic variant in the gene associated with the condition being evaluated **Explanation of change** Clarification	March 23, 2025

	Genetic Testing for Inherited Conditions **General requirements – Genetic testing for inherited conditions**	
Genetic Testing for	Confirmatory genetic testing of the identified variant(s) is considered **medically necessary** if **ALL** of the criteria above [not	March 23, 2025

Inherited Conditions	included here] are met and **EITHER** of the following apply: • An individual identified to have a pathogenic or likely pathogenic germline variant in genes with established clinical utility based on FDA approved direct-to-consumer genetic testing • An individual identified to have a pathogenic or likely pathogenic germline variant in genes with established clinical utility based on results of IRB approved clinical research studies **Testing may be performed only once per lifetime for a given condition.** **Explanation of change** Added confirmatory genetic testing (expansive) for individuals identified to have a pathogenic or likely pathogenic germline variant in genes with established clinical utility based on results of IRB approved clinical research studies Clarified for testing based on FDA approved direct-to-consumer genetic testing that testing is also for an individual identified to have a pathogenic or likely pathogenic germline variant in genes with established clinical utility	

	Cardiac conditions	
Hereditary cardio-myopathy syndromes	**Hereditary cardiomyopathy syndromes** Genetic testing for pathogenic variants associated with hereditary hypertrophic cardiomyopathy (HCM), arrhythmogenic right ventricular cardiomyopathy/dysplasia (ARVC/D), or inherited dilated cardiomyopathy (DCM) is considered medically necessary when ALL of the following criteria are met: • The individual to be tested has a first-degree relative with supporting clinical features of one of the above-named inherited cardiomyopathy syndromes (HCM, ARVC/D, DCM) • The individual to be tested has been clinically screened to exclude an alternate, acquired etiology of cardiomyopathy (e.g., ischemic cardiomyopathy, cardiac amyloidosis, etc.) • The genetic testing is focused on pathogenic variants relevant to the individual's suspected clinical diagnosis and known familial genetics **OR** • For clinically symptomatic individuals under the age of 18 for whom there is no known family history, a genetic syndrome has not been identified via clinical diagnosis, and an alternate, acquired etiology of cardiomyopathy (e.g., ischemic cardiomyopathy, cardiac amyloidosis, etc.) has been excluded **Explanation of change** New criteria for genetic testing in a pediatric population (expansive)	March 23, 2025

	Hereditary aortopathies	
	Hereditary aortopathies Targeted genetic testing for pathogenic variants associated with significantly increased risk for heritable thoracic aortic disease (HTAD) may be **medically necessary** when **ANY** of the following are met: • The individual to be tested has a personal history of TAD before age 60 AND other causes of acquired cardiac disease	March 23, 2025

	have been excluded • The individual to be tested has a personal history of TAD at any age AND an additional personal history of aneurysm AND/OR dissection/rupture of other arteries • The individual to be tested has other physical findings consistent with a syndromic connective tissue disorder in which an increased genetic risk for TAD is known but the underlying diagnosis cannot be established. (Examples include, but are not limited to, Marfan syndrome, Loeys-Dietz syndrome, vascular Ehlers-Danlos syndrome, or smooth muscle dysfunction syndrome) • The individual to be tested is currently asymptomatic but has one or more first- or second-degree blood relative(s) who are unavailable for genetic testing but had a history of TAD, unexplained sudden cardiac death, and/or aneurysms/dissections in other arteries Genetic testing for a known pathogenic variant in a gene associated with increased genetic risk for aortopathy is medically necessary when ALL of the following are met: • The individual has a first- or second-degree blood relative who has a pathogenic variant associated with HTAD • The testing is targeted to the gene of the known familial pathogenic or likely pathogenic variant **Explanation of change** New medical necessity criteria for hereditary aortopathies (expansive)	

	Post-mortem testing after sudden cardiac death	
Post-mortem testing after sudden cardiac death	**Post-mortem testing after sudden cardiac death** After sudden cardiac death, genetic testing for pathogenic variants associated with cardiac channelopathies is considered **medically necessary** on an asymptomatic individual when ALL of the following criteria are met: • The decedent was a first- or second-degree relative of the individual requesting the test • Sudden cardiac death occurred at or before age 50 • The cause of sudden cardiac death remains unexplained despite the clinical history and autopsy, toxicology, and cardiac pathology findings **Explanation of change** Clarifications	March 23, 2025

	Neurological conditions	
Neurological conditions	Genetic testing for treatment of pathogenic variants associated with inherited neurological conditions may be **medically necessary** when the general requirements OR multi-gene panel criteria listed above [not included here] are met. Genetic testing for screening or diagnosis of **ANY** of the following common categories of neurological conditions is considered **not medically necessary**: • Alzheimer's dementia • Frontotemporal dementias (i.e., Parkinsons's disease, Pick disease, and others)	March 23, 2025

	• Motor neuron diseases (such as amyotrophic lateral sclerosis) Single gene testing for SOD1 pathogenic variants is considered medically necessary when **BOTH** of the following criteria are met: • The individual is an adult with a clinical diagnosis of amyotrophic lateral sclerosis (ALS) • The individual is a candidate for treatment with tofersen (Qalsody) per the FDA label *Note: This guideline does not address testing to guide selection of FDA approved therapeutics with specific indications based on biomarker test results. Please refer to the Carelon Guidelines for Pharmacogenomic Testing.* **Explanation of change** Expanded criteria to include the new FDA approved Qalsody (tofersen) to treat patients with amyotrophic lateral sclerosis (ALS) associated with a mutation in the superoxide dismutase 1 (SOD1) gene (SOD1-ALS)	

	Thrombophilia testing	
Thrombophilia testing	Thrombophilia genetic testing for common pathogenic variants associated with Factor V Leiden or the prothrombin (Factor II) gene G20210A is considered medically necessary to inform anticoagulation decision-making when **ANY** of the following criteria are met: • An individual who had a venous thromboembolism (VTE) at or before age 50 in association with unprovoking OR weakly provoking factors • An individual with recurrent VTE • An individual with VTE **AND EITHER** of the following: ○ Two or more family members with a history of VTE ○ One first-degree relative with VTE at or before age 40 • An individual with VTE involving the cerebral or splanchnic veins • An individual contemplating pregnancy who has a first-degree relative with VTE AND a confirmed hereditary thrombophilia • An individual with an unprovoked VTE who is planning to stop anticoagulation. Test for thrombophilia if test results would change this decision. **Not Medically Necessary:** MTHFR-gene variant testing for hereditary thrombophilia risk assessment is considered **not medically necessary.** **Explanation of change** Criteria in first bullet separated into multiple bullets for clarity. Aligned phrasing of criteria for consistency (i.e., An individual…). Specified the definition of “strong family history” for clarity (bullet 3). Changed “known” to “confirmed” for clarity (bullet 5). Removed restriction of low bleeding risk (bullet 6). Removed criterion in last bullet referring to contemplation of estrogen use with a first degree relative with VTE and a known hereditary thrombophilia test for that thrombophilia	March 23, 2025

Radiation Oncology Guidelines

Legend	Text color	Indicates…
Guideline Change Summary	**Blue**	Change to guideline wording
	Black	Preservation of existing guideline wording
		Changes expected to be…
Explanation of Change	**Green**	More expansive on appropriateness
	Red	More restrictive on appropriateness
	Black	Have minimal if any impact on appropriateness review and exists primarily to clarify intent

The following updates will apply to the Carelon Clinical Appropriateness **Guidelines for Radiation Oncology.** You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

Carelon Guideline	Policy Change Summary	Effective Date
	Radiation Therapy (excludes Proton) **Special Treatment Procedure and Special Physics Consult**	
Radiation Therapy (excludes Proton)	**Special treatment procedure is indicated when extra planning time and effort is documented for ANY of the following:** • Cytotoxic chemotherapy and/or targeted therapy and/or immunotherapy within 90 days of RT • Brachytherapy when combined with external radiation therapy • Proton therapy • Total body or hemibody radiation • Pediatric patient requiring daily anesthesia and daily physician supervision during treatment • Certain cases requiring reconstruction of previous radiation plan, complex planning, and physics input • Stereotactic body radiation therapy (SBRT) in a complex medical setting (e.g..treating a patient on a ventilator) ○ Special treatment procedure is NOT medically necessary for uncomplicated SBRT treatment (such as for a single bone metastasis) • Other (documentation of special circumstances or time-consuming plan required) **Explanation of change** Limited the scenarios where special treatment procedure is indicated, to more closely align with recent ASTRO guidance.	March 23, 2025

	Breast Cancer	
Breast Cancer	• **Accelerated partial breast irradiation (APBI) is appropriate only for individuals who meet ALL of the following criteria:** ○ Age 40 or greater for invasive disease or greater than 50 for DCIS ○ Tumor less than or equal to 2 cm with pathologically negative surgical margins ○ Lymph nodes are negative or show only immunohistochemical involvement, N0 or N0(i+) ○ Distance between the edge of the applicator and the skin is at least 6 mm **Explanation of change** Reduced the minimum age at which patients with invasive disease meet criteria for accelerated partial breast irradiation (APBI).	March 23, 2025

	Head and Neck Cancers (including Thyroid)	
Head and neck	**Head and neck** Intensity Modulated Radiation Therapy (IMRT) is appropriate for head and neck cancers when **ANY** of the following conditions are met: • Glottic cancer, stage III and IV • Other advanced head and neck cancers • Lymphomas of the head and neck region • To treat a previously irradiated field Stereotactic Body Radiation Therapy (SBRT) is appropriate for head and neck cancer when the following condition is met: • Only to treat a previously irradiated field Brachytherapy is appropriate for head and neck cancer when the following condition is met: • To treat cancers including cancers of the lip, oral cavity, tongue (particularly base of tongue), tonsils, sinuses, nasopharynx, pharynx, and other neck cancers **Exclusions** Indications other than those addressed in this guideline are considered not medically necessary including, but not limited to: • Neutron therapy **Explanation of change** Removed indication for neutron therapy as this is no longer routinely used.	March 23, 2025

	Lung Cancer: Small Cell and Non-Small Cell	
Primary Lung Cancers Non-small cell lung cancer	**Primary Lung Cancers** **Non-small cell lung cancer** Stereotactic Body Radiation Therapy (SBRT) is appropriate for non-small cell lung cancer when **ANY** of the following conditions are met: • As an alternative to surgical resection when (**ALL must apply**) ○ Treatment intent is cure ▪ There is no evidence of nodal or distant metastases based on conventional staging techniques (Stage IA, IB, or IIA with negative lymph nodes) ○ Single lesion measuring less than or equal to 5 cm ○ Lesion is inoperable for **EITHER** of the following reasons: ▪ Tumor location ▪ Individual is not a surgical candidate ▪ To treat a previously irradiated field The maximum number of fractions that is medically necessary for SBRT is 5. **Small cell lung cancer** Stereotactic Body Radiation Therapy (SBRT) is appropriate for small cell lung cancer when **ANY** of the following conditions are met: • As an alternative to surgical resection when (**ALL must apply**) ○ Treatment intent is cure ▪ There is no evidence of nodal or distant metastases based on conventional staging techniques (Stage IA, IB, or IIA with negative	March 23, 2025

	lymph nodes) ○ Single lesion measuring less than or equal to 5 cm ○ Lesion is inoperable for **EITHER** of the following reasons: ▪ Tumor location ▪ Individual is not a surgical candidate ▪ To treat a previously irradiated field The maximum number of fractions that is medically necessary for SBRT is 5. **Explanation of change** Clarified that the maximum number of fractions for SBRT is 5 in both NSCLC and SCLC	

	Oligometastatic Extracranial Disease	
Oligometastatic Extracranial Disease	**Stereotactic Body Radiation Therapy (SBRT) is considered medically necessary for extracranial oligometastatic disease when ALL of the following conditions are met:** • One (1) to three (3) metastatic lesions involving the lungs, liver, adrenal glands, or bone • Primary tumor is breast, colorectal, melanoma, non-small cell lung, prostate, renal cell, or sarcoma • Primary tumor is controlled • No prior history of metastatic disease For oligoprogressive disease, SBRT is approved for 1-3 lesions if there has been prior control with systemic therapy. **Explanation of change** Added scenario for oligoprogressive extracranial disease	March 23, 2025

	Other Tumor Types: Sarcoma, Thymoma and Thymic Carcinoma, Pediatric Tumors, and Other Malignancies	
Other Tumor Types: Sarcoma, Thymoma and Thymic Carcinoma, Pediatric Tumors, and Other Malignancies	**Pediatric individuals (age 20 years or younger)** Intensity Modulated Radiation Therapy (IMRT), Stereotactic Radiosurgery (SRS), or Stereotactic Body Radiation Therapy (SBRT) is appropriate for pediatric patients when the following condition is met: • To treat pediatric individuals (age 20 years or younger) with a radiosensitive tumor **Explanation of change** Combined criteria for IMRT, SRS, and SBRT Expanded criteria for SRS and SBRT to include any radiosensitive tumor	March 23, 2025

	Prostate Cancer	
Prostate Cancer	**Fractionation** **When the above criteria are met, the following fractionation applies:** The recommended EBRT/IMRT fractionation to treat localized prostate cancer when the pelvic lymph nodes will not be treated is either 60 Gy in 20 fractions or 70 Gy in 28 fractions. In men with significant baseline obstructive urinary symptoms, conventional	March 23, 2025

	fractionation of up to 39 fractions is considered **medically necessary.** Up to 28 fractions of EBRT/IMRT are considered medically necessary for localized or locally recurrent prostate cancer when the pelvic lymph nodes will be treated. Up to 32 fractions of EBRT/IMRT are considered medically necessary as adjuvant treatment to the prostate bed after prostatectomy. Up to 37 fractions of EBRT/IMRT are considered medically necessary for salvage treatment after prostatectomy. **Explanation of change** Modified number of fractions indicated, due to larger dose given in each individual fraction (no change in total dose to be given). Added scenario for salvage treatment after prostatectomy Also added max fraction number for salvage RT	

	Perirectal Hydrogel Spacer for Prostate Radiotherapy	
Perirectal Hydrogel Spacer for Prostate Radiotherapy	**The use of an implanted hydrogel spacer between the prostate and rectum is medically necessary when primary definitive radiation therapy will be used to treat prostate cancer using** any form of external beam radiation therapy (3D conformal, IMRT, SBRT) **Explanation of change** Expanded the use of hydrogel spacers to include them in patients receiving any form of external beam radiation therapy	March 23, 2025

	Proton Beam Therapy	
Proton Beam Therapy	This guideline outlines different applications of proton beam therapy in the treatment of malignant and benign tumors and arteriovenous malformations. For all PBT requests outside of approved criteria, case control plan comparison is insufficient justification for PBT. A direct isodose comparison for an IMRT plan specific to the patient request is mandatory for consideration. **Explanation of change** Added clarifying statement that case control plan comparison is insufficient and that direct IMRT isodose comparison is required	March 23, 2025

	Therapeutic Radiopharmaceuticals	
Pheochromo-cytoma and Paraganglioma	**Pheochromocytoma and Paraganglioma** 131I iobenguane (Azedra®) is no longer produced or distributed. **Explanation of change** Removed criteria for the use of Azedra since it is no longer produced or distributed	March 23, 2025

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DERMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Amniotic Membrane and Amniotic Fluid	643	**Policy revised.** AmnioExcel added to the list of medically necessary products for the treatment of nonhealing diabetic lower-extremity ulcers.	January 1, 2025	Commercial Medicare	No action required.
Bioengineered Skin and Soft Tissue Substitutes	663	**Policy revised.** mVASC and TheraSkin added to medically necessary statement for diabetic lower-extremity ulcers. Several products added to investigational list.	January 1, 2025	Commercial Medicare	No action required.

GENERAL SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Treatment of Hyperhidrosis	406	**Policy clarified.** Endoscopic transthoracic sympathectomy and surgical excision of axillary sweat glands (CPT 32664) retired and removed from the policy. **This is a covered service.** 32664 Thoracoscopy, surgical; with thoracic sympathectomy .	October 1, 2024	Commercial	No action required.

OBSTETRICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Assisted Reproductive Services	086	**Policy clarified.** Cryochoice kits are not covered.	October 1, 2024	Commercial	Prior authorization is still required.

ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Ablation Procedures for Peripheral Neuromas	719	**Policy 719 retired.** This is a covered service.	October 1, 2024	Commercial	No action required.

PLASTIC SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Plastic Surgery	068	**Policy clarified.** Hair transplants statement removed. Coverage is determined by the subscriber certificate.	October 1, 2024	Commercial	Prior authorization is still required.
Gender Affirming Services	189	Investigational indications **revised.**	January 1, 2025	Commercial Medicare	Prior authorization is still required.

PULMONOLOGY SLEEP DISORDER MANAGEMENT

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Actigraphy	533	**Policy 533 retired.** Code 95803 transferred to MP 400 Medical Technology Assessment Non-Covered List. 95803 Actigraphy testing, recording, analysis, interpretation and report (minimum of 72 hours to 14 consecutive days of recording)	October 1, 2024	Commercial	No action required.

TRANSPLANTATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Allogeneic Pancreas Transplant	328	**Policy revised.** Policy Guidelines updated to remove obesity-related criteria.	October 1, 2024	Commercial	Procedure is performed inpatient.

UROLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Whole Gland Cryoablation of the Prostate	149	**Policy 149 retired.** This is a covered service.	October 1, 2024	Commercial	No action required.

September 2024

BEHAVIORAL HEALTH PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Esketamine Nasal Spray (Spravato™) and Intravenous Ketamine for Mental Health Conditions	087	**Policy clarified.** If the medication is received from a Retail Specialty Pharmacy, it must be shipped to the providers office. Prior authorization reviews are managed by the Behavioral Health Unit.	January 1, 2025	Commercial Medicare	Prior authorization is still required.

CARDIOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Transcatheter Mitral Valve Repair or Replacement	692	**Policy revised.** New medically necessary indications added for transcatheter mitral valve-in-valve replacement for patients with a degenerated bioprosthetic valve who are at high or prohibitive risk of open surgery.	December 1, 2024	Commercial	No action required.

COMPLEMENTARY MEDICINE

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Com-	178	**Policy clarified.**	September	Commercial	No action

plementary Medicine		Investigational indications added: ▪ cranial manipulation (chiropractic intervention) ▪ sacro-occiptal technique (chiropractic intervention) ▪ functional medicine. Cupping therapy **clarified** to specify bloodletting cupping.	1, 2024	Medicare	required.

MULTISPECIALTY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Biofeedback for Miscellaneous Indications	187	**Policy clarified** to include ongoing investigational indications of Neurofeedback.	September 1, 2024	Commercial	No action required. This is not a covered service.
Neurofeedback	515	**Policy #515 retired.** Ongoing investigational indications on neurofeedback transferred to MP 187 Biofeedback for Miscellaneous Indications.	September 1, 2024	Commercial Medicare	No action required. This is not a covered service.
Medical Technology Assessment Noncovered List	400	**Policy revised** to add: Salivary Hormone Test. **Including but not limited to the One Day Hormone Check™ Gastrointestinal Composition Tests **Including but not limited to Microbiomix™ Clarified to add exceptions to Salivary Cortisol Test. ** Exceptions are for individuals who have symptoms of Cushing's Syndrome.	September 1, 2024	Commercial Medicare	No action required. These services are not covered.

NEUROLOGY NEUROSURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Navigated Transcranial Magnetic Stimulation	596	**Policy #596 retired.** Transfer ongoing investigational indications to MP 400 Medical Technology Assessment Non-Covered List.	September 1, 2024	Commercial Medicare	No action required. This is not a covered service.
High Intensity Laser Therapy for Chronic Musculo-skeletal Pain Conditions and Bell's Palsy	104	**New medical policy** describing investigational indications.	December 1, 2024	Commercial Medicare	No action required. This is not a covered service.
Medical Technology Assessment Noncovered List	400	**Policy clarified. Syn-One test** for Parkinson's disease added to non-covered list.	September 1, 2024	Commercial Medicare	No action required. This is not a covered service.

OBSTETRICS - ASSISTED REPRODUCTIVE SERVICES

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Preimplantation Genetic Testing	088	**Policy clarified.** Any services related to thaw, freeze, or refreeze are only approved for medically necessary preimplantation genetic testing services.	September 1, 2024	Commercial Medicare	Prior authorization is still required.

ORGAN TRANSPLANTATION

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medical Technology Assessment Noncovered List	400	**Policy clarified.** Code 81560 removed from MP 400. Ongoing investigational indications transferred to MP 182 Immune Cell Function Assay in Solid Organ Transplantation.	September 1, 2024	Commercial Medicare	No action required. This is not a covered service.

		81560: Transplantation medicine, measurement of donor and third party-induced CD154+T-cytotoxic memory cells			
Immune Cell Function Assay in Solid Organ Transplantation	182	**Policy clarified.** Investigational policy statements edited for clarity. Use of immune cell function assay testing for all other indications in the setting of transplantation medicine is considered investigational.	September 1, 2024	Commercial Medicare	No action required. This is not a covered service.

PHARMACY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma	066	**Policy revised. Tisagenlecleucel and brexucabtagene autoleucel** were updated to address Philadelphia-chromosome positive individuals. **Tisagenlecleucel, axicabtagene ciloleucel and lisocabtagene maraleucel** additional indications were added. **Tisagenlecleucel** is medically necessary for relapsed or refractory individuals with follicular lymphoma. **Axicabtagene ciloleucel** is medically necessary for adults with large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line	August 23, 2024	Commercial	Prior authorization is still required.

		chemoimmunotherapy. **Lisocabtagene maraleucel** is medically necessary for adults with large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy or is refractory to first-line chemoimmunotherapy or relapse after first line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation due to comorbidities or age.			
Immunomodulators for Skin Conditions	010	Drug Rinvoq will get a prescriber criteria added for atopic dermatitis.	December 1, 2024	Commercial	Prior authorization is required.
Medical Utilization Management (MED UM) & Pharmacy Prior Authorization	033	Drug Dupixent will get a prescriber criteria added for atopic dermatitis.	December 1, 2024	Commercial	Prior authorization is required.

August 2024

CARDIOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Ambulatory Event Monitors and Mobile Cardiac Outpatient Telemetry	347	**Policy #347 retired.** Coverage information transferred to new MP #119 Ambulatory Electrocardiograph (AECG) Monitoring.	October 1, 2024	Commercial	No action required.
Progenitor Cell Therapy for the Treatment of Damaged Myocardium Due to Ischemia	652	**Policy 652 retired.** Ongoing investigational indications transferred to MP 400, Medical Technology Assessment Non-Covered List.	August 1, 2024	Commercial Medicare	No action required.

DERMATOLOGY PLASTIC SURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Negative Pressure Wound Therapy in the Outpatient Setting	543	**Policy clarified** and reformatted. Policy statements unchanged. Prior authorization is no longer required. Procedure-to-diagnoses edits will be implemented.	November 1, 2024	Commercial	No action required.

ENDOCRINOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Medicare Advantage Management	132	**Policy revised.** Prior authorization for type 2 diabetes is no longer required for codes A4238, A4239 and A9277 under MP #107 Continuous Glucose Monitoring. Procedure-to-diagnoses edits will be implemented.	October 1, 2024	Medicare	No action required. Prior authorization **is not required** for T2D.

HEMATOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Gene Therapies for Thalassemia	215	**Policy revised** to include medically necessary and investigational indications for Exagamglogene autotemcel (Casgevy) for individuals with transfusion dependent beta thalassemia when certain conditions are met. Prior Authorization	August 1, 2024	Commercial Medicare	No action required. Prior authorization **is required.**

		Request Form: Casgevy™ (Exagamglogene autotemcel) for Beta thalassemia, #217			

NEUROLOGY NEUROSURGERY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Implantable Peripheral Nerve Stimulation for Chronic Pain Conditions	103	**New medical policy** describing investigational indications. PNS to treat chronic pain of peripheral nerve origin is considered investigational.	November 1, 2024	Commercial Medicare	No action required.
Endovascular Therapies for Extracranial Vertebral Artery Disease	730	**Policy 730 retired.** Codes 0075T and 0076T are still considered investigational/not covered.	August 1, 2024	Commercial	No action required.
Medical Technology Assessment Non-Covered List	400	**Policy revised** to include InTandem Medical Device /Rhythmic Auditory Stimulation (RAS).	August 1, 2024	Commercial Medicare	No action required.

NEUROSURGERY ORTHOPEDICS

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Intraoperative Neuro-physiologic Monitoring Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring	211	**Policy revised.** Motor evoked potentials expanded to include additional medically necessary indications.	November 1, 2024	Commercial	No action required.

OBSTETRICS – ASSISTED REPRODUCTIVE SERVICES

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Assisted Reproductive Services	086	**Policy clarified.** All frozen eggs/embryos must be used before any fresh cycle may be approved.	August 1, 2024	Commercial	No action required. Prior authorization **is required**.

ONCOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Adoptive Cell Therapies for Melanoma	089	**New medical policy** describing medically necessary and investigational indications. Prior Authorization Request Form for Lifileucel (Amtagvi), #096	August 1, 2024	Commercial Medicare	No action required. Prior authorization **is required**.
Adoptive Immunotherapy	455	**Policy clarified.** Reference and link to MP #089 Adoptive Cell Therapies for Melanoma, #089 added.	August 1, 2024	Commercial Medicare	No action required. This is not a covered service.

OPHTHALMOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Intravitreal and Punctum Corticosteroid Implants	272	**Policy revised.** Policy statement added for new investigational indication for Dextenza for ocular itching associated with allergic conjunctivitis.	November 1, 2024	Commercial Medicare	No action required.

PHARMACY NEUROLOGY

POLICY TITLE	POLICY	POLICY CHANGE	EFFECTIVE	PRODUCTS	PROVIDER ACTIONS

	NO.	SUMMARY	DATE	AFFECTED	REQUIRED
Monoclonal Antibodies for Treatment of Alzheimer Disease	946	**Policy clarified** **Donanemab-AZBT (Kisunla):** medically necessary and investigational indications added. **Aducanumab (Aduhelm):** removed from the policy. This drug was discontinued by the manufacturer. **J0172** Injection, aducanumab-avwa, 2 mg transferred to MP 400 Medical Technology Assessment Non-Covered List.	August 1, 2024	Commercial	No action required. Prior authorization is still required.
Medicare Advantage Part B Medical Utilization Management	125	**Donanemab-AZBT (Kisunla)** is added to Part B Medical Utilization Management.	August 1, 2024	Medicare	Providers will need to submit prior authorization requests for Kisunla.

UROLOGY GYNECOLOGY LABORATORY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Identification of Micro-organisms Using Nucleic Acid Probes	555	**Policy revised.** Mycoplasma genitalium added to list of medically necessary nucleic acid testing. Code 87563 will be covered on effective date. 87563 Infectious agent detection by nucleic acid (DNA or RNA); Mycoplasma genitalium, amplified probe technique.	November 1, 2024	Commercial Medicare	No action required.

July 2024

CARDIOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Trans-esophageal Echo-cardiography (TEE)	114	**New medical policy** describing medically necessary and investigational indications. Local Coverage Determination Transesophageal Echocardiography L33579 is followed for Medicare Advantage products.	October 1, 2024	Commercial	No action required. Prior authorization is **not required.**
Transthoracic Echo-cardiography (TTE)	115	**New medical policy** describing medically necessary and not medically necessary indications. Local Coverage Determination Transthoracic Echocardiography L33577 is followed for Medicare Advantage products.	October 1, 2024	Commercial	No action required. Prior authorization is **not required.**
Cardiac Catheterization and Coronary Angiography	116	**New medical policy** describing medically necessary and not medically necessary indications. Local Coverage Determination Cardiac Catheterization and Coronary Angiography L33557 is followed for Medicare Advantage products.	October 1, 2024	Commercial	No action required. Prior authorization is **not required.**
Percutaneous Coronary Intervention	117	**New medical policy** describing medically necessary indications and coverage limitations. Local Coverage Determination Percutaneous Coronary Intervention L33623 is followed for Medicare Advantage products.	October 1, 2024	Commercial	No action required. Prior authorization is **not required.**

Single Chamber and Dual Chamber Permanent Cardiac Pacemakers	118	**New medical policy** describing medically necessary and investigational indications. Billing and Coding: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers A54909 is followed for Medicare Advantage products.	October 1, 2024	Commercial	No action required. Prior authorization is **not required.**
Ambulatory Electro-cardiograph (AECG) Monitoring	119	**New medical policy** describing medically necessary and not medically necessary indications. Ambulatory Electrocardiograph (AECG) Monitoring L39490 is followed for Medicare Advantage products.	October 1, 2024	Commercial	No action required. Prior authorization is **not required.**
Leadless Cardiac Pacemakers	038	**Policy revised.** The Aveir™ DR dual chamber pacing system is considered investigational.	October 1, 2024	Commercial	No action required. Prior authorization is **not required.**
Implantable Cardioverter Defibrillator	070	**Policy revised.** Policy statements and policy guidelines updated for pediatric indications.	October 1, 2024	Commercial	No action required.

CARDIOLOGY PULMONOLOGY ENDOCRINOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)	082	**Policy implementation delayed** until further notice. (This new policy was previously announced in June 2024 with an effective date of September 1, 2024.)	Delayed until further notice.	Commercial Medicare	No action required.

Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid and Artificial Pancreas Device Systems	107	**Policy revised.** Prior authorization is no longer required for type 2 diabetes for codes A4238, A4239 and A9277. Procedure-to-diagnoses edits will be implemented. **Policy clarified** to indicate that all other uses of CGM are considered investigational.	October 1, 2024	Commercial	No action required.

MULTISPECIALTY NON-INVASIVE VASCULAR STUDIES

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Non-invasive Vascular Studies	691	**Policy revised** to include medically necessary and investigational indications for cerebrovascular arterial studies (extracranial and transcranial doppler). Codes 93880, 93882, 93886, 93888, 93890, 93892, and 93893. Local Coverage Determination (LCD) Non-Invasive Vascular Studies L33627 is followed for Medicare Advantage products.	October 1, 2024	Commercial	No action required. Prior authorization is still **not required.**

OBSTETRICS - ASSISTED REPRODUCTIVE SERVICES

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Assisted Reproductive Services	086	**Clarifications** made to the noncovered section for assisted embryo hatching.	July 1, 2024	Commercial	No action required.

PULMONOLOGY

POLICY TITLE	POLICY NO.	POLICY CHANGE SUMMARY	EFFECTIVE DATE	PRODUCTS AFFECTED	PROVIDER ACTIONS REQUIRED
Molecular Testing in the Management of Pulmonary Nodules	029	**Policy revised.** Investigational policy statements updated to include the REVEAL Lung Nodule characterization test.	October 1, 2024	Commercial	No action required.

GENETIC TESTING GUIDELINES

Legend	Text color	Indicates…
Guideline Change Summary	**Blue**	Change to guideline wording
	Black	Preservation of existing guideline wording
		Changes expected to be…
Explanation of Change	**Green**	More expansive on appropriateness
	Red	More restrictive on appropriateness
	Black	Have minimal if any impact on appropriateness review and exists primarily to clarify intent

The following updates will apply to the Carelon Clinical Appropriateness **Guidelines for Genetic Testing.** You may access and download a copy of the current guidelines here. For questions related to the guidelines, please contact Carelon via email at MedicalBenefitsManagement.guidelines@carelon.com

Carelon Guideline	Policy Change Summary	Effective Date
Cell-free DNA Testing (Liquid Biopsy) for the Management of Cancer		
Individuals with metastatic breast cancer who may benefit from PIK3CA/AKT1/PTEN or ESR1-targeted therapy	Liquid (ctDNA) based testing, to include PIK3CA, AKT1, PTEN and/or ESR1 somatic tumor testing, is considered medically necessary to identify individuals who may benefit from the use of alpelisib, capivasertib plus fulvestrant or elacestrant (or other FDA approved agents targeting these same pathways) when **ALL** of the following criteria are met: • The individual is either an adult man OR postmenopausal woman • The individual has ER-positive and HER2-negative metastatic breast cancer • The individual is a candidate for use per drug label of an applicable FDA approved targeted agent • The individual has not had prior testing for the targeted gene(s) of interest in the metastatic setting • There is insufficient tumor tissue available for NGS-based somatic profiling or tissue biopsy is unsafe or considered infeasible due to the individual's clinical condition **Explanation of change** Expanded criteria to include a wider scope of testing for metastatic disease: AKT1 and PTEN (related to capivasertib/fulvestrant therapy) Clarifications	November 17, 2024
Individuals without malignancy for	**Not Medically Necessary:**	November 17, 2024

whom liquid biopsy is used for screening	**Individuals without malignancy for whom liquid biopsy is used for screening** • Liquid (ctDNA) based testing is considered not medically necessary for individuals without invasive malignancy for whom the liquid biopsy test is being used for early initial cancer diagnosis or cancer screening **Individuals with invasive solid tumor malignancy for whom liquid biopsy is used to assess for minimal residual disease (MRD) during and after treatment** • Liquid (ctDNA) based testing is considered not medically necessary for individuals with invasive solid tumor malignancy for whom the liquid biopsy test is being used to assess for MRD during and after treatment **Explanation of change** Clarified that liquid screening tests are not medically necessary	

Carelon Guideline	Policy Change Summary	Effective Date
Prenatal Testing [change to Screening] using cell free DNA		
General Requirements	Prenatal screening using cfDNA should occur only once per fetus per pregnancy. **Explanation of change** Clarification – changed prenatal testing to prenatal screening throughout guideline	November 17, 2024
Condition-Specific Requirements	**Viable singleton or twin pregnancy** Prenatal screening using cell-free DNA (cfDNA) is considered **medically necessary** in viable singleton or twin pregnancies at 9 weeks gestation or later for aneuploidies of the following chromosomes: • 13 • 18 • 21 • X • Y **This includes the following indications:** • As follow-up to abnormal maternal serum screen results when diagnostic testing is declined • Pregnancies with multiple anomalies **AND** diagnostic testing is not possible **Explanation of change** Clarifications • Combined “Sex prediction for pregnancies at risk for an X-linked disorder” with below as an exception under NMN list • Expanded criteria to include follow-up screening for abnormal maternal serum screen results in viable singleton/twin pregnancies when diagnostic testing is declined and screening for pregnancies with multiple anomalies when diagnostic testing is not possible	November 17, 2024
The use of cfDNA screening is considered not	**Not Medically Necessary:** The use of cfDNA screening is considered not medically necessary for clinical scenarios including, but not limited to, the following:	November 17, 2024

medically necessary for clinical scenarios including, but not limited to, the following:	• Higher order gestations (≥3 fetuses) • Fetal demise • Co-twin demise (vanishing twin) • Multiple fetal anomalies • Concurrent screening with other maternal serum biomarkers • Prior to 9 weeks gestation The use of cfDNA screening is considered not medically necessary when screening for the following: • Sex only (without family history of an X-linked disorder) • Single genes (e.g., CFTR, HBB, SMN1, RhD) • Microdeletions (e.g., DiGeorge syndrome, Cri-du-chat syndrome) • Twin zygosity (monozygotic versus dizygotic) • Genome-wide copy number variants • Aneuploidies of other autosomal chromosomes, e.g., trisomy 7, trisomy 15, trisomy 16, trisomy 22, etc. • Polygenic risk assessment *Note: Some of the tests listed above have a role in care under certain circumstances, but they should not be routinely offered.* **Explanation of change** Clarifications Combined above "Sex prediction for pregnancies at risk for an X-linked disorder" with exception "Sex only (without family history of an X-linked disorder)" under NMN list	

Carelon Guideline	Policy Change Summary	Effective Date
Somatic Testing of Solid Tumors		
Metastatic or Advanced Cancer (Tumor change to Tissue Agnostic Testing)		
Tissue-agnostic testing for patients with advanced solid tumors	**Tissue-agnostic testing for patients with advanced solid tumors** Multi-gene panel testing is considered medically necessary when **ALL** of the following are true: • The individual has a metastatic or advanced solid tumor and adequate performance status for cancer treatment • A genomic biomarker-linked therapy has been approved by the FDA for the individual's specific clinical scenario, or there are established genomic biomarker-based treatment contraindications or exclusions • There are no existing indications for the planned therapy such that its use does not depend on the results of genetic testing (i.e., immune checkpoint inhibitor indications) • There are no satisfactory tumor-specific standard therapies available • Testing falls into ANY of the following categories: • Mismatch-repair (MMR) deficiency ▪ MLH1, MSH2, MSH6, PMS2 or EPCAM genes by PCR or NGS testing ▪ Microsatellite testing (MSI) and/or dMMR testing ▪ MLH-1 promoter methylation and/or BRAF V600E mutation testing with nuclear expression loss of MLH1 and PMS2 by immunohistochemistry ○ Tumor mutational burden (TMB) testing as determined by an FDA-approved test with reporting	November 17, 2024

	using the threshold of ≥10 mutations/megabase (mut/Mb) ○ NTRK and RET fusion testing • BRAF V600E mutation testing **Explanation of change** Added clarification about TMB testing by FDA-approved test with reporting threshold ≥ 10 mutations/megabase (mut/Mb)	
	Cancer-specific Criteria	
Bladder Cancer (Urothelial Carcinoma, including the Upper Tract)	Targeted (i.e., 50 or less genes) tissue-based somatic tumor testing for FGFR variants is considered medically necessary for individuals with urothelial tumors of the bladder or upper urinary tract when **ALL** of the following criteria are met: • The individual has biopsy-proven urothelial malignancy • The urothelial malignancy is locally advanced (stage IIIB), recurrent, or metastatic (stage IV) • The individual is a potential candidate for an FDA-approved targeted therapy prescribed on the basis of the FGFR test result • The individual has not had prior FGFR testing in the locally advanced, recurrent, or metastatic setting Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR), or mismatch repair deficiency (dMMR by IHC) is considered medically necessary when BOTH of the following criteria are met: • The individual has biopsy-proven urothelial carcinoma of the bladder or upper urinary tract. • The individual has not had prior MSI or dMMR testing Note: Tumor agnostic genetic testing indications may also apply depending on the clinical scenario (e.g., there are no satisfactory tumor-specific standard therapies available, there are no indications for planned therapy that would apply independent of the results of genetic testing [such as immune checkpoint inhibitor indications], and progression of disease). See the Tissue Agnostic Testing guideline for details. **Explanation of change** Clarification about prior FGFR testing Expansive changes for microsatellite instability/mismatch repair deficiency (MSI/dMMR)	November 17, 2024
Brain Cancer (Malignant Glioma)	Targeted (i.e., 50 or less genes) tissue-based somatic tumor testing is considered medically necessary for individuals with malignant gliomas of the brain when **ALL** of the following criteria are met: • The individual has biopsy-proven, primary malignant glioma of the brain • Genetic testing includes at least the following: ○ BRAF V600E ○ IDH1 and IDH2 • The individual has not had prior testing for these genes Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR) or mismatch repair deficiency (dMMR by IHC) is considered medically necessary when **ALL** of the following	November 17, 2024

	criteria are met: • The individual has biopsy-proven, malignant glioma of the brain • The individual is under age 50 years and IDH wild type • The individual has not had prior MSI or dMMR testing **Explanation of change** New clinical scenario considered clarifications for what may have otherwise been reviewed using general (umbrella) criteria	
Breast Cancer, Metastatic	Testing of tumor tissue for somatic pathogenic variants of PIK3CA, AKT1, PTEN, and ESR1 is considered medically necessary for postmenopausal females and adult males when **ALL** of the following criteria are met: • The individual has ER-positive and HER2-negative metastatic breast cancer • The individual is a candidate for treatment per FDA-label with alpelisib or capivasertib plus fulvestrant, AND/OR the individual is a candidate for treatment per FDA label with elacestrant • The individual has not had prior testing (via circulating cell-free DNA testing or tissue-based testing) for the targeted gene(s) of interest in the metastatic setting *Note: Cell-free DNA testing (liquid biopsy) guideline criteria may apply; see Cell-free DNA Testing guidelines. Also, tumor agnostic genetic testing indications may also apply, depending on the clinical scenario (e.g., there are no satisfactory tumor-specific standard therapies available, there are no indications for planned therapy that would apply independent of the results of genetic testing [such as immune checkpoint inhibitor indications], and progression of disease). See the Tissue Agnostic Testing guideline for details.* **Explanation of change** Expanded breast cancer criteria to include a wider scope of testing for metastatic disease: AKT1 and PTEN (related to capivasertib/fulvestrant therapy)	November 17, 2024
Cholangio-carcinoma (Biliary Tract Cancers)	Tissue-based somatic tumor testing for pathogenic variants in individuals with cholangiocarcinoma is considered medically necessary when **ALL** of the following criteria are met: • The individual has biopsy-proven cholangiocarcinoma • The cholangiocarcinoma is locally advanced, unresectable, or metastatic • The panel testing to include analysis of pathogenic variants in these genes: IDH1, FGFR, and BRAF • The individual is a potential candidate for FDA-approved targeted therapy prescribed on the basis of the panel test results • The individual has not had prior somatic tumor testing for IDH1, FGFR, and BRAF in the metastatic setting *Note: Tumor agnostic genetic testing indications may also apply, depending on the clinical scenario (e.g., there are no satisfactory tumor-specific standard therapies available, there are no indications for planned therapy that would apply independent of the results of genetic testing [such as immune checkpoint inhibitor indications], and progression of disease). See the Tissue*	November 17, 2024

	Agnostic Testing guideline for details. **Explanation of change** Clarified language around specific pathogenic variants for which testing is indicated	
Colorectal Cancer, Localized and Metastatic	**Universal testing for all patients with newly diagnosed localized or metastatic colorectal cancer** Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR) or mismatch repair deficiency (dMMR by IHC) is considered medically necessary when **BOTH** of the following criteria are met: ▪ The individual has biopsy-proven adenocarcinoma of the colon or rectum ▪ The individual has not had prior MSI or dMMR testing **Localized colorectal cancer** Targeted (i.e., 50 or less genes) tissue-based somatic tumor testing is considered medically necessary for individuals with localized (stage II-III) colorectal cancer when BOTH of the following criteria are met: • The individual has biopsy-proven adenocarcinoma of the colon or rectum • Includes ANY or ALL of the following, with no prior testing o MSI testing by PCR and/or dMMR IHC testing o BRAF V600E o KRAS o MLH-1 promoter methylation (applicable when there is nuclear expression loss of MLH1 and PMS2 by IHC) *See Hereditary Cancer Testing guideline for further details regarding indications for germline MMR testing.* **Explanation of change** Expanded criteria for MSI/dMMR testing to allow in individuals with de novo metastatic disease, whereas current criteria would have allowed it in localized disease or refractory metastatic disease (as per tumor agnostic guidelines)	November 17, 2024
Metastatic colorectal cancer	**Metastatic colorectal cancer** Targeted (i.e., 50 or less genes) tissue-based somatic tumor testing is considered medically necessary for individuals with recurrent or metastatic colorectal cancer and may be performed on the primary tumor or a metastatic site when **ALL** of the following criteria are met: • The individual has biopsy-proven adenocarcinoma of the colon or rectum • Assessment includes ANY or ALL of the following: o POLE/POLD1 mutations o Extended RAS testing (KRAS and NRAS exons 2,3, and 4) o BRAF V600E o HER2 amplification testing o MLH-1 promoter methylation (applicable when there is nuclear expression loss of MLH1 and PMS2 by IHC) • There has been no prior testing for these molecular aberrations *Note: Tumor agnostic genetic testing indications may also apply,*	November 17, 2024

	depending on the clinical scenario (e.g., there are no satisfactory tumor-specific standard therapies available, there are no indications for planned therapy that would apply independent of the results of genetic testing [such as immune checkpoint inhibitor indications], and progression of disease). See the Tissue Agnostic Testing guideline for details. **Explanation of change** Expanded POLE/POLD1 testing because now it could be invoked as a reason for repeat testing, if necessary, if it was not included in testing as per prior guideline criteria Clarifications	
Endometrial Carcinoma (removed "Advanced")	Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR) or mismatch repair deficiency (dMMR by IHC) is considered medically necessary when BOTH of the following criteria are met: • The individual has biopsy-proven endometrial carcinoma • The individual has not had prior MSI or dMMR testing Targeted (i.e., 50 or less genes) tissue-based somatic tumor testing is considered medically necessary for individuals with endometrial carcinoma and may be performed on the primary tumor or a metastatic site when ALL of the following criteria are met: • The individual has biopsy-proven endometrial carcinoma • Assessment includes the following, as applicable: ○ MLH-1 promoter methylation (applicable when there is nuclear expression loss of MLH1 and PMS2 by IHC) ○ POLE mutation testing (NGS) ○ P53 mutation testing (NGS or IHC) • There has been no prior testing for these molecular aberrations *Note: Tumor agnostic genetic testing indications may also apply, depending on the clinical scenario (e.g., there are no satisfactory tumor-specific standard therapies available, there are no indications for planned therapy that would apply independent of the results of genetic testing [such as immune checkpoint inhibitor indications], and progression of disease). See the Tissue Agnostic Testing guideline for details. Carelon Guidelines for Hereditary Cancer Testing* **Explanation of change** Expanded routine testing for MSI/dMMR; also expanded POLE and p53 testing Limited panel size	November 17, 2024
Melanoma, Advanced	Tissue-based somatic tumor testing for BRAF V600E pathogenic variant by validated IHC, PCR, or NGS methods for individuals with resectable or unresectable high-risk stage IIC, stage III or stage IV cutaneous melanoma is considered **medically necessary** when **BOTH** of the following criteria are met: • The individual has biopsy-proven cutaneous malignant melanoma • Prior testing has not been performed Tissue-based somatic tumor testing for individuals with	November 17, 2024

	resectable or unresectable high-risk stage IIC, stage III or stage IV melanoma that is BRAF V600E **wild-type or mucosal melanoma** is considered medically necessary when **ALL** of the following criteria are met: • The individual has biopsy-proven malignant melanoma • Prior testing has not been performed • Testing includes ANY or ALL of the following: ○ KIT variant testing ○ NRAS variant testing ○ Additional BRAF variant testing Testing of individuals with metastatic **uveal melanoma for HLA-A*0201** is considered **medically necessary** when **ALL** of the following criteria are met: • The individual has biopsy-proven uveal melanoma and evidence of metastatic disease • Prior testing for HLA-A*0201 has not been performed • The individual is a candidate for treatment with tebentafusp **Note: Tumor agnostic genetic testing indications may also apply, depending on the clinical scenario (e.g., there are no satisfactory tumor-specific standard therapies available, there are no indications for planned therapy that would apply independent of the results of genetic testing [such as immune checkpoint inhibitor indications], and progression of disease). See the Tissue Agnostic Testing guideline for details*. **Explanation of change** Minor wording changes to improve readability	
Non-Small Cell Lung Cancer, Localized (stage IB-IIIA)	Tissue-based somatic testing is considered **medically necessary** to identify EGFR pathogenic variant in individuals with localized NSCLC when **BOTH** of the following criteria are met: • Biopsy-proven, stage IB-IIIA NSCLC with **ANY** of the following characteristics: ○ An adenocarcinoma component on histology ○ Non-squamous, non-small cell histology ○ Squamous cell carcinoma histology when **ANY** of the following clinical features are present: ▪ Age 50 years or younger ▪ Those who never smoked cigarettes (<100 cigarettes in a lifetime) ▪ Those who quit smoking >15 years ago • Test results will determine candidacy for treatment with Osimertinib **Explanation of change** Clarifications about how light or absent tobacco exposure is defined	November 17, 2024
Non-Small Cell Lung Cancer, Metastatic Current guideline	Tissue-based NGS panel testing is considered **medically necessary** to identify pathogenic variants in individuals with stage IIIB, IIIC, or metastatic NSCLC when **ALL** of the following criteria are met: • Biopsy-proven NSCLC with **EITHER** of the following characteristics: ○ Any adenocarcinoma component on histology	November 17, 2024

	○ Non-squamous, non-small cell histology ○ Squamous cell carcinoma histology when A**NY** of the following clinical features are present: ▪ Age 50 years or younger ▪ Those who never smoked cigarettes (<100 cigarettes in a lifetime) ▪ Those who quit smoking >15 years ago • The multi-gene NGS panel testing contains, at minimum*, testing of appropriate molecular aberrations (mutations, rearrangements, fusions, or amplifications) in **ALL** of the following genes: EGFR, ALK, ROS1, BRAF, ERBB2 (HER2), KRAS, MET exon 14 skipping, NTRK, and RET • The individual is a candidate for targeted therapy that may be prescribed based on the panel test results • The individual has not had prior NGS testing in the metastatic setting, unless **BOTH** of the following are met: ○ There is evidence of disease progression while on EFGR-targeted therapy ○ Tissue biopsy of a progressing lesion is being used for additional testing **Testing may be more focused if other techniques (such as IHC or FISH) are simultaneously (or previously) used for specific genes listed in the criteria that are not also included on the multi-gene panel.* *Note: Tumor agnostic genetic testing indications may also apply, depending on the clinical scenario (e.g., there are no satisfactory tumor-specific standard therapies available, there are no indications for planned therapy that would apply independent of the results of genetic testing [such as immune checkpoint inhibitor indications], and progression of disease). See the Tissue Agnostic Testing guideline for details.* **Explanation of change** New criteria for metastatic squamous cell carcinoma Allowance for repeat NGS testing in the setting of progressive disease, if a progressing lesion is being used for the repeat testing	
Ovarian Cancer (Epithelial)	Targeted (i.e., 50 or less genes) tissue-based somatic tumor testing to determine HRD status by testing for pathogenic variants of BRCA1, BRCA2 with concomitant evaluation for genomic instability through an FDA approved test is considered **medically necessary** in individuals with locally advanced (stage III), metastatic (stage IV), or recurrent epithelial ovarian cancer when **ALL** of the following criteria are met: • The individual has biopsy-proven epithelial ovarian cancer • The individual does not have previously established pathogenic variants of BRCA 1 or BRCA2 through germline testing • The individual has not had prior testing that establishes HRD status in the locally advanced (stage III), metastatic (stage IV), or recurrent setting • The individual is a candidate for treatment with an FDA-approved PARP inhibitor Germline testing for pathogenic variants is considered medically necessary for all individuals with epithelial ovarian carcinoma. *See Hereditary Cancer Testing guideline for further details.*	November 17, 2024

	Note: Tumor agnostic genetic testing indications may also apply, depending on the clinical scenario (e.g., there are no satisfactory tumor-specific standard therapies available, there are no indications for planned therapy that would apply independent of the results of genetic testing [such as immune checkpoint inhibitor indications], and progression of disease). See the Tissue Agnostic Testing guideline for details. **Explanation of change** Clarifications regarding HRD testing and prior testing More restrictive to the extent that HRD testing must include evaluation of genomic instability through an FDA approved test	
Pancreatic Adenoca-rcinoma	Germline testing for pathogenic variants is considered **medically necessary** for all individuals with pancreatic adenocarcinoma. *See Hereditary Cancer Testing guideline for further details.* Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR) or mismatch repair deficiency (dMMR by IHC) is considered **medically necessary** when BOTH of the following criteria are met: • The individual has biopsy-proven pancreatic adenocarcinoma • The individual has not had prior MSI or dMMR testing Targeted (i.e., 50 or less genes) tissue-based somatic tumor testing is considered **medically necessary** when **ALL** of the following criteria are met: • The individual has biopsy-proven locally advanced (stage III), metastatic (stage IV), or recurrent pancreatic adenocarcinoma • The NGS panel includes BRCA1, BRCA2, PALB2, KRAS, as applicable • The individual has not had prior NGS testing in the locally advanced, metastatic, or recurrent setting *Note: Tumor agnostic genetic testing indications may also apply, depending on the clinical scenario (e.g., there are no satisfactory tumor-specific standard therapies available, there are no indications for planned therapy that would apply independent of the results of genetic testing [such as immune checkpoint inhibitor indications], and progression of disease). See the Tissue Agnostic Testing guideline for details.* ***Explanation of change*** *Added criteria for targeted (50 or fewer genes) somatic testing beyond MSI/dMMR in locally advanced, metastatic, or recurrent pancreatic adenocarcinoma*	November 17, 2024
Prostate Cancer, Metastatic	Tissue-based somatic tumor testing for microsatellite instability (MSI by PCR) or mismatch repair deficiency (dMMR by IHC) is considered **medically necessary** when **BOTH** of the following criteria are met: • The individual has biopsy-proven adenocarcinoma of the prostate • The individual has not had prior MSI or dMMR testing Tissue-based NGS panel testing is considered **medically necessary** to identify pathogenic variants in individuals with metastatic prostate cancer when **ALL** of the following criteria are	November 17, 2024

	met: • The individual has biopsy-proven adenocarcinoma of the prostate • The individual is a candidate for ONE of the following therapies: ○ FDA-approved PARP inhibitor (olaparib, rucaparib, or another PARP inhibitor approved for use in this setting) ○ FDA-approved PD-1 inhibitor (pembrolizumab or another checkpoint inhibitor approved for use in this setting) • The NGS panel includes BRCA2, BRCA1, and may also include other genes encoding molecules involved in homologous recombination DNA damage repair (DDR), such as ATM, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PABLB2, RAD51B, RAD51C, RAD51D, and RAD54L • The individual has not had prior NGS testing in the metastatic setting Germline testing for pathogenic variants is considered **medically necessary** for all individuals with metastatic prostate adenocarcinoma. *See Hereditary Cancer Testing guideline for further details.* *Note: Tumor agnostic genetic testing indications may also apply, depending on the clinical scenario (e.g., there are no satisfactory tumor-specific standard therapies available, there are no indications for planned therapy that would apply independent of the results of genetic testing [such as immune checkpoint inhibitor indications], and progression of disease). See the Tissue Agnostic Testing guideline for details.* **Explanation of change** Mostly clarification for MSI/dMMR testing; specified appropriateness of MSI/dMMR testing is in metastatic prostate cancer Moved ATM from required to "may be included" genes in approvable NGS panels Clarified the HRD genes which may be in panels in addition to BRCA testing	
Thyroid Cancer	**Testing of indeterminate thyroid nodules (ITN)** Use of next-generation gene expression classifier testing from fine needle aspirate sampling of a thyroid nodule is considered **medically necessary** when **ALL** of the following criteria are met: • There has been no prior testing of the same thyroid nodule • Initial cytopathology is reported as **ANY** of the following (Bethesda III or IV) categories: ○ Atypia of undetermined significance (AUS) ○ Follicular lesion of undetermined significance (FLUS) ○ Suspicious for follicular neoplasm (SFN) ○ Follicular neoplasm (FN) • The ITN is <4 cm in size **AND** does **NOT** have findings highly suspicious for malignancy on ultrasound (American Thyroid Association high suspicion pattern or American College of Radiology TIRADS 5) • **ONE** of the following gene expression classifiers may be	November 17, 2024

	used when performed as a stand-alone classifier test: ○ ThyGeNEXT/ThyraMIR multiplatform test ○ ThyroSeq Genomic Classifier ○ Afirma GSC **Explanation of change** Afirma GSC added as a gene expression classifier that may be used Clarifications	
Somatic genetic testing of thyroid malignancy	**Somatic genetic testing of thyroid malignancy** Tissue-based somatic tumor testing is considered **medically necessary** for individuals with advanced thyroid carcinoma that is not amenable to radioactive iodine therapy when the following criteria* are met: • The individual has biopsy proven unresectable, locally advanced, recurrent, or metastatic thyroid carcinoma or anaplastic thyroid carcinoma (any stage) • The testing includes assessment for pathogenic variants of BRAF V600E, ALK, NTRK, and RET • The individual is considered a potential candidate for FDA-approved oral targeted therapy based on the results of this testing **See additional guidelines concerning tissue agnostic somatic testing or hereditary cancer risk testing depending on the clinical scenario.* **Explanation of change** Modified language so that BRAF V600E, ALK, NTRK, and RET testing can be done in anaplastic thyroid cancer at any stage, or in unresectable, locally advanced, recurrent, or metastatic thyroid cancer	November 17, 2024

Carelon Guideline	Policy Change Summary	Effective Date
Somatic Testing of Hematologic Malignancies		
Acute Lymphocytic Leukemia	Tissue- (OR bone marrow-) based (OR alternatively, peripheral blood if morphologically detectable circulating blasts) somatic genetic testing (50 or fewer genes) is considered **medically necessary** for children or adults with acute lymphoblastic leukemia (**ALL**) when the following criterion are met: • Testing is for the purpose of establishing the diagnosis, to stratify risk, or to identify actionable therapeutic targets • A multi-gene panel contains genes that are identified with B-ALL or T-ALL, such as ABL1, ABL2, CRLF2, CSF1R, FLT3, FGFR, NTRK, LYN, PTK2Br, IL7R, JAK1, JAK2, JAK3, ETV6, RUNX1, TCF3, TCF4, PBX1, DUX4, PAX5, KMT2A, HLF, ZNF384, MEF2D, ZNF384, MYC, PDGFRB, SH2B3, TP53, IKZF1, NUTM1, MEF2D, ZNF384, RAS, PTEN, NOTCH1, and FBXW7 Chromosomal analyses of bone marrow specimens (or alternatively, peripheral blood if morphologically detectable circulating blasts), which may also include FISH testing, to detect and characterize clonal chromosomal abnormalities that have important diagnostic, prognostic, and therapeutic implications are considered **medically necessary** for children and adults with ALL.	November 17, 2024

	The use of NGS testing on bone marrow specimen is considered **medically necessary** in children or adults with ALL to measure minimal residual disease (MRD) at the end of initial treatment induction and end of initial consolidation and at similar defined points over the course of sequential therapies. BCR-ABL kinase domain point mutation analysis is considered **medically necessary** in the evaluation of individuals with BCR-ABL (Philadelphia chromosome) positive ALL to evaluate treated individuals who manifest suboptimal response to initial tyrosine kinase inhibitor therapy or loss of response to tyrosine kinase inhibitor therapy. PCR testing for BCR-ABL1 quantification on bone marrow specimen is considered **medically necessary** in the monitoring of Philadelphia chromosome-positive ALL. **Explanation of change** Clarifications. Statement about NGS testing on bone marrow specimen may be slightly restrictive, as it specifies time points where testing is appropriate (end of initial induction, end of initial consolidation, etc.)	
Acute Myelogenous Leukemia	Tissue-based (OR alternatively, peripheral blood if morphologically detectable circulating blasts) somatic genetic testing (50 or fewer genes) is considered medically necessary for individuals with acute myelogenous leukemia (AML) when the following criterion are met: • Testing is for the purpose of establishing the diagnosis, to stratify risk, or to identify actionable therapeutic targets • A multi-gene panel contains genes that are identified with AML, such as FLT3, IDH1, IDH2, NPM1, CBFB, MYH1, CEBPA, MLLT3, KMT2A, DEK, NUP214, KAT6A, CREBBP, GATA2, EVI1, DDX41, TP53, ASXL1, BCOR, EZH2, RUNX1, SF3B1, SRSF2, STAG2, U2AF1, and ZRSR2 Chromosomal analyses of preferred bone marrow specimens, which may also include FISH testing, to detect and characterize clonal chromosomal abnormalities that have important diagnostic, prognostic, and therapeutic implications are considered **medically necessary** for individuals with AML. The use of multi-gene panel NGS testing on peripheral blood or bone marrow specimens is considered **not medically necessary** in members with AML to measure minimal residual disease (MRD). The use of focused testing of peripheral blood or bone marrow using RT-qPCR is considered **medically necessary** to measure minimal residual disease (MRD) in acute promyelocytic leukemia, or NPM1 or core binding factor AML when used at appropriate defined points over the course of therapy such as at the end of initial treatment induction, at the end of initial consolidation, or at the completion of other sequential therapies. **Explanation of change** Clarifications (bulleted criteria) Added an indication for focused testing using RT-qPCR to measure minimal residual disease (MRD)	November 17, 2024

Chronic Myeloid Leukemia	PCR testing for BCR-ABL1 quantification is considered **medically necessary** for response assessment every 3 months during active treatment with tyrosine kinase inhibitor therapy. PCR testing for BCR-ABL1 quantification is considered medically necessary for monitoring patients who have undergone discontinuation of tyrosine kinase inhibitor therapy with assessment not more frequent than the following schedule: monthly for the first 6 months after discontinuation, bimonthly for months 7-12, and every 3 months thereafter. **Explanation of change** Modified the timing for BCR-ABL1 quantification for monitoring in the first year after completion of tyrosine kinase inhibitor (TKI) therapy Added allowance for BCR-ABL1 quantification for monitoring patients at 3-month intervals beyond one year after completion of TKI therapy	November 17, 2024
Myeloproliferative Neoplasms	Bone marrow tissue-based **OR** peripheral blood somatic genetic testing (50 or fewer genes) is considered **medically necessary** for initial evaluation of suspected myeloproliferative neoplasms (MPN) (e.g., essential thrombocytosis, polycythemia vera, chronic neutrophilic leukemia, and primary myelofibrosis) **BOTH** of the following criteria are met: • PCR, FISH, or NGS testing is targeting applicable JAK2, CALR, CSF3R, and MPL genes for diagnostic workup and (if applicable) a focused set of additional genes for initial risk stratification in the event that a specific myeloproliferative neoplasm is diagnosed • **ONE** of the following clinical scenarios: ○ Hemoglobin ≥16.5 g/dL in male and hemoglobin ≥16.0 g/dL in female ○ Hematocrit greater than 49% in male and hematocrit greater than 48% in female ○ Platelet count ≥450 X 109/L ○ Leukocytosis (white blood cell) ≥11 X 109/L **Explanation of change** Added allowance for additional focused testing for initial risk stratification if a specific myeloproliferative neoplasm is diagnosed on initial diagnostic workup	November 17, 2024
Myelodysplastic Syndrome	Somatic testing (i.e., 50 or fewer genes) of bone marrow tissue **OR** peripheral blood is considered **medically necessary** for individuals with clinically diagnosed or suspected myelodysplastic syndrome when **BOTH** of the following criteria are met: • Testing is for the purpose of establishing the diagnosis, to stratify risk, or to identify actionable therapeutic targets • A multi-gene panel contains genes that are identified with MDS, such as ASXL1, DNMT3A, EZH2, NRAS, RUNX1, SF3B1, SRSF2, STAG2, TET2, TP53, U2AF1, ZRSR2, and UBA1 Chromosomal analyses of preferred bone marrow specimens to detect and characterize clonal chromosomal abnormalities that have important diagnostic, prognostic, and therapeutic implications are considered **medically necessary** for individuals	November 17, 2024

	with myelodysplastic syndrome. **Explanation of change** Clarified that testing can be pursued for diagnosis or risk stratification and clarified the list of genes that may be associated with MDS	