February 2026

Billing chart: Blue Cross highlights medical, benefit policy changes

You'll find the latest information about procedure codes and Blue Cross Blue Shield of Michigan billing guidelines in the following chart.

This billing chart is organized numerically by procedure code. Newly approved procedures will appear under the *New Payable Procedures* heading. Procedures for which we have changed a billing guideline or added a new payable group will appear under *Updates to Payable Procedures*. Procedures for which we are clarifying our guidelines will appear under *Policy Clarifications*. New procedures that are not covered will appear under *Experimental Procedures.*

We'll publish information about new Blue Cross groups or changes to group benefits under the *Group Benefit Changes* heading.

For more detailed descriptions of Blue Cross' policies for these procedures, check under the *Commercial Policy* tab in Benefit Explainer on Availity®. To access this online information:

1. Log in to **availity.com**.**
2. Click on *Payer Spaces* on the Availity menu bar.
3. Click on the BCBSM and BCN logo.
4. Click on *Benefit Explainer* on the *Applications* tab.
5. Click on the C*ommercial Policy* tab.
6. Click on *Topic*.
7. Under *Topic Criteria*, click on the circle for *Unique Identifier* and click the drop-down arrow next to *Choose Identifier Type*, then click on *HCPCS Code.*
8. Enter the procedure code.
9. Click on *Finish*.
10. Click on *Search*.

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Code*	**BCBSM changes to:** **Basic benefit and medical policy, group variations, payment policy, guidelines**
UPDATES TO PAYABLE PROCEDURES, POLICY CLARIFICATIONS, EXPERIMENTAL PROCEDURES	
0795T, 0796T, 0797T, 0801T, 0802T, 0803T, 33274, 33275, 0798T, 0799T, 0800T, 0804T **Experimental:** **0823T, 0824T, 0825T, 0826T**	**Basic benefit and medical policy** *Leadless cardiac pacemakers* The policy has been updated to cover procedure codes *0795T, *0796T, *0797T, *0801T, *0802T and *0803T when criteria are met, effective Nov. 1, 2025. Right ventricular single chamber leadless cardiac pacemakers are established when criteria are met. Device replacement of right ventricular single chamber leadless cardiac pacemakers is established when criteria are met. The Aveir™ DR dual chamber pacing system is established when criteria are met.

	Right atrial cardiac pacemakers are considered experimental. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. For axillary transvenous pacemakers, there is a concern that leads or the generator could be affected by the recoil of using a firearm (for example, rifles or shotguns). Thus, leadless cardiac pacemakers can provide an alternative for patients who suffer lead fracture or malfunction from mechanical stress and may be considered when axillary venous access is present only on one side of the body that wouldn't allow use of equipment producing such mechanical stress (for example, a firearm). **Inclusions** The **Micra™ VR** or **Aveir™** right ventricular single chamber transcatheter pacing system when **both** conditions below are met: 1. The individual has an indication for a pacemaker such as high-grade atrioventricular, or AV, block in the presence of atrial fibrillation **or** has significant bradycardia with **one** of the following: • Normal sinus rhythm with rare episodes of 2° or 3° AV block or sinus arrest • Chronic atrial fibrillation • Severe physical disability, see details below[a] 2. The individual has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as **any** of the following: • History of an endovascular or cardiovascular implantable electronic device (CIED) infection or who are at high risk for infection[b] • Venous access issues such as limited access for transvenous pacing given venous anomaly, occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous, or AV, fistula for hemodialysis • Presence of or at risk of tricuspid valve replacement or severe tricuspid valve regurgitation The **Micra™ AV** right ventricular single chamber transcatheter pacing system when **both** conditions below are met: 1. The individual has an indication for a pacemaker such as high-grade AV block in the presence of atrial fibrillation **or** has significant bradycardia with

	one of the following: • Normal sinus rhythm with rare episodes of 2° or 3° AV block or sinus arrest • Chronic atrial fibrillation • Severe physical disability, see details below[a] • There is an indication for VDD pacing and the individual may benefit from maintenance of AV synchronous ventricular pacing 2. The individual has a significant contraindication precluding placement of conventional single-chamber ventricular pacemaker leads such as any of the following: • History of an endovascular or cardiovascular implantable electronic device, or CIED, infection or who are at high risk for infection[b] • Venous access issues such as limited access for transvenous pacing given venous anomaly, occlusion of axillary veins or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis • Presence of or at risk of tricuspid valve replacement or severe tricuspid valve regurgitation The Aveir™ DR dual chamber pacing system when **both** conditions below are met: 1. The individual exhibits any of the following: • Sick sinus syndrome • Chronic, symptomatic 2° or 3° AV block • Recurrent Adams-Stokes syndrome • Symptomatic bilateral bundle branch block when tachyarrhythmia and other causes have been ruled out 2. The individual has a significant contraindication precluding placement of conventional dual chamber pacing system leads such as any of the following: • History of an endovascular or cardiovascular implantable electronic device, or CIED, infection or who are at high risk for infection[b] • Venous access issues such as limited access for transvenous pacing given venous anomaly, occlusion of axillary veins, or planned use of such veins for a semi-permanent catheter or current or planned use of an arteriovenous fistula for hemodialysis • Presence of or at risk of tricuspid valve replacement or severe tricuspid valve regurgitation The Micra™ and Aveir™ single-chamber transcatheter pacing systems and the Aveir™ DR dual-chamber

	pacing system in individuals who are medically eligible for a conventional pacing system but have lifestyle or anatomic reasons directing use of leadless pacing (for example, limited or occluded venous access, active individuals where avoiding leads [example, repetitive arm motion] or pocket-related morbidity is of value). [a]Clinical input suggests that severe physical disability encompasses a variety of comorbidities where conventional pacemaker placement would confer undue short- or long-term risk or further compromise a limited ability to meet activities of daily living, including compliance with postoperative care instructions. [b]The 2019 European Heart Rhythm Association, or EHRA, international consensus paper on the prevention, diagnosis and treatment of cardiac implantable electronic device, or CIED, infections has been endorsed by the Heart Rhythm Society, or HRS, and lists the following non-modifiable patient-related risk factors for CIED infections: • End-stage renal disease • Corticosteroid use • Renal failure • History of device infection • Chronic obstructive pulmonary disease • Heart failure (New York Heart Association, or NYHA, Class ≥II) • Malignancy • Diabetes mellitus Additional risk factors for infection include but are not limited to: • Immunosuppression • Chest radiation/mastectomy • Chronic infections. **Device replacement** Device replacement in **any** of the following scenarios: • Device interrogation indicates that the device is nearing the end of life (elective replacement indicator). • Device isn't functioning correctly or can't be reprogrammed to provide optimal pacemaker support. • Device needs to be explanted due to infection. **Exclusions** • Any FDA contraindication. • The Micra™ and Aveir™ right ventricular single chamber transcatheter pacing systems in all other situations in which the above criteria aren't met.

	• The Aveir™ DR dual chamber pacing system in all other situations in which the above criteria aren't met. • All right atrial single chamber pacing systems.

11920-11922, 17380, 17999,* 19318, 19325, 19350, 21120-21123, 21125, 21127, 21137-21139, 21209, 30400, 30410, 30420, 31599, 31899,** 54520, 55970, 55980, 56805, 57291, 57292, 57335, 58150, 58152, 58180, 58260, 58260, 58262, 58275, 58291, 58541-58544, 58550, 58552-58554**
 	
****Unlisted procedures**
 	
Non-covered: 11950-11952, 11954, 15769, 15771-15774, 15820-15826, 15828, 15830, 15832-15839, 15876-15879, 19316, 21208, 30430, 30435, 30450, 69300, Q2026, Q2028
	Basic benefit and medical policy
	
	Gender affirming services
	
	The medical policy statement and policy language have been updated due to executive orders 14168 and 14187, effective Jan. 1, 2026.
	
	Reference the policy for verbiage changes and specific treatment guidelines.
	
	Medical policy statement
	Selected medical and surgical treatments for gender dysphoria are **established** when criteria are met. The established treatments for gender dysphoria include:
	• Puberty suppression in adolescents.
	• Hormone therapy (for masculinization/feminization) for adolescents and adults who meet criteria.
	• Medically necessary gender affirming surgery for adults:
	  ○ Genitalia surgery
	  ○ Mastectomy — defined in this policy as surgical removal of the breast
	  ○ Augmentation mammoplasty (implants)
	  ○ Thyroid reduction chondroplasty (tracheal shave)
	  ○ Facial feminization
	  ○ Facial masculinization
	
	Note: Surgery can't be used to reverse effects of hormone therapy used to affirm an individual's gender identity or expression.
	
	To ensure appropriate preventive medical care, any anatomical structure present that warrants screening should continue to be screened, regardless of gender identity. Examples include:
	• Breast cancer screening in transgender and gender diverse people with breasts formed during natal puberty who haven't undergone gender-affirming chest surgery and for transgender and gender diverse people who have received estrogens, taking into account the length of time of hormone use, dosing, current age and age at which the hormones were initiated.
	• Prostate cancer screening for transgender and gender diverse people who have retained their

	prostate. • Cervical screening for transgender and gender diverse people who currently have or previously had a cervix following local guidelines for individuals assigned female at birth. • Obstetric services for transgender and gender diverse people when they are pregnant.
21120-21123, 21141-21146, 21193, 21196, 21198, 21199, 21685, 42140, 42145, 42975, 64582-64585, 64568 **Experimental:** **0978T-0980T, 41512, 41530, 42299, S2080**	**Basic benefit and medical policy** *Obstructive sleep apnea and snoring – surgical treatment* Certain surgical procedures, as stated in the inclusionary criteria below, are **established** for the treatment of clinically significant obstructive sleep apnea, or OSA, when criteria are met. The procedure selected should be based on the patient's anatomy and the OSA etiology. Adenotonsillectomy in pediatric patients with OSA and hypertrophic tonsils is **established** when criteria are met. Hypoglossal nerve stimulation, using an FDA-approved device, is **established** when criteria are met. Drug-induced sleep endoscopy, or DISE, to evaluate appropriateness of FDA-approved hypoglossal nerve stimulation is **established** when criteria for hypoglossal nerve stimulation are met. Other surgical procedures and submucosal cryolysis therapy for the treatment of clinically significant OSA are **experimental**. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes The medical policy statement, inclusionary and exclusionary criteria, have been updated, effective Jan. 1, 2026. **Inclusions** • Palatopharyngoplasty (for example, uvulopalatopharyngoplasty, uvulopharyngoplasty, uvulopalatal flap, expansion sphincter pharyngoplasty, lateral pharyngoplasty, palatal advancement pharyngoplasty, relocation pharyngoplasty) for the treatment of clinically significant** obstructive sleep apnea, or OSA, syndrome in adult patients who haven't responded to or don't tolerate continuous positive airway

	pressure, or CPAP, or failed an adequate trial of an oral appliance. • Hyoid suspension, surgical modification of the tongue or maxillofacial surgery, including mandibular-maxillary advancement, or MMA, in adult patients with clinically significant** OSA and objective documentation of hypopharyngeal obstruction who haven't responded to or don't tolerate CPAP or failed an adequate trial of an oral appliance. **Clinically significant OSA is defined as patients who have: o Apnea/Hypopnea Index, or AHI, or Respiratory Disturbance Index, or RDI, of 15 or more events per hour, or o AHI or RDI of at least five events per hour with one or more signs or symptoms associated with OSA (for example, excessive daytime sleepiness, hypertension, cardiovascular heart disease or stroke). • Adenotonsillectomy in pediatric patients with OSA and hypertrophic tonsils and one of the following: o AHI or RDI of at least five per hour o AHI or RDI of at least 1.5 per hour in a patient with excessive daytime sleepiness, behavioral problems or hyperactivity • Hypoglossal nerve stimulation using an FDA-approved device in adult individuals (all the following): o Individual is 18 years of age or older. o AHI is ≥15 and ≤100 events per hour. o Total number of central apneas are ≤25% of the total AHI. o Has been confirmed to fail,** or can't tolerate, CPAP therapy despite attempts to improve compliance. o Non-concentric retropalatal obstruction on drug-induced sleep endoscopy. Non-concentric retropalatal obstruction confirmation can be performed via drug-induced sleep endoscopy at the time of implantation of the hypoglossal nerve stimulator if a prior in-office volitional snore, during flexible laryngoscopy, demonstrated anterior-posterior velum collapse. o Body mass index is less than or equal to 35 kg/m^2. o The sleep study used for the AHI is performed within 24 months of the first consultation for the hypoglossal nerve stimulator.

	CPAP failure is defined as AHI ≥15 despite CPAP use or failure to use CPAP ≥4 hours per night for ≥5 nights per week. • Hypoglossal nerve stimulation using an FDA-approved device in adolescent or young-adult individual with Down syndrome (all the following): o Individual is 13 to 21 years of age. o Individual had a prior adenotonsillectomy or has a contraindication to an adenotonsillectomy (both of the following): ▪ AHI is greater than 10 and less than 50. ▪ Total number of central and mixed apneas are less than 25% of the total AHI. o Individual has one of the following:: ▪ A tracheostomy ▪ Ineffective treatment with CPAP due to noncompliance, discomfort, undesirable side effects, persistent symptoms despite compliant use or refusal to use the device o BMI at the 95th percentile or lower for age. o Non-concentric retropalatal obstruction on drug-induced sleep endoscopy. Non-concentric retropalatal obstruction confirmation can be performed via drug-induced sleep endoscopy at the time of implantation of the hypoglossal nerve stimulator if a prior in-office volitional snore during flexible laryngoscopy demonstrated anterior-posterior velum collapse. • Drug-induced sleep endoscopy, or DISE: o To evaluate the appropriateness of FDA-approved hypoglossal nerve stimulation when all the criteria for hypoglossal nerve stimulation are met. **Exclusions • Laser-assisted palatoplasty, or LAUP • Midline glossectomy, or MLG • Palatal stiffening procedures including, but not limited to, cautery-assisted palatal stiffening operation, injection of a sclerosing agent and the implantation of palatal implants • Radiofrequency volumetric tissue reduction, or RVTR, of the tongue • Radiofrequency reduction of the palatal tissues (such as Somnoplasty) • Tongue base suspension (such as Repose system) • Submucosal cryolysis therapy • All other minimally invasive surgical procedures not described above

	• All interventions for the treatment of snoring in the absence of documented OSA; snoring alone isn't considered a medical condition. • DISE when above criteria aren't met. **Exclusions for hypoglossal nerve stimulation** • Any anatomical finding that would compromise the performance of the device. • Any condition or procedure that has compromised neurological control of the upper airway. • Members who are unable or don't have the necessary assistance to operate the sleep remote. • Members who are pregnant or plan to become pregnant. • Members who are known to require magnetic resonance imaging (this doesn't apply to a model that is MR compatible). • Members with an implantable device that may be susceptible to unintended interaction with the device. • Hypoglossal nerve stimulation for those not meeting the inclusion criteria. • Hypoglossal nerve stimulators that are not FDA-approved.
27299, 29914, 29915, 29916, 29999**** ****Unlisted code**	**Basic benefit and medical policy** *Surgical treatment of femoroacetabular impingement* Open or arthroscopic treatment of femoroacetabular impingement is **established** when criteria are met. The medical policy statement and exclusionary criteria have been updated, effective Jan. 1, 2026. **Inclusions** Open or arthroscopic treatment of femoroacetabular impingement may be appropriate when all the following conditions have been met: Age • Individual is between 15 years of age (must be skeletally mature with documented closure of the growth plates) and 55 years (and not considered a candidate for hip replacement). **Note:** Age shouldn't be a strict cut off for individuals older than 55 who have minimal hip arthritis and meet all other criteria. Signs and symptoms • Significant hip pain worsened by flexion activities

	(for example, squatting or prolonged sitting) that limits daily activities; **and**
	• Symptoms have failed to respond to non-operative therapy for at least three months, including all the following:
	  ○ Activity modification, including restriction of aggressive activities and avoidance of symptomatic movements
	  ○ Pharmacological intervention with NSAIDs or acetaminophen
	  ○ Physical therapy with rehabilitation of core hip musculature, including documentation of dates, duration of treatment, and patient's response
	  ○ Intra-articular injection or injections
	• All other reasonable causes of pain have been ruled out
	• Positive FADIR or FABER test
	
	Imaging evidence
	• Impingement (one of the following):
	  ○ Cam impingement confirmed by:
	  ▪ Alpha angle of > 55 degrees
	  ○ Pincer impingement confirmed by:
	  ▪ Center edge angle > 39 degrees
	  ▪ Positive cross-over sign
	  ▪ Acetabular retroversion or overcoverage
	  ▪ Coxa profunda
	  ▪ Tönnis angle less than 0 degrees
	  ▪ Rim fracture/ossified labrum
	• Minimal degeneration of the hip (Tonnis grade 1 or less), absence of joint space narrowing on weight-bearing A-rays and minimal cartilage injury (Outerbridge grade II or less).
	
	Note: The medical record must contain documentation of the risk/benefit of the procedure and address any significant/uncontrolled comorbid conditions or complications.
	
	Exclusions
	• Evidence of advanced osteoarthritis (such as Tonnis grade 2 or 3, or joint space of less than 2 mm)
	• Evidence of advanced chondral damage (Outerbridge grade III or IV)
	• Condition that prevents access to the hip (for example, advanced arthrofibrosis or ankylosis)
	• Individuals with osteogenesis imperfecta or diseases associated with hypermobility of the joints (Marfan syndrome, Ehlers-Danlos syndrome)
	• Use of capsular plication as the sole treatment of FAI surgery

	• All other surgical treatments of FAI not meeting the above criteria
37243, 75894	**Basic benefit and medical policy** *Transcatheter Arterial Chemoembolization of Hepatic Tumors* Transcatheter arterial chemoembolization of hepatic tumors is **established** when criteria are met. The medical policy statement and inclusionary criteria have been updated, effective Jan. 1, 2026. **Inclusions** • Unresectable hepatocellular cancer confined to liver not associated with portal vein thrombosis and liver function not characterized as Child-Pugh class C. • Liver metastasis in symptomatic individuals with metastatic neuroendocrine tumors whose symptoms persist despite therapy and who aren't candidates for surgical liver resection. • Liver metastasis in individuals with liver-dominant metastatic uveal melanoma. • Bridge to transplant in individuals with hepatocellular cancer where the intent is to prevent further tumor growth and to maintain an individual's candidacy for liver transplant. • If criteria for TACE are met, TACE in combination with radiofrequency ablation may be considered a treatment option, when recommended by the oncology specialist. **Note:** When using transcatheter arterial chemoembolization of the liver as a bridge to transplantation to prevent further tumor growth, the candidate should have the following characteristics: a single tumor less than 5 cm or no more than three tumors each less than 3 cm in size, absence of extrahepatic disease or vascular invasion, and Child-Pugh class A or B. **Exclusions** • Treatment of liver metastases from any other tumors or to treat hepatocellular cancer that doesn't meet the criteria noted above including recurrent hepatocellular carcinoma. • As a neoadjuvant or adjuvant therapy in hepatocellular cancer that is considered resectable. • Treatment of hepatocellular tumors prior to liver transplantation except as noted above. • Treatment of unresectable cholangiocarcinoma.

38204-38215, 38230, 38232, 38240-38242, S2140, S2142, S2150 **Experimental:** **0337U**	**Basic benefit and medical policy** *BMT-HCT for plasma cell dyscrasias* Specified bone marrow/hematopoietic cell transplants for plasma cell dyscrasias, including multiple myeloma, plasma cell leukemia, plasmacytoma and POEMS syndrome are established when criteria are met. A **repeat** allogeneic bone marrow transplant or stem cell boost (ablative or non-myeloablative) is established when criteria are met. The medical policy statement, inclusionary and exclusionary criteria have been updated, effective Jan. 1, 2026. **Inclusions** The following hematopoietic cell transplantations for multiple myeloma including plasma cell leukemia and plasmacytoma are considered established: • Single autologous HSCT for the treatment of active or symptomatic multiple myeloma, or MM • A second autologous HSCT for the treatment of active or symptomatic MM for **one** of the following: o As a tandem[a] autologous HSCT following autologous HSCT o In an individual with progressive disease following a previous autologous HSCT o Repeat autologous HCT for relapsed disease with a minimum length of remission of two years • Tandem[a] transplant with or without maintenance therapy can be considered for **any** of the following: o All individuals who are candidates for hematopoietic cell transplantation o Individuals who don't achieve at least a very good partial response, or VGPR, after the first autologous hematopoietic cell transplantation (A very good partial response, as defined by the International Myeloma Working Group, or IMWG, is a serum and urine M-protein detectable by immunofixation but not on electrophoresis or ≥90% reduction in serum M-protein plus urine M-protein level <100 mg per 24 hours. [Revised based on the new criteria by IMWG.]) o Individuals with high-risk features • Tandem[a] transplantation with an initial round of **autologous** hematopoietic cell transplantation followed by a non-marrow-ablative conditioning regimen and **allogeneic** hematopoietic cell

	transplantation to treat individuals of newly diagnosed multiple myeloma. • Myeloablative or nonmyeloablative **allogeneic** hematopoietic cell transplant in individuals with responsive or primary progressive disease as salvage[b] therapy when these individuals have undergone *a* **prior autologous** hematopoietic cell transplant. • Allogeneic HCT for any eligible individual with early relapse (less than 24 months) after primary therapy that included an autologous HCT or with high-risk features (such as cytogenetics, extramedullary disease, plasma cell leukemia or high lactate dehydrogenase) provided that they responded favorably to salvage[b] therapy before allogeneic HCT. **Repeat allogeneic** bone marrow transplants when **one** of the following criteria are met: • Graft failure or failure to engraft is present after an allogeneic bone marrow transplant for an approved allogeneic hematopoietic stem cell transplant.[c] • Stem cell boosting in the setting of graft failure following an approved allogeneic or autologous hematopoietic stem cell transplant.[c] [a]Tandem transplantation refers to a planned infusion (transplant) of previously harvested hematopoietic stem cells with a repeat hematopoietic stem cell infusion (transplant) that is performed within six months of the initial transplant. This is distinguished from a repeat transplantation requested or performed more than six months after the first transplant and is used as salvage therapy after failure of initial transplantation or relapsed disease. [b]Single or second (salvage refers to treatments used after a condition hasn't responded to standard therapy) autologous hematopoietic cell transplantation. [c]See criteria for allogeneic hematopoietic cell transplantation above. **Exclusions** • **Allogeneic hematopoietic cell transplantation**, myeloablative or nonmyeloablative, as initial therapy of newly diagnosed multiple myeloma is considered experimental. • More than two tandem transplants, two single transplants, or a single and a tandem transplant per individual for the same condition. • The routine harvesting or storage of an individual's umbilical cord blood for possible use at some unspecified time in the future. **POEMS syndrome**

	Inclusions **Autologous** hematopoietic cell transplantation to treat POEMS syndrome. **Exclusions** **Allogeneic** and tandem hematopoietic cell transplantation to treat POEMS syndrome.
64490-64495, 64633-64636, 0213T-0218T **Experimental:** **64625, 64999**** ****Unlisted code**	**Basic benefit and medical policy** *Facet joint denervation* Diagnostic medial branch blocks, or MBBs, are **established** to help diagnose facet joint pain when criteria are met. Diagnostic facet joint injections are **established** for diagnosis and treatment of neck back pain when criteria are met. Therapeutic facet joint injections are **established** for treatment of the axial neck and back pain when criteria are met. Radiofrequency denervation of cervical, thoracic and lumbar facet joints is **established** for pain management when criteria are met. Therapeutic medial branch blocks or alternative methods of facet joint denervation such as pulsed, endoscopic, cryoneurolysis (for example, Iovera), cooled (for example, Coolief), chemical or laser ablation are considered experimental. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. The medical policy statement, inclusionary and exclusionary criteria have been updated, effective Jan. 1, 2026. **Inclusions and exclusions** **Radiofrequency denervation inclusions** A. Initial radiofrequency ablation at up to two levels (up to four facet joints/medial nerve branches) may be considered established when **all** the following are met: 1. Presence of primarily cervical, thoracic or lumbar pain, without untreated radiculopathy or neurological deficits, that has been present for at least three months.

	2. Symptoms that don't respond to three months of non-operative treatment.** 3. Two successful diagnostic-only anesthetic medial branch blocks (without steroids) each resulting in greater than 80% reduction in pain and improvement in function for the expected duration of the analgesic. 4. Advanced radiographic imaging (CT/MRI) doesn't show any other explanation for pain. 5. Bilateral procedures must be performed within the same session unless there is documentation of medical contraindication. B. Repeat facet radiofrequency ablation at the same location or locations may be established when **all** the following are met: 1. The above criteria were initially met. 2. Documentation confirms at least 50% reduction in pain and improvement in function for at least six months. 3. Planned procedures don't exceed two per region (cervical/thoracic or lumbar/sacrum) within a rolling 12 months. 4. Ongoing participation in concurrent non-operative treatment regimen, including chiropractic/physical therapy or home exercise program, rehabilitation program or functional restoration program. 5. Ablation series won't be authorized. There must be documentation of evaluation and response to each ablation before approval for repeat procedures. **Non-operative treatments must be dated within the past 12 months and include a combination of all the following, unless the provider documents a contraindication: • Analgesic or anti-inflammatory medication, any route • Activity modification or joint conservation techniques (for example, limiting physical activity or repetitive motion, use of an assistive device, etc.) • Active participation in a home exercise program, rehabilitation program, or functional restoration program **Denervation exclusions** 1. Infection or prior spinal fusion at site planned for procedure (unless there is a question of pseudofusion) 2. Pulsed, endoscopic, cryoneurolysis (for example, Iovera), cooled (for example, Coolief), chemical or

	laser ablation 3. More than one type of pain management procedure in one day. Only one type of pain management procedure may be performed in one day (epidural steroid injections, facet joint injection, SI joint injection, neuroablation, trigger point injections, greater trochanteric or other injections, etc.), and in only one region (cervical/thoracic or lumbar/sacrum). 4. Peripheral nerve ablations (genicular, cluneal, occipital, suprascapular, obturator, etc.) 5. Pulsed radiofrequency denervation, laser denervation, chemodenervation (for example, alcohol, phenol or high concentration local anesthetics) and cryodenervation. 6. SI joint radiofrequency ablation The medical record must contain documentation of the risk/benefit of the procedure and address any significant/uncontrolled comorbid conditions or complications, including bleeding disorder. **Note:** General anesthesia, conscious sedation and monitored anesthesia care are all considered not medically necessary for pain management injection/ablation procedures except on a limited case-by-case basis with supporting documentation in the medical record. **Diagnostic medial branch block injection inclusions** **Note:** All injections should be performed with fluoroscopic guidance. A. An initial medial branch block, or MBB, may be considered established when **all** the following criteria are met: 1. Presence of moderate to severe primarily axial back or neck pain for at least three months duration that is worsened by extension, lateral bending or rotation that interferes with performance of daily activities. 2. Absence of radicular symptoms due to nerve root compression shown on advanced radiographic imaging (CT/MRI) (stenosis, disc herniation, etc.). 3. Up to two unilateral or bilateral levels are planned per session, regardless of region (cervical/thoracic or lumbar). 4. Symptoms that don't respond to four weeks of non-operative treatment.** 5. Appropriate advanced radiographic imaging (CT/MRI) has been performed and other reasonable sources of pain have been ruled out (such as infection, tumor or fracture).

	Subsequent injections of any type require documentation of the response to each injection according to the inclusion criteria above before approval for repeat injections B. A second or subsequent medial branch block may be considered established when done at least two weeks after the first and when **all** the following are met: 1. Criteria were met for the first diagnostic procedure. 2. The medical record shows at least 80% reduction in pain and improvement in function for the expected duration of the analgesic. 3. No more than four total sessions are done within a rolling 12 months per spinal region (cervical/thoracic or lumbar). Subsequent injections of any type require documentation of the response to each injection according to the inclusion criteria above before approval for repeat injections. **Diagnostic medial branch block injection exclusion** Therapeutic medial branch blocks are considered experimental. **Initial diagnostic facet injection inclusions** A. An initial diagnostic facet injection (local anesthetic alone) may be considered medically necessary when **all** the following are met: 1. Presence of axial neck or low back pain. 2. Pain is moderate to severe and prevents the patient from performing activities of daily living. 3. Symptoms that don't respond to three months of non-operative treatment.** 4. Clinical assessment or imaging rule out non-facet pathology that could support alternative diagnoses (for example, fracture, tumor, infection, deformity, etc.). Subsequent injections of any type require documentation of the response to each injection according to the inclusion criteria above prior to approval for repeat injections **Non-operative treatments must be dated within the past 12 months and include a combination of **all** the following, unless the provider documents a

	contraindication: • Analgesics or anti-inflammatory medications (for example, acetaminophen, NSAIDS, corticosteroids), any route • Activity modification/joint conservation techniques (for example, limiting physical activity or repetitive motion, use of an assistive device, etc.) • Active participation in a home exercise program, rehabilitation program or functional restoration program. **Therapeutic facet joint injections inclusions** A. Therapeutic facet joint injection may be considered established for **any** of the following: 1. For initial treatment of a facet cyst causing nerve root compression or displacement, confirmed by appropriate advanced radiographic imaging (such as MRI or CT), with other symptom causes ruled out 2. One-time repeat facet cyst rupture if the symptoms return and the medical record showed at least 50% reduction in pain and improvement in function after initial procedure 3. Facet-related pain after two positive medial branch blocks when **all** the following are met: a. Up to two unilateral or bilateral levels planned for the procedure b. One of the following indications is present: i. Prior therapeutic injection within the past year that resulted in at least 50% reduction in pain and improvement in function for at least three months. ii. Medical record demonstrates rationale why radiofrequency ablation isn't a treatment option. 4. Facet-related pain after one positive diagnostic facet joint injection when **all** the following are met: a. Up to two unilateral or bilateral levels planned for the procedure b. The medical record shows at least 80% reduction in pain and improvement in function for the expected duration of the analgesic after diagnostic injection c. Medical record demonstrates rationale why radiofrequency ablation isn't a treatment option d. No more than four total sessions are done within a rolling 12 months per spinal region (cervical/thoracic or lumbar) e. Documentation confirms ongoing

	participation in concurrent non-operative treatment regimen, including a home exercise program, rehabilitation program, or functional restoration program f. No more than four total sessions are done within a rolling 12 months per spinal region (cervical/thoracic or lumbar) **Diagnostic and therapeutic facet joint injection exclusions** 1. Bilateral procedures requested for separate sessions won't be approved unless there is a provider-documented contraindication and justification for separate sessions 2. Injection series won't be authorized; there must be documentation of evaluation and response to each injection before approval of repeat injections 3. Facet joint injections (diagnostic or therapeutic) are considered contraindicated if **any** of the following are present: a. For injections containing steroids, presence of conditions that may be exacerbated by steroids (for example, when any of the following conditions are uncontrolled: diabetes, hypertension or CHF) b. Individuals who have severe bleeding disorders or whose anticoagulation therapy has been difficult to manage will be reviewed on a case-by-case basis c. Allergy to any part of the injectate (anesthetic, corticosteroids, etc.) d. Systemic infection or local infection at the planned injection site e. Presence of untreated radiculopathy or neurogenic claudication (unless caused by a facet joint synovial cyst) f. Planned facet joint intervention at fused spinal level g. Planned procedure at the site of a previously successful radiofrequency ablation h. Presence of untreated radiculopathy or neurogenic claudication (unless caused by a facet joint synovial cyst) i. Planned procedure to be performed under ultrasound guidance 4. Due to lack of evidence to establish safety or efficacy, only one type of pain management procedure may be performed in one day (epidural steroid injections, facet joint injection, SI joint injection, trigger point injections, greater trochanteric, etc.), and in only one region (cervical/thoracic or lumbar/sacrum). 5. The only exception is for a transforaminal epidural

	steroid injection at the same time as a facet cyst aspiration or rupture. 6. Performance of diagnostic procedures in the presence of anything that can provide a false positive (for example, performed with sedation or monitored anesthesia). **Note**: General anesthesia, conscious sedation and monitored anesthesia care are all considered not medically necessary for pain management injection/ablation procedures except on a limited case-by-case basis with supporting documentation in the medical record **Note:** In June 2005, the American Medical Association's CPT Editorial Panel determined that the unlisted CPT code *64999 should be used for pulsed RF treatment as opposed to other specific codes.
64628, 64629	**Basic benefit and medical policy** *Radiofrequency ablation of basivertebral nerve* Radiofrequency ablation of the basivertebral nerve is established when criteria are met. The medical policy statement, inclusionary and exclusionary criteria have been updated, effective Jan. 1, 2026. **Inclusions** Basivertebral nerve ablation, with an FDA-approved device, for one or more levels of L3 through S1 when **all** the following are met: • Individual is skeletally mature (≥ 18 years of age). • Moderate to severe chronic low back pain that is primarily axial[a] in nature. • Pain is refractory to at least six months of non-operative treatment[b] within the past year, including at least six weeks of detailed professional directed exercise program (such as physical therapy). • Other etiologies for pain have been ruled out by clinical history, physical exam, imaging (for example, lumbar spine x-rays, MRI), injections or other diagnostic studies. • Type 1 or Type 2 Modic changes are noted at the vertebral body or bodies to be treated, on an MRI between L3 and S1. ○ Type 1 – inflammation, edema, vertebral endplate changes, disruption and fissuring of the endplate, vascularized fibrous tissues

	within the adjacent marrow, hypo-intensive signals ○ Type 2 – changes to the vertebral body marrow including replacement of normal bone marrow by fat, and hyper-intensive signals [a]Pain that is localized (for example, lower back) and is **not** accompanied by motor or sensory dysfunction in the associated extremities (for example, legs). [b] Pharmacological therapy (for example, analgesics, anti-inflammatory drugs, muscle relaxants), exercise, spinal manipulation, acupuncture, cognitive-behavioral therapy and physical therapy. **Notes:** • When performing ablations for members with implanted electric devices (spinal cord stimulator, pacemaker/defibrillator, etc.), manufacturer guidelines should be followed regarding turning off or monitoring the device during the ablation procedure. • Due to lack of evidence to establish safety or efficacy, only one type of pain management procedure may be performed each day (epidural steroid injections, facet joint injection, SI joint injection, neuroablation, trigger point injections, greater trochanteric, or other injections, etc.), and in only one region (cervical/thoracic or lumbar/sacrum). **Exclusions** • Imaging suggests other etiologies for pain including: ○ Active or recurrent facet symptoms ○ Disc extrusion or protrusion 6 mm or greater ○ Spondylolisthesis 3 mm or greater ○ Spondylolysis at any level ○ Lumbar scoliosis greater than10 degrees ○ Spinal tumor ○ Fracture • History of spine fragility fracture • Osteoporosis (T-score < -2.5) • Trauma/compression fracture • Spinal cancer • Imaging-confirmed spinal stenosis with neurogenic claudication (pain, numbness or weakness into the buttocks, thighs or calves, often brought on by standing or walking and relieved by flexion or sitting) • Active or recurrent radicular pain (pain that travels along a dermatomal distribution into the lower

	extremity, which can be associated with numbness, weakness or tingling) • Prior lumbar spine surgery (discectomy/laminectomy allowed if greater than six months ago and radicular pain resolved) • Bed bound or other condition that prevent early mobility • BMI > 40 • Active, untreated substance/drug use disorder • Uncontrolled moderate to severe depression, evaluated by psychiatric examination or by a validated depression screening test (for example, Beck Depression Inventory, PHQ-9, etc.) • Presence of severe cardiac or pulmonary compromise • Pregnancy, less than 12 months postpartum, or current breast-feeding • Active systemic infection, spine infection or bleeding diathesis • Any current litigation related to back pain or injury • Planned in conjunction with any other procedures, or within six weeks of any prior procedure • Repeat basivertebral ablation at the same site as a previous BVN ablation • Above criteria aren't met
76641, 76642	**Basic benefit and medical policy** *Ultrasound for Breast Cancer Screening* Breast ultrasound for breast cancer screening as an adjunct to mammography is established when criteria are met. The medical policy statement, inclusionary and exclusionary criteria have been updated, effective Jan. 1, 2026. **Inclusions** **One** of the following must be met: 1. Whole breast ultrasound or targeted ultrasound of the breast, for those at average risk of breast cancer and greater, when used to complete a screening mammogram or to address findings on the initial screening mammogram. 2. Whole breast ultrasound, as an adjunct to mammography, for breast cancer screening when **all** the following are met: o Individual qualifies for an annual screening magnetic resonance imaging — refer to *Magnetic Resonance Imaging of the Breast* medical policy for criteria for individuals with

	extremely dense breasts, high risk considerations, suspected cancer and for surveillance. o Individual is unable to undergo a breast MRI. o Supplemental screening with contrast-enhanced mammogram, or CEM, or molecular breast imaging, or MBI, isn't available or accessible. **Exclusions** • Criteria above aren't met • Breast ultrasound for screening as a standalone technique **Note:** Blue Cross Blue Shield of Michigan and Blue Care Network follow National Comprehensive Cancer Network, or NCCN, 2A and above recommendations. Due to frequent NCCN updates, please refer to the appropriate guideline for the most recent standards and intended coverage.
77046, 77047, 77048, 77049	**Basic benefit and medical policy** *MRI of the breast* Magnetic resonance imaging of the breast is established when criteria are met. The inclusionary criteria have been updated, effective Jan. 1, 2026. **Inclusions** **Note:** All the following policy statements refer to performing MRI of the breast with a breast coil and the use of contrast. MRI of the breast without the use of a breast coil, regardless of the clinical indication, is considered experimental. A. Annual MRI of the breast for screening (as an adjunct to mammography) for breast cancer in individuals when **one** of the following are met: 1. MRI of the breast, for those at average risk of breast cancer and greater, when used to complete a screening mammogram or to address findings on the initial screening mammogram. 2. For those with extremely dense breasts** when **both** of the following criteria are met: • Individuals are aged 50 or greater • Individual has **extremely dense breasts** noted on her current, up-to-date mammogram. **Note:** Currently the ideal frequency of

	supplemental screening MRI in this population is not known and therefore the annual screening allowance may change in the future. 3. High-risk considerations** There is no standardized method for determining a woman's risk of breast cancer that incorporates all possible risk factors. There are validated risk prediction models, but they are based primarily on family history. The following list includes individual factors known to indicate a high risk of breast cancer: • An individual diagnosed with lobular carcinoma in situ, or LCIS, atypical lobular hyperplasia, or ALH, or atypical ductal hyperplasia, or ADH • An individual with a genetic predisposition to breast cancer, in herself or a first-degree relative, that includes **any** of the following**:** o Bannayan-Riley-Ruvalcaba syndrome o BRCA1 and BRCA2 mutations o Cowden syndrome (PTEN) o Li-Fraumeni syndrome (TP53) • An individual with **any** of the following gene mutations: ATM, BARD 1, CDH1, CHEK2, NF1, PALB2, PTEN, RAD51C, RAD51D, STK11, TP53 • An individual with a lifetime risk of 20% or greater of developing breast cancer identified by models that are largely defined by family history (for example, BOADICEA/CanRisk, BRCAPRO, Tyrer-Cuzick). • An individual who received radiation therapy, or RT, with exposure to the breast tissue between 10 and 30 years of age. A number of factors may increase the risk of breast cancer but do not by themselves indicate high risk. It is possible that combinations of these factors may be indicative of high risk, but it is not possible to give quantitative estimates of risk. As a result, it may be necessary to individualize the estimate of risk, whereby one would need to take into account the numerous risk factors. A number of risk factors, not individually indicating high risk, are included in the National Cancer Institute Breast Cancer Risk Assessment Tool (also called the Gail model). Risk factors in the model can be accessed online at **bcrisktool.cancer.gov**.*** **For any individual above who qualifies for an MRI but can't undergo breast MRI, supplemental screening with contrast-enhanced mammogram, or CEM, or molecular breast imaging, or MBI, should be considered. Whole breast ultrasound may be done if CEM or MBI aren't

	available/accessible.
	***Blue Cross Blue Shield of Michigan doesn't own or control this website.
	
	B. MRI of the breast for the following indications:
	
	Suspected breast cancer
	• Single follow-up MRI at six months following a breast MRI with BI-RADS category 3 findings
	• Differentiation of palpable mass from surgical scar tissue
	• Lesion/abnormality characterization when other imaging (such as ultrasound, mammography) are inadequate to localize the lesion for biopsy
	• Metastatic cancer of unknown primary and suspected to be of breast origin or malignant axillary lymph node (breast origin) and no mammographic findings of primary breast carcinoma
	• Evaluation of pathologic nipple** discharge after nondiagnostic mammography and ultrasound
	• Suspected breast implant-associated anaplastic large cell lymphoma in individuals with textured implants when ultrasound is nondiagnostic
	
	**Pathologic nipple discharge: persistent and reproducible on exam, spontaneous, unilateral, single duct and clear or bloody
	
	Diagnostic workup and management of breast cancer
	
	When one of the following criteria are met:
	• To determine the extent of disease in biopsy-proven breast cancer in either of the following:
	  ○ Ductal carcinoma in situ, or DCIS, when the lesion is greater than 2 cm
	  ○ Invasive breast carcinoma
	• To define the relationship of the tumor to the fascia and its extension into the pectoralis major, serratus anterior or intercostal muscles before surgery
	• Preoperative tumor mapping of the involved breast to evaluate the presence of multicentric disease in individuals with clinically localized breast cancer with the exception of DCIS (see criteria for DCIS above), who are candidates for breast-conservation therapy
	• Presurgical planning in individuals with locally advanced breast cancer (before and after completion of neoadjuvant chemotherapy) to permit tumor localization and characterization
	• Suspected recurrence in individuals with tissue

	transfer flaps (rectus, latissimus dorsi and gluteal) post-reconstruction • Suspected recurrence of breast cancer in individuals when clinical, mammographic or sonographic findings are inconclusive • Post-lumpectomy with close or positive margins to evaluate residual disease • Malignant axillary lymph node (breast origin) and no breast mass on physical exam, mammogram or on ultrasound **Surveillance of breast cancer** Annual surveillance in individuals with a personal history of breast cancer after breast conserving therapy or unilateral mastectomy is recommended in **any** of the following scenarios: • Heterogeneously or extremely dense breasts • Those diagnosed with breast cancer before the age of 50 • Those who meet criteria for MRI breast screening (see inclusion A above) **Exclusions** • Screening technique, either alone or as an adjunct to mammography, in individuals not meeting the criteria above. • Diagnosis of low-suspicion findings on conventional testing, immediate biopsy is not indicated, and the patient is referred for short-interval follow-up. • Diagnosis of a suspicious breast lesion to avoid biopsy. **Note:** Blue Cross Blue Shield of Michigan and Blue Care Network follow National Comprehensive Cancer Network, or NCCN, 2A and above recommendations. Due to frequent NCCN updates, please refer to the appropriate guideline for the most recent standards and intended coverage.
77301, 77338, 77385, 77386, 77387, G6015, G6016	**Basic benefit and medical policy** *IMRT: Abdomen, pelvis and chest* Intensity-modulated radiation therapy, or IMRT, is established when criteria are met. It is an approach to delivering radiation therapy for patients with cancer of the anus and anal canal. IMRT is established when criteria are met for the treatment of cancers of the abdomen, pelvis and chest.

	It is based on analysis of dosimetric data, including comparative models, if necessary. The medical policy statement has been updated, effective Jan. 1, 2026. **Inclusionary and exclusionary guidelines:** Refer to medical policy statements.
78072, 78830, 78832 **Experimental:** **78999**** ****Unlisted code**	**Basic benefit and medical policy** *SPECT/CT fusion imaging* SPECT/CT fusion imaging is established when criteria are met. The medical policy statement and inclusionary criteria have been updated, effective Jan. 1, 2026. **Inclusions** SPECT/CT fusion is established for the following conditions: • Preoperative evaluation: for preoperative evaluation to further localize a lesion identified on planar scintigraphy or SPECT when additional anatomic information is needed to direct surgery and that information hasn't already been provided by CT or MRI. • Selective internal radiation therapy, or SIRT o For planning SIRT o For evaluation of administered dose activity and distribution following radioembolization • Bone imaging o Avascular necrosis: When MRI can't be performed or is nondiagnostic, in **either** of the following scenarios: ▪ Diagnosis following negative or inconclusive radiographs ▪ Preoperative planning for osteonecrosis with femoral head collapse o Fracture: Including occult or stress fracture in **any** of the following scenarios: ▪ Suspected spinal fractures when other imaging (radiographs, CT, or MRI) is nondiagnostic ▪ Suspected skeletal injury in non-accidental trauma when MRI can't be performed or is nondiagnostic ▪ Suspected fracture, when MRI can't be performed or is nondiagnostic, at the following high-risk/weight bearing sites:

	• Femoral neck; proximal femur • Tibia (anterior/lateral/plateau) • Great toe sesamoid • Patella • Scaphoid • Lunate • Talus • Navicular • Metatarsal base (second and fifth digits) ▪ Indeterminate bone lesions: for further characterization of indeterminate bone lesions when MRI, CT, or planar scintigraphy is equivocal ▪ Infection, not otherwise specified, in **either** of the following scenarios: • Diagnosis and management of osteomyelitis when MRI, CT or planar scintigraphy is nondiagnostic • Evaluation of sternal wound infection or dehiscence when CT chest is nondiagnostic ▪ Osseous metastatic disease: osseous metastatic disease, not otherwise specified in **either** of the following scenarios: • Diagnostic workup and management when **both** of the following apply: ○ Patients have documented malignancy and signs or symptoms concerning bony metastatic disease ○ Suspicious findings on CT, MRI, or planar bone scintigraphy require further clarification • To determine bone invasion prior to surgical resection of head and neck malignancies when CT, PET/CT or MRI are nondiagnostic ▪ Postoperative joint or spine pain when other imaging (radiographs, CT, or MRI) is nondiagnostic ▪ Spondylolysis/spondylolisthesis (pars defect) when other imaging studies are nondiagnostic. • Stroke or transient ischemic attack: For the evaluation of non-acute ischemia to determine candidacy for vascular intervention. • Leukocyte scintigraphy is considered established in **either** of the following scenarios: ○ For diagnosis and management of osteomyelitis of the skull base or calvarium when CT, MRI, or planar scintigraphy is equivocal ○ For diagnosis and management of osteomyelitis or septic arthritis at other sites (with or without

	bone marrow scintigraphy) when radiograph, ultrasound, or arthrocentesis is nondiagnostic or not sufficient to guide treatment and when CT, MRI or planar scintigraphy are equivocal • Sentinel node localization: When clinical evaluation is negative nodal involvement in the following scenarios: o Stage I-III invasive breast cancer o DCIS when mastectomy is planned o Cervical cancer that is stage IA1 with lymphovascular invasion (LVI), IA2, IB1, or IIA1 o Head and neck cancer when decisions are being made regarding mandibular resection o Melanoma that is stage IA with adverse features, IB, stage II, in-transit or locally recurrent o Penile cancer o Uterine cancer confined to the uterus o Vulvar cancer (T1 or T2) • Neuroendocrine cancer: Diagnostic workup and management of documented neuroendocrine cancer in the following scenarios: o As clinically indicated for neuroblastoma or tumors of the autonomic nervous system (pheochromocytoma, paragaglioma, ganglioneuroma) in **any** of the following scenarios: ▪ Suspected metastatic disease ▪ Suspected neuroblastoma or tumor of the autonomic nervous system based on CT, MRI or abnormal serum or urine metanephrine levels ▪ For pheochromocytoma/paragaglioma prior to planned I131 iobenguane treatment • Parathyroid adenoma: To identify tumor for surgical planning, localization of residual tissue in patients with recurrent or persistent disease following parathyroidectomy. SPECT-CT for parathyroid adenoma evaluation is done when all other testing is inconclusive or nondiagnostic. • Neuroendocrine cancer o Diagnostic workup of documented well-differentiated neuroendocrine cancer in **either** of the following scenarios: ▪ Biopsy-proven well-differentiated neuroendocrine tumor ▪ Suspected well-differentiated neuroendocrine tumor based on endoscopy, conventional imaging or biochemical markers when not amenable to biopsy o Management in **either** of the following scenarios: ▪ Prior to planned peptide receptor radioligand

	therapy, or PRRT, for well-differentiated neuroendocrine tumor ▪ When identification of more extensive disease will change management and **any** of the following criteria are met: • Equivocal findings of disease progression on conventional imaging. • Clinical or biochemical progression with negative conventional imaging. • When the original disease was only detectable by somatostatin receptor-based imaging. • Thyroid cancer o Diagnostic workup for differentiated thyroid cancer in **any** of the following scenarios: ▪ Prior to planned definitive radioactive iodine therapy in low-risk patients. ▪ Post thyroidectomy when radioactive iodine therapy is planned (except in low-risk patients). ▪ For known or suspected metastatic disease when radioactive iodine therapy is planned. o Management as indicated for differentiated thyroid cancer in **any** of the following scenarios: ▪ Immediately following radioactive iodine therapy. ▪ Evaluation of persistent disease found on post radioactive iodine therapy imaging. ▪ Evaluation for suspected recurrent thyroid cancer found during surveillance (such as elevated Tg, stable or rising antithyroglobulin antibodies, abnormal ultrasound during surveillance). o Surveillance as indicated for intermediate or high risk differentiated thyroid cancer six to 12 months after therapy has been completed. • Back pain when all other diagnostic workups are inconclusive. **Exclusions** SPECT/CT fusion imaging for any other condition than listed above.
81191-81194, 81210, 81275, 81276, 81311, 81403, 81404, 88363, 81455, 81456, 0037U, 0111U, 0211U, 0239U, 0242U, 0326U, 0334U, 0471U, 0473U **Experimental:** **86152, 86153, 0530U**	**Basic benefit and medical policy** *Somatic biomarker testing for targeted treatment in metastatic colon cancer* *KRAS*, *NRAS*, *BRAF, NTRK, RET and HER2* mutation analyses on tumor tissue are established when criteria are met.

	KRAS, *NRAS*, *BRAF, NTRK, RET and HER2* variant analysis using circulating tumor DNA or circulating tumor cell testing (liquid biopsy) is established when criteria are met.
	
	The medical policy statement, inclusionary criteria and policy title have been updated, effective Jan. 1, 2026.
	
	Inclusions (for all FDA-approved therapies, please check the FDA site)
	• *KRAS*, *NRAS, BRAF (V600E) and RET* mutation analysis is established in patients with metastatic colorectal cancer to determine their nonresponse to EGFR inhibitor drugs such as Vectibix® (panitumumab) and Erbitux® (cetuximab).
	• *NTRK* mutation analysis is established in patients with tumors that are pan-wild-type (normal/no mutation) in *KRAS, NRAS* and *BRAF.* The following medications are FDA approved when NTRK mutation is identified (for example, Repotrectinib, Larotrectinib, entrectinib).
	• Human epidermal receptor 2, or HER2, amplification testing is established for patients with metastatic colorectal cancer.
	• Anti-HER2 therapy is only indicated in HER2-ampliified tumors that are also RAS and BRAF wild type.
	• If the tumor is already known to have a KRAS/NRAS or BRAF mutation, HER2 testing isn't indicated.
	• A Proprietary Laboratory Analyses, or PLA, test is considered established when all the following criteria are met:
	  ○ The individual meets the FDA criteria listed in the label for the therapeutic.
	  ○ The test is an FDA-approved companion diagnostic test.
	  ○ Please refer to the established codes for current coverage. A code may not be listed but could still be established if it is an FDA-approved companion diagnostic test.
	
	Circulating tumor DNA (liquid biopsy)
	The clinical utility of circulating tumor DNA and circulating tumor cells for management of advanced solid cancers has been established when **all** the following criteria are met.
	• May be considered established for guidance in the selection of appropriate targeted FDA therapeutic options for **any** of the following conditions:
	  ○ Metastatic cancers

	○ Inoperable locally advanced cancers ○ Refractory cancers ○ Recurrent cancers ○ Advanced cancer (stages III or IV) • Individual hasn't been previously tested using the same liquid biopsy panel, unless a new primary cancer diagnosis is made, and further cancer treatment is being considered or individual is experiencing a relapse. • There is clinical documentation that tissue-based testing can't be performed (for example, insufficient sample, inaccessible tumor or where there may be a delay in obtaining tumor sample) **or** tissue-based testing isn't required when there is an FDA-approved companion diagnostic device that is a circulating tumor test (liquid biopsy). **Exclusions** • The use of circulating tumor DNA and circulating tumor cells is considered investigational when criteria above for colorectal cancer aren't met. • The use of circulating tumor DNA and circulating tumor cell testing is considered investigational for measurable residual disease, or MRD, testing and cancer screening (for example, Galleri). **Note:** Blue Cross Blue Shield of Michigan and Blue Care Network follow National Comprehensive Cancer Network, or NCCN, 2A and above recommendations. Due to frequent NCCN updates, please refer to the appropriate guideline for the most recent standards and intended coverage.
81351, 81352, 81353 **Experimental:** **81479**** ****Unlisted code**	**Basic benefit and medical policy** *Genetic testing for li-fraumeni syndrome* Genetic testing for TP53 to confirm a diagnosis for Li-Fraumeni syndrome is established when criteria are met. The medical policy statement has been updated, effective Jan. 1, 2026. **Inclusions** • To confirm a diagnosis of Li-Fraumeni syndrome under one of the following conditions: ○ In an individual who meets either the classic or the Chompret** clinical diagnostic criteria for Li-Fraumeni syndrome. ○ In individuals with early-onset breast cancer

	(age of diagnosis <31 years). ○ Pediatric hypodiploid acute lymphoblastic leukemia.*** • For carrier or presymptomatic testing in relatives of individuals with known TP53 gene variants. ***The NCCN Pediatric Acute Lymphoblastic Leukemia panel considers "pediatric" to include any patient age ≤18 years, as well as adolescent and young adult patients >18 years treated in a pediatric oncology setting; the latter could include patients up to age 30 years. **Exclusions** Genetic testing for a germline TP53 variant for all other indications. **Chompret criteria**** Chompret et al (2001) developed criteria that have the highest positive predictive value, and that, when combined with the classic LFS criteria, provide the highest sensitivity for identifying individuals with LFS. The Chompret criteria were updated in 2009 to assist in identifying families with milder phenotypes. The Chompret criteria will also identify individuals with de novo TP53 pathogenic variants, whereas the classic LFS criteria require a family history. **The Chompret criteria, most recently updated in 2015, are defined as the following: • Proband with tumor belonging to the LFS tumor spectrum (for example, soft tissue sarcoma, osteosarcoma, CNS tumor, premenopausal breast cancer, adrenocortical carcinoma) before age 46 years **and** at least one, first- or second-degree relative with LFS tumor (except breast cancer if the proband has breast cancer) before age 56 years or with multiple tumors. • Proband with multiple tumors (except multiple breast tumors), two of which belong to the LFS tumor spectrum and the first of which occurred before age 46 years. • Patient with adrenocortical carcinoma, rhabdomyosarcoma of embryonal anaplastic subtype, or choroid plexus tumor, irrespective of family history. • Proband with breast cancer before age 31 years. **Testing criteria for Li-Fraumeni syndrome** Testing is clinically indicated in the following scenarios:**

	General testing criteria
	• Individual from a family with a known TP53[a] P/LP variant. • Classic Li-Fraumeni syndrome, or LFS, criteria:[b] Combination of an individual diagnosed at age <45 years with a sarcoma[c] **and** a first-degree relative diagnosed at age <45 years with cancer **and** an additional first- or second-degree relative in the same lineage with cancer diagnosed at age <45 years, or a sarcoma at any age.
	Chompret criteria (one of the following): Individual with a tumor from LFS tumor spectrum (for example, soft tissue sarcoma, osteosarcoma, central nervous system, or CNS, tumor, breast cancer, adrenocortical carcinoma, or ACC), before 46 years of age, **and** at least one first- or second-degree relative with any of the aforementioned cancers (other than breast cancer if the proband has breast cancer) before the age of 56 years or with multiple primaries at any age. Individual with multiple tumors (except multiple breast tumors), two of which belong to LFS tumor spectrum with the initial cancer occurring before the age of 46 years. Individual with ACC, or choroid plexus carcinoma or rhabdomyosarcoma of embryonal anaplastic subtype, at any age of onset, regardless of family history. Breast cancer before 31 years of age. Personal or family history of pediatric hypodiploid acute lymphoblastic leukemia. In individuals with cancer with a P/LP TP53 variant identified on tumor-only genomic testing, germline testing should be considered for:[d, e, f] 1. Those meeting one or more of the other LFS testing criterion above after reevaluation of personal and family history. 2. Those diagnosed age <30 years with any cancer. 3. Those with clinical scenario not meeting these criteria but warranting germline evaluation per clinical discretion.
	**Other cancers associated with LFS but not in the testing criteria include melanoma, colorectal, gastric, and prostate. [a]When this gene is included as part of a multi-gene panel, an individual does not need to meet these testing criteria if

	testing criteria on other testing criteria pages are met. [b]Li FP, et al. Cancer Res 1988;48:5358-5362. [c]In contrast to other types of sarcomas, germline TP53 P/LP variants are rare in those with Ewing sarcoma, gastrointestinal stromal tumor (GIST), desmoid tumor, or angiosarcoma. [d]For testing in the pediatric setting, see Frebourg T, et al. Eur J Hum Genet 2020;28:1379-1386. [e]This should prompt a careful evaluation of personal and family history of the individual to determine the yield of germline sequencing. Somatic TP53 P/LP variants are common in many tumor types in absence of a germline P/LP variant. [f]Mandelker D, et al. Ann Oncol 2019;30:1221-1231. National Comprehensive Cancer Network guidelines recommend TP53 testing for individuals who meet classic LFS criteria and Chompret criteria.

82530, 82533
 	
Experimental:
82626-82627, 82670-82672, 82677, 82679, 82681, 84144, 84402-84403, 84410, S3650, S3652
	Basic benefit and medical policy
	
	Salivary testing for hormone levels
	
	For individuals with signs and symptoms of Cushing's syndrome, late night salivary cortisol testing is established when criteria are met.
	
	Salivary hormone testing of estrogens, progesterone, testosterone or DHEA is experimental. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes.
	
	The medical policy statement and exclusionary criteria have been updated, effective Jan. 1, 2026.
	
	Inclusions
	For individuals with signs and symptoms of Cushing's syndrome, late night salivary cortisol testing is established.
	
	Exclusions
	Any testing of salivary hormones — estrogens, progesterone, testosterone and DHEA — is considered experimental for the screening, diagnosis **or** monitoring of **any** of the following conditions:
	• Ovulation
	• Menopause
	• Changes related to aging
	• Preterm labor
	• Other gonadal dysfunction such as:
	  ○ Infertility
	  ○ Endometriosis
	  ○ Polycystic ovary disease, or PCOS
	  ○ Premenstrual syndrome

	○ Osteoporosis ○ Sexual dysfunction ○ Seasonal affective disorder ○ Depression ○ Multiple sclerosis ○ Sleep disorders ○ Diseases related to aging
83993	**Basic benefit and medical policy** *Fecal calprotectin* Fecal calprotectin testing is established when criteria are met. The medical policy statement, inclusionary and exclusionary criteria have been updated, effective Jan. 1, 2026. **Inclusions** Pediatric individuals (one of the following): • As an adjunctive test to confirm the diagnosis of inflammatory bowel disease, or IBD • To confirm a recurrence or relapse of IBD • To determine whether endoscopy is needed Adult individuals (one of the following): • To differentiate between inflammatory bowel disease and non-inflammatory bowel disease (including irritable bowel syndrome) • To monitor individuals with inflammatory bowel disease (for example, assess for response to therapy or relapse) **Exclusions** Fecal calprotectin testing in any other clinical situation.
95782, 95783, 95800, 95801, 95805-95808, 95810, 95811, G0398, G0399 **Non-covered:** **94762, E0445, G0400**	**Basic benefit and medical policy** *Diagnosis of sleep disorders* An unattended sleep study/home sleep apnea test is established when criteria are met. Polysomnography, or PSG, an in-laboratory sleep study/sleep apnea test, and a split-night PSG are established when criteria are met. Multiple sleep latency testing, or MSLT, and maintenance of wakefulness testing, or MWT, for the diagnosis of narcolepsy or idiopathic hypersomnia are established when criteria are met.

	Noninvasive pulse oximetry as a sole test (as an alternative to polysomnography or as a cardiorespiratory study) for diagnosing sleep related breathing disorders is experimental. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. The inclusionary criteria have been updated, effective Jan. 1, 2026. **Initial unattended (unsupervised) home sleep apnea test, or HSAT** **Inclusions** This should be performed with a minimum of three recording channels (using, at a minimum, the following sensors: nasal pressure, chest and abdominal respiratory inductance plethysmography, and oximetry; **or** using Peripheral Arterial Tone, or PAT, with oximetry and actigraphy). Both 1 and 2 need to be met. 1. Individuals 18 years of age or older with one of the following: a. Observed apneas during sleep. b. A combination of at least two of the following: ▪ Excessive daytime sleepiness evidenced by an Epworth sleepiness >10, inappropriate daytime napping (for example, during driving, conversation or eating), or sleepiness that interferes with daily activities and isn't explained by other conditions ▪ Habitual snoring or gasping/choking episodes associated with awakenings ▪ Treatment-resistant hypertension (persistent hypertension in an individual taking three or more antihypertensive medications) ▪ Obesity, defined as a body mass index $\geq$ 30 kg/m^2 or neck circumference defined as >17 inches in men or >16 inches in women ▪ Craniofacial or upper airway soft tissue abnormalities ▪ Unexplained nocturia not attributable to any other causes or conditions c. 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 the criteria listed under "b" (above). d. Any of the following conditions that may suggest

	OSA when the etiology is unclear: ▪ Right heart failure ▪ Polycythemia ▪ Sustained supraventricular or ventricular tachyarrhythmia occurring solely during sleep ▪ Pulmonary hypertension 2. No exclusions/contraindications to a home sleep apnea test (see below, Exclusions/contraindications to HSAT[a]). **Repeat unattended (unsupervised) follow-up home sleep apnea test for individuals with established OSA** **Inclusions** This should be performed in individuals with no contraindications to HSAT (see below, Exclusions/contraindications to HSAT[a]) with a minimum of three recording channels using, at a minimum, the following sensors: nasal pressure, chest, and abdominal respiratory inductance plethysmography and oximetry; **or** using (Peripheral Arterial Tone, or PAT, with oximetry and actigraphy) A follow-up home sleep apnea study is considered established for an individual with an established diagnosis of OSA and no contraindication to a home sleep apnea study (see below[a]) when **any** of the following apply: • On one occasion following: o Upper airway surgery performed to treat OSA or improve compliance with PAP therapy o 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 • Before implantation of a hypoglossal nerve stimulator in a patient who hasn't had a diagnostic study (home or lab) within the preceding 18 months **[a]Exclusions/contraindications to HSAT:** • Individuals younger than 18 years of age • Moderate or severe chronic pulmonary disease – forced expiratory volume in 1 second/forced vital capacity (FEV1/FVC) less than or equal to 0.7 and FEV1 less than 80% of predicted • Moderate or severe congestive heart failure – New York Heart Association, or NYHA, class III or IV • Congestive heart failure with a history of ventricular

	fibrillation or sustained ventricular tachycardia in an individual who doesn't have an implanted defibrillator • Cognitive or physical impairment that results in inability to apply the home sleep apnea testing equipment when another individual isn't available to assist with this task • Diagnosis suspected or established for **one** of the following conditions: o Central sleep disorder o Narcolepsy o Idiopathic hypersomnia o Parasomnias except bruxism and somniloqui (sleep talking) o Nocturnal seizures o Periodic limb movement disorder, or PLMD, when one of the following are present: pregnancy, renal failure, iron deficiency anemia, peripheral neuropathy, use of antidepressant or antipsychotic medications, or continued hypersomnia and clinical symptoms of PLMD after sleep disordered breathing is ruled out by home sleep apnea testing • Previous technically suboptimal home sleep apnea test when the reason for the suboptimal study is likely to recur • Oxygen dependence • Chronic opioid use when discontinuation is not an option • Body mass index greater than 33 kg/m2 and elevated serum bicarbonate level above 28 mmol/L • Obesity hypoventilation syndrome o Established diagnosis of obesity hypoventilation syndrome defined as a BMI greater than 30 kg/m^2 and hypoventilation that can't be solely attributed to other conditions such as pulmonary disease, skeletal restriction, neuromuscular weakness, hypothyroidism, pleural pathology or medications. Documentation of hypoventilation requires **any** of the following: ▪ Increase in arterial partial pressure of carbon dioxide, or $PaCO_2$, (or surrogate measure) to a value exceeding 55 mmHg for at least 10 minutes ▪ Greater than 10 mmHg increase in arterial $PaCO_2$ (or surrogate measure) during sleep (compared to an awake supine value) to a value exceeding 50 mmHg for at least 10 minutes ▪ Sleep oximetry demonstrates oxygen saturation ≤ 88% for ≥ 5 consecutive minutes of nocturnal recording time

	(minimum recording time of two hours), recorded while breathing the patient's prescribed fraction of inspired oxygen (FiO_2) • Documented neuromuscular disease (for example, Parkinson's, myotonic dystrophy, ALS) when another individual isn't available to assist with application of the home sleep apnea testing equipment. **Initial attended (supervised) sleep study performed in a sleep lab** **Inclusions** Individuals 18 years of age or older (one of the following): 1. The initial unattended (unsupervised) study was negative, inadequate (the reason for the inadequate or suboptimal HSAT is likely to recur on second attempt), equivocal or non-diagnostic and clinical suspicion for OSA remains 2. Individuals 18 years of age or older who have a contraindication to a home sleep study (see above Exclusions/contraindications to HSAT[a]) **and** meet the following criteria: a. Observed apneas during sleep b. A combination of at least two of the following: ▪ Excessive daytime sleepiness evidenced by an Epworth sleepiness >10, inappropriate daytime napping (for example, during driving, conversation or eating), or sleepiness that interferes with daily activities and isn't explained by other conditions ▪ Habitual snoring or gasping/choking episodes associated with awakenings ▪ Treatment-resistant hypertension (persistent hypertension in an individual taking three or more antihypertensive medications) ▪ Obesity, defined as a BMI $\geq$30 kg/m^2 or neck circumference > 17 inches in men or >16 inches in women ▪ Craniofacial or upper airway soft tissue abnormalities ▪ Unexplained nocturia not attributable to any other causes or conditions c. 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 the criteria listed under "b" above. d. **Any** of the following conditions that may suggest OSA when the etiology is unclear: ▪ Right heart failure

	▪ Polycythemia ▪ sustained supraventricular or ventricular tachyarrhythmia occurring solely during sleep ▪ Pulmonary hypertension Individuals 18 years of age or older with suspected sleep disorders other than OSA: An in-lab supervised sleep study may be considered when there is suspicion of **any** of the following: • Central sleep apnea, or CSA[b], to support the suspicion of CSA in this context, **one** of the following must be documented: o Heart failure o Stroke within the preceding 90 days o Chronic opiate or narcotic use o Chiari malformation • Narcolepsy • Nocturnal seizures • Parasomnia that is likely to result in harm to the individual or others • Idiopathic hypersomnia • Periodic limb movement disorder, or PLMD,[c] to support a suspicion of PLMD in this context, **one** of the following must be documented: o Pregnancy o Renal failure o Iron deficiency anemia o Peripheral neuropathy o Use of antidepressant or antipsychotic medications • Nocturnal desaturation (due to severe COPD or certain restrictive thoracic disorders) [b]OSA should be excluded before considering central sleep apnea, or CSA, in individuals who snore. [c]A diagnosis of PLMD requires that the individual have ongoing hypersomnia or insomnia. Individuals with OSA or restless leg syndrome should have these conditions treated before evaluation for PLMD. Individuals younger than 18 years of age: **Inclusions** • Individuals younger than 18 years of age with a moderate to high probability of OSA (one of the following) o Habitual snoring in association with one or more of criteria below: ▪ Restless or disturbed sleep ▪ Behavioral disturbance or learning

	disorders including deterioration in academic performance, attention deficit disorder, hyperactivity ▪ Frequent awakenings ▪ Enuresis (bedwetting) ▪ Growth retardation or failure to thrive o Excessive daytime somnolence or altered mental status not explained by other conditions o Polycythemia not explained by other conditions o Cor pulmonale not explained by other conditions o Witnessed apnea with duration greater than two respiratory cycles o Labored breathing during sleep o Hypertrophy of the tonsils or adenoids in individuals at significant surgical risk such that the exclusion of OSA would allow avoidance of surgery o Suspected congenital central alveolar hypoventilation syndrome or sleep-related hypoventilation due to neuromuscular disease or chest wall deformities o Clinical evidence of a sleep-related breathing disorder in infants who have experienced an apparent life-threatening event o For exclusion of OSA in an individual who has undergone adenotonsillectomy for suspected OSA more than eight weeks previously o The initial study was inadequate, equivocal or non-diagnostic and the child's parents or caregiver report that the breathing patterns observed at home were different from those during testing. **Repeat attended (supervised) sleep study performed in a sleep lab** **Inclusions** Individuals 18 years of age or older: 1. When a diagnosis of OSA has **not** been established • Initial supervised sleep test was unsuccessful (equipment failure or less than six hours of recording) 2. For an **established diagnosis of OSA** or all other sleep disorders and criteria below are met: A follow-up in-lab sleep study is considered established for an individual with a diagnosis of OSA if **any** of the following apply: • On **one** occasion following: o Upper airway surgery performed to treat OSA or improve compliance with PAP therapy o Initiation of use of an oral appliance

	• To reevaluate the diagnosis of OSA and need for continued CPAP if there is significant weight loss (defined as 10% of body weight) since the most recent sleep study in an individual with exclusions or contraindications to HSAT(see above Exclusions/contraindications to HSAT[a]) • Before implantation of a hypoglossal nerve stimulator in a patient who hasn't had a diagnostic study (home or lab) within the preceding 18 months • To optimize device settings on one occasion following insertion of a hypoglossal or phrenic nerve stimulator A follow-up in-lab sleep study is considered established for an individual with a diagnosis of OSA or other sleep disorder if **any** of the following apply: • To titrate CPAP/BPAP in a patient with a **contraindication to the use of APAP[d]** or for whom an attempt at APAP titration has been unsuccessful • To titrate CPAP/BPAP in a patient with a **contraindication to the use of APAP[d]** (or has failed APAP re-titration) whose attempted split-night study didn't adequately establish appropriate CPAP/BPAP treatment parameters • To re-titrate CPAP/BPAP in a patient with a **contraindication to the use of APAP[d]** (or has failed APAP re-titration) and has recurrence or worsening of symptoms despite PAP adherence as defined by Centers for Medicare & Medicaid Services criteria (use of PAP for at least four hours per night on 70% of nights during a consecutive 30-day period) [d] **Contraindications to the use of auto-adjusting positive airway pressure, or APAP** • Congestive heart failure • Moderate or severe chronic obstructive pulmonary disease: FEV1/FVC less than or equal to 0.7 and FEV1 less than 80% of predicted • Chronic opiate use • Use of supplemental oxygen for 24 hours daily • Central sleep apnea (defined as having at least 50% central events or more than five central events per hour) • Neuromuscular disorders (for example, muscular dystrophy, myasthenia gravis) • Obesity hypoventilation syndrome defined as a BMI greater than 30 kg/m^2 and hypoventilation that can't be solely attributed to other conditions such as pulmonary disease, skeletal restriction, neuromuscular weakness, hypothyroidism, pleural pathology or medications. Documentation of

	hypoventilation requires **any** of the following: ○ Increase in arterial $PaCO_2$ (or surrogate measure) to a value exceeding 55 mmHg for at least 10 minutes ○ Greater than 10 mmHg increase in arterial $PaCO_2$ (or surrogate measure) during sleep (compared to an awake supine value) to a value exceeding 50 mmHg for at least 10 minutes ○ Sleep oximetry demonstrates oxygen saturation ≤ 88% for ≥ 5 consecutive minutes of nocturnal recording time (minimum recording time of two hours), recorded while breathing the patient's prescribed FiO_2. **Inclusions** Individuals younger than 18 years of age: • Initial study was inadequate, equivocal or non-diagnostic and the child's parents or caregiver report that the breathing patterns observed at home were different from those during testing. • A patient with established OSA continues to exhibit persistent snoring or other symptoms of sleep disordered breathing despite PAP adherence as defined by CMS criteria (use of PAP for at least four hours per night on 70% of nights during a consecutive 30-day period). • The patient has undergone adenotonsillectomy more than eight weeks previously for management of established OSA. • To reevaluate the diagnosis of OSA and need for continued PAP if there is significant weight loss (defined as 10% of body weight) since the most recent sleep study. • To initiate or titrate CPAP or BPAP in a patient whose diagnostic study confirms that the patient is a candidate for positive airway pressure therapy, and split-night study hasn't been performed or was inadequate: ○ In pediatric individuals, an AHI greater than 1.5 is considered abnormal, and an AHI of 10 or more may be considered severe. • The initial sleep study has led to a diagnosis other than OSA and the repeat study is requested because of a change in clinical status or to assess efficacy after a change in therapy. • Before implantation of a hypoglossal nerve stimulator in a patient who hasn't had a diagnostic study (home or lab) within the preceding 18 months. **Multiple sleep latency testing, or MSLT, and maintenance of wakefulness testing, or MWT**

	Inclusions
	Initial MSLT and MWT are considered established for suspected narcolepsy when **both** of the following criteria are met:
	• Excessive daytime sleepiness has been present for at least eight weeks
	• The patient has at least **one** of the following:
	  ○ Disrupted nocturnal sleep
	  ○ Cataplexy
	  ○ Hallucinations (hypnagogic or hypnopompic)
	  ○ Sleep paralysis
	  ○ The patient has undergone polysomnography, or PSG, since the onset of symptoms
	  ○ Symptoms persist despite adequate treatment of obstructive sleep apnea (if present)
	
	Repeat MSLT or MWT are considered established for suspected narcolepsy when **both** of the following criteria are met:
	• Previous MSLT or MWT didn't provide a diagnosis of narcolepsy
	• The patient has continued symptoms suggestive of narcolepsy
	
	Repeat MWT is considered established for occupational safety evaluation when **both** of the following criteria are met:
	• The patient has an established diagnosis of a sleep breathing disorder or narcolepsy
	• The test is performed while on the current treatment to determine adequacy of therapy
	
	MSLT or MWT is considered established for idiopathic hypersomnia when **both** of the following criteria are met:
	• Excessive daytime sleepiness has been present for at least eight weeks
	• The patient has at least **one** of the following:
	  ○ Difficult morning awakening
	  ○ Prolonged sleep during primary sleep period
	  ○ Sleep drunkenness
	  ○ Frequent non-refreshing daytime naps
	  ○ The patient has undergone PSG or HSAT and symptoms persist despite adequate treatment of obstructive sleep apnea (if present)
	
	Exclusions
	Noninvasive pulse oximetry as a sole test (as an **alternative** to polysomnography or as a cardiorespiratory study) for diagnosing sleep related breathing disorders.

A7030-A7039, A7046, E0470-E0472, E0486, E0561, E0562, E0601 **Experimental:** **A7047, A7049, E0485, E0492, E0493, E0530, E1399**	**Basic benefit and medical policy** *Obstructive sleep apnea – non-surgical* Positive pressure airway devices for the treatment of obstructive sleep apnea are established when criteria are met. Oral appliances for the treatment of OSA are established when criteria are met. Palate and mandible expansion devices for the treatment of OSA are considered experimental. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. Nasal expiratory positive airway pressure, or nasal EPAP, for the treatment of OSA is considered experimental. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. Oral pressure therapy for the treatment of OSA is considered experimental. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. The use of sleep position training devices for the treatment of positional OSA are considered experimental. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. The use of an abbreviated daytime sleep session for acclimation to CPAP (PAP-NAP) is considered experimental. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. The use of neuromuscular electrical stimulation of the tongue for the treatment of OSA is considered experimental. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. The medical policy statement, inclusionary and exclusionary criteria have been updated, effective Jan. 1, 2026. **Inclusions** Auto-adjusting positive airway pressure, or APAP, for the titration of pressure in individuals with clinically

	significant OSA defined as those who have one of the following: • An AHI, RDI or Respiratory Event Index, or REI, of at least 15 events per hour • An AHI, RDI or REI of at least five events per hour in an individual with one or more signs or symptoms associated with OSA (for example, excessive daytime sleepiness, hypertension, cardiovascular heart disease, or stroke) • If there is a significant change in weight or change in symptoms suggesting that CPAP should be re-titrated or possibly discontinued. There is no established threshold for significant change in weight. Studies have reported improvements in OSA with an average weight loss of 20 kg or 20% of body weight. Continuous Positive Airway Pressure, or CPAP, in adult or pediatric individuals with clinically significant OSA. • Clinically significant OSA in adults is one of the following: o An AHI, RDI, or REI ≥15 o An AHI, RDI, or REI ≥5 in an individual with one or more signs or symptoms associated with OSA (for example, excessive daytime sleepiness, hypertension, cardiovascular heart disease or stroke) • Clinically significant OSA in pediatric individuals is one of the following: o An AHI or RDI ≥5 o An AHI or RDI ≥1.5 in an individual with excessive daytime sleepiness, behavioral problems or hyperactivity Bilevel positive airway pressure, or BiPAP, or APAP in both pediatric and adult individuals with clinically significant OSA who have failed a prior trial of CPAP or for whom bilevel positive airway pressure is found to be more effective in the sleep lab. Oral appliances (tongue-retaining devices or mandibular advancing/positioning devices) in adults with clinically significant OSA when the following criteria are met (verify coverage of oral appliances under the DME benefit), all the following: • Diagnosis of OSA, as defined by one of the following: o An AHI, RDI or REI of at least 15 events per hour o An AHI, RDI or REI of at least five events per hour in an individual with one or more signs or symptoms associated with OSA (for example,

	excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease, or history of stroke) • A trial of CPAP has failed, isn't tolerated by the individual, or is contraindicated. • The device is prescribed by the treating physician. • The device is custom fitted by a dentist (preferably a dentist with certification/additional training in dental sleep medicine). • There is a dental evaluation that documents the absence of both temporomandibular dysfunction and periodontal disease. Impressions, models, fabrication, materials, insertion/fitting, training, subsequent adjustments/modifications of the appliance, repairs and ancillary appliances are included with the OSA appliance and aren't separately billable for the first 90 days after provision of the oral appliance. Replacement of an oral appliance may be considered at the end of the 5-year reasonable useful lifetime (RUL), or prior, if there is a change in the individual's condition. **Note:** CPAP has been shown to have greater effectiveness than oral appliances in general. This difference in efficacy is more pronounced for individuals with severe OSA, because oral appliances have been shown to be less efficacious in individuals with severe OSA than in individuals with mild-to-moderate OSA. Therefore, it is particularly important that individuals with severe OSA have an initial trial of CPAP and that all reasonable attempts are made to continue treatment with CPAP, prior to the decision to swit ch to an oral appliance. Definition of an oral appliance for OSA** • A custom-fabricated appliance, using digital or physical impressions and models of an individual individual's oral structures and physical needs. • Oral appliances must be custom made but it may include a prefabricated component in the final appliance. The device may not be primarily prefabricated. • Includes all appliances, including titration appliances. • Made of biocompatible materials. • Engages the maxillary and mandibular arches/must have good retention to the dentition and prevent dislodging. • Includes a mechanism that advances the mandible

	in increments of 1 mm or less with a protrusive adjustment range of at least 5 mm. This mechanism may or may not include fixed mechanical hinges or metallic materials. • Reversal of the advancement is possible. • The protrusive setting must be verifiable.** **An appropriate oral appliance will allow for optimal protrusion of the mandible (for example, less than 5 mm) to produce the desired relative opening of the airway, without contributing to an increased risk of temporal mandibular joint dysfunction. **Exclusions** • Diagnosis of snoring without sleep apnea. • Use of CPAP, BiPAP, APAP and oral appliances for the treatment of OSA when the above criteria aren't met. • Prefabricated (not custom-fit) devices (for example, sport mouth guards, mouth guards that can be purchased in a retail store or pharmacy). • Screening tests (for example, questionnaire, pulse oximetry, rhinometry and laryngometry, etc.) performed by a dentist. • Use of an abbreviated daytime sleep session for acclimation to CPAP (PAP-NAP). • Use of neuromuscular electrical stimulation of the tongue. • Palate and mandible expansion devices for the treatment of OSA. • Nasal Expiratory Positive Airway Pressure and oral pressure therapy devices. • Use of sleep positioning trainers including those with vibration (for example, NightBalance Lunoa SPT system) for the treatment of positional OSA.
E0678, E0679, E0680, E0681, E0682 **Additional informational policy codes: E0650-E0652, E0655-E0657, E0660, E0665-E0669, E0671-E0673, E0677** **Non-covered unlisted procedures: E0676, E1399**	**Basic benefit and medical policy** *Compression pumps/appliances for lymphedema* Pneumatic compression pumps and appliances for upper and lower extremities are established when criteria are met. Pneumatic compression pumps and appliances for the trunk/chest are established when criteria are met. Pneumatic compression pumps and appliances for the head/neck are experimental. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

	Non-pneumatic compression appliances for upper and lower extremities are established when criteria are met.
	
	Procedure codes E0678, E0679, E0680, E0681 and E0682 are being changed from experimental to payable, effective Nov. 1, 2025, to reflect the policy update.
	
	Inclusions
	Single-compartment or multichamber nonprogrammable (without calibrated gradient pressure) lymphedema pumps applied to the limb are established for the treatment of lymphedema that has failed to respond to conservative measures.**
	
	Single-compartment or multichamber programmable (with calibrated gradient pressure) lymphedema pumps applied to the limb are established for the treatment of lymphedema when (both of the following):
	• The individual is otherwise eligible for nonprogrammable pumps.
	• There is documentation that the individual has unique characteristics that prevent satisfactory pneumatic compression with single-compartment or multichamber nonprogrammable lymphedema pumps (for example, significant scarring).
	
	A non-pneumatic compression device applied to the limb is established for the treatment of lymphedema that has failed to respond to conservative measures.**
	
	**Conservative measures: A four-week trial of conservative therapy demonstrating failed responses to treatment is required. The four-week trial of conservative therapy must include all the following:
	
	• Regular and compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression
	  ○ Adequate compression is defined as sufficient pressure at the lowest pressure point to cause fluid movement, and sufficient pressure across the gradient (from highest to lowest pressure point) to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point.
	  ○ The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally.
	• Regular exercise

	• Elevation of the limb
	
	The use of lymphedema pumps and appliances to treat the trunk or chest is limited to individuals with all the following:
	• Lymphedema beyond the upper and lower extremities.
	• Have failed conservative therapy.***
	• Have failed therapy with lymphedema pumps and appliances to the upper and lower extremities only.
	
	***Conservative measures: A four-week trial of conservative therapy must include all the following:
	• At least four weeks of regular, daily, multiple-hour home usage of the E0650 or E0651 after careful, in-person fitting, training and supervision by a technician who is skilled in and who regularly and successfully uses the appliance provided.
	• Compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression
	  ○ Adequate compression is defined as sufficient pressure at the lowest pressure point to cause fluid movement, and sufficient pressure across the gradient (from highest to lowest pressure point) to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point.
	  ○ The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally.
	• Regular exercise.
	• Elevation where appropriate.
	• Manual lymphatic drainage (where available) and self-manual lymphatic drainage, or MLD, for at least 30 minutes per day.
	• Evaluation of diet and implementation of any necessary change.
	• Medications as appropriate (for example, diuretics or other treatment of congestive failure, etc.).
	• Correction (where possible) of anemia or hypoproteinemia.
	
	Exclusions
	• Single-compartment or multichamber lymphedema pumps applied to the limb are considered experimental in all situations not mentioned above.
	• The use of lymphedema pumps to treat head/neck lymphedema in patients is considered experimental.
	
	Note: Reference policy for additional coding

	information.
E1905, A9291, A9292, G0552, G0553, G0554	**Basic benefit and medical policy** *Digital health technologies: therapeutic applications* The medical policy has been updated to exclude SleepioRx®, effective Jan. 1, 2026. The use of Freespira® is considered experimental for all indications including treatment of panic disorder or post-traumatic stress disorder, or PTSD. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. The use of NightWare® is considered experimental for all indications including treatment of nightmare disorder or nightmares from PTSD. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. The use of RelieVRx® is considered experimental for all indications including treatment of chronic lower back pain. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. The use of Stanza® is considered experimental for all indications including the treatment of fibromyalgia. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. The use of SleepioRx® is considered experimental for all indications including the treatment of chronic insomnia and insomnia disorders. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes.
J1413	**Basic benefit and medical policy** *Elevidys™ (delandistrogene moxeparvovec-rokl)* Effective Nov. 14, 2025, the gene and cellular therapy drug Elevidys™ (delandistrogene moxeparvovec-rokl) is considered experimental for the following updated indications: Elevidys is an adeno-associated virus vector-based gene therapy indicated in individuals at least 4 years of age. **Limitations of use**

	Elevidys isn't recommended in patients with: • Preexisting liver impairment (defined as gamma-glutamyl transferase [GGT] > 2 x upper limit of normal or total bilirubin > the upper limit of normal not due to Gilbert's syndrome) or active hepatic viral infection due to the high risk of acute serious liver injury and acute liver failure. • Recent vaccination (within four weeks of treatment) due to immunogenicity and potential safety concerns active or recent (within four weeks) infections due to safety concerns.
J3490, J3590	**Basic benefit and medical policy** *Enoby® (denosumab-qbde)* Enoby® (denosumab-qbde) is considered established when criteria are met, effective Sept. 26, 2025. Enoby is a RANK ligand, or RANKL, inhibitor indicated for the following treatments: • Of postmenopausal women with osteoporosis at high risk for fracture • To increase bone mass in men with osteoporosis at high risk for fracture • Of glucocorticoid-induced osteoporosis in men and women at high risk for fracture • To increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer • To increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer **Dosage and administration** • Pregnancy must be ruled out before administration of Enoby. • Before initiating Enoby in patients with advanced chronic kidney disease, including dialysis patients, evaluate for the presence of chronic kidney disease mineral and bone disorder with intact parathyroid hormone, serum calcium, 25(OH) vitamin D, and 1,25(OH)2 vitamin D. • Enoby should be administered by a health care provider. • Administer 60 mg every six months as a subcutaneous injection in the upper arm, upper thigh or abdomen. • Instruct patients to take calcium 1,000 mg daily and at least 400 IU vitamin D daily. **Dosage forms and strengths**

	Injection: 60 mg/mL solution in a single-dose prefilled syringe Enoby (denosumab-qbde) isn't a benefit for URMBT.
J3490, J3590	**Basic benefit and medical policy** **Itvisma® (onasemnogene abeparvovec-brve)** Effective Nov. 24, 2025, Itvisma® (onasemnogene abeparvovec-brve) is covered for its FDA-approved indications. Itvisma (onasemnogene abeparvovec-brve) is an adeno-associated virus, or AAV, vector-based gene therapy indicated for the treatment of spinal muscular atrophy, or SMA, in adult and pediatric patients 2 years of age and older with confirmed mutation in SMN1 gene. **Dosage and administration** For single-dose intrathecal injection only. • The recommended dose of Itvisma (onasemnogene abeparvovec-brve) is 1.2×10^{14} vector genomes, or vg. • Administer Itvisma (onasemnogene abeparvovec-brve) as an intrathecal bolus injection over approximately one to two minutes. • Postpone Itvisma (onasemnogene abeparvovec-brve) in patients with infections until the infection has resolved and the patient is clinically stable. • Starting one day prior to Itvisma (onasemnogene abeparvovec-brve) injection, administer systemic corticosteroids equivalent to oral prednisolone at 1 mg/kg of body weight per day for a total of 30 days. At the end of the 30-day period, check liver function by clinical examination and by laboratory testing. For patients with unremarkable findings, taper the corticosteroid dose gradually over the next 28 days. If liver function abnormalities persist, continue systemic corticosteroids (equivalent to oral prednisolone at 1 mg/kg/day) until findings become unremarkable, and then taper the corticosteroid dose gradually over the next 28 days or longer if needed. Don't stop systemic corticosteroids abruptly. • If at any time patients don't respond adequately to the equivalent of 1 mg/kg/day oral prednisolone, based on the patient's clinical course, prompt consultation with a gastroenterologist or hepatologist and adjustment to the recommended corticosteroid regimen may be considered.

	Dosage forms and strengths Each single-dose vial contains 1.2×10^{14} vg of onasemnogene abeparvovec in 3 mL of suspension. Itvisma (onasemnogene abeparvovec-brve) has a nominal concentration of 4×10^{13} vg/mL, and each vial contains an extractable volume of not less than 3 mL. This drug isn't a benefit for URMBT.
J3490, J3590	**Basic benefit and medical policy** **Waskyra™ (etuvetidigene autotemcel)** The gene and cellular therapy drug Waskyra™ (etuvetidigene autotemcel) is covered for its FDA-approved indications effective, Dec. 9, 2025. Waskyra is an autologous hematopoietic stem cell-based gene therapy indicated for the treatment of pediatric patients aged 6 months and older and adults with Wiskott-Aldrich Syndrome, or WAS, who have a mutation in the WAS gene for whom hematopoietic stem cell transplantation, or HSCT, is appropriate and no suitable human leukocyte antigen, or HLA-, matched related stem cell donor is available. Waskyra (etuvetidigene autotemcel) isn't a benefit for URMBT.
J3490, J3590	**Basic benefit and medical policy** *Xtrenbo™ (denosumab-qbde)* Effective Sept. 26, 2025, Xtrenbo™ (denosumab-qbde) is a RANK ligand (RANKL) inhibitor indicated for: • Prevention of skeletal-related events in patients with multiple myeloma and in patients with bone metastases from solid tumors. • Treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity. • Treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy. **Dosage and administration** • Xtrenbo (denosumab-qbde) should be administered by a health care provider. • Xtrenbo (denosumab-qbde) is intended for subcutaneous route only and should not be

	administered intravenously, intramuscularly, or intradermally. • Multiple myeloma and bone metastasis from solid tumors: Administer 120 mg every four weeks as a subcutaneous injection in the upper arm, upper thigh or abdomen. • Giant cell tumor of bone: Administer 120 mg every four weeks with additional 120 mg doses on days 8 and 15 of the first month of therapy. Administer subcutaneously in the upper arm, upper thigh or abdomen. • Administer calcium and vitamin D as necessary to treat or prevent hypocalcemia. • Hypercalcemia of malignancy: Administer 120 mg every four weeks with additional 120 mg doses on days 8 and 15 of the first month of therapy. Administer subcutaneously in the upper arm, upper thigh or abdomen. **Dosage forms and strengths** Injection: 120 mg/1.7 mL (70 mg/mL) solution in a single-dose vial Xtrenbo (denosumab-qbde) isn't a covered benefit for URMBT.
J9024	**Basic benefit and medical policy** **Tecentriq Hybreza™ (atezolizumab and hyaluronidase-tqjs)** Tecentriq Hybreza™ (atezolizumab and hyaluronidase-tqjs) is considered established when criteria are met, effective Oct. 2, 2025. The approved indications have been updated for Tecentriq Hybreza (atezolizumab and hyaluronidase-tqjs) to include the following: In combination with lurbinectedin, for the maintenance treatment of adult patients with ES-SCLC whose disease hasn't progressed after first-line induction therapy with Tecentriq or atezolizumab and hyaluronidase-tqjs, carboplatin and etoposide.
J9119	**Basic benefit and medical policy** **Libtayo® (cemiplimab-rwlc)** Libtayo® (cemiplimab-rwlc) is considered established when criteria are met, effective Oct. 8, 2025.

	The approved indications have been updated for Libtayo (cemiplimab-rwlc) to include the following: Libtayo is a programmed death receptor-1 (PD-1) blocking antibody indicated for the adjuvant treatment of adult patients with CSCC at high risk of recurrence after surgery and radiation.
J9271	**Basic benefit and medical policy** **Omisirge® (omidubicel-onlv)** Effective Dec. 5, 2025, Omisirge® (omidubicel-onlv) is covered for its FDA-approved indications. Omisirge (omidubicel-onlv) is a nicotinamide modified allogeneic hematopoietic progenitor cell therapy derived from cord blood indicated for the treatment of adults and pediatric patients 6 years and older with severe aplastic anemia, or SAA, following reduced intensity conditioning. This drug isn't a benefit for URMBT.
J9301	**Basic benefit and medical policy** **Gazyva® (obinutuzumab)** Gazyva® (obinutuzumab) is payable for the updated FDA-approved indications, effective Oct. 17, 2025. Gazyva (obinutuzumab) is a CD20-directed cytolytic antibody indicated for the treatment of adult patients with active lupus nephritis, or LN, who are receiving standard therapy.
S2053-S2055, 44120-44121, 44132, 44133, 44135, 44136, 44715, 44720, 44721, 44799, 47133, 47135, 47140-47147, 47399** ****Unlisted code**	**Basic benefit and medical policy** *Small bowel and liver transplant* A small bowel/liver or multivisceral transplant (requiring all the stomach, liver, duodenum, pancreas and intestines to be transplanted) is established when criteria are met. A modified multivisceral transplantation can involve the stomach, pancreas, large and small intestines but excludes the liver (if the recipient's liver function is normal) is established when criteria are met. A small bowel/liver or multivisceral transplant is established for treatment of portomesenteric thrombosis

	when criteria are met. Small bowel/liver transplant or multivisceral retransplant is established when criteria are met. A small bowel/liver transplant or multivisceral transplant is considered experimental in all other situations. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes. The medical policy statement and inclusionary criteria have been updated, effective Jan. 1, 2026. **Inclusions** The individual selected for small bowel/liver, multivisceral transplant or modified multivisceral transplant must meet the transplanting institution's protocol eligibility criteria. These criteria should include: • Documentation of patient compliance with medical management • Adequate cardiopulmonary status **and** • Intestinal failure** **or** • Portomesentaric thrombosis **Intestinal failure results from surgical resection, congenital defect or disease-associated loss of absorption, is characterized by reduced absorption and the inability to maintain protein-energy, fluid, electrolyte or micronutrient balance who have been managed with long-term total parenteral nutrition, or TPN and who have developed evidence of impending end-stage liver failure. **Potential contraindications for transplant/ retransplant** **Note:** Final patient eligibility for transplant is subject to the judgment and discretion of the requesting transplant center. Potential contraindications represent situations where proceeding with transplant isn't advisable in the context of limited organ availability. Contraindications may evolve over time as transplant experience grows in the medical community. Clinical documentation supplied to the health plan should demonstrate that attending staff at the transplant center have considered all contraindications as part of their overall evaluation of potential organ transplant recipients and have decided to proceed. • Known current malignancy, including metastatic

	cancer • Recent malignancy with high risk of recurrence • History of cancer with a moderate risk of recurrence • Systemic disease that could be exacerbated by immunosuppression • Untreated systemic infection making immunosuppression unsafe, including chronic infection • Other irreversible end-stage disease not attributed to intestinal failure • Psychosocial conditions or chemical dependency affecting ability to adhere to therapy **Small bowel/liver specific** Evidence of intolerance of total parenteral nutrition, or TPN, includes, but is not limited to, multiple and prolonged hospitalizations to treat TPN-related complications, or the development of progressive but reversible liver failure. In the setting of progressive liver failure, small bowel transplant may be considered a technique to avoid end-stage liver failure related to chronic TPN, thus avoiding the necessity of a multivisceral transplant. **Note:** The consideration for a risk-reducing procedure (for example, CABG) performed at the same time as the organ transplant is a consideration based on the medical consultation review. **Exclusions** Small bowel-liver-multivisceral transplants are considered investigational in all other situations. All transplants must be prior authorized through the Human Organ Transplant Program. **Note:** There are individual policies for each of these organs (small bowel, liver) that contain more detailed information.
Q2054	**Basic benefit and medical policy** **Breyanzi® (lisocabtagene maraleucel)** The gene and cellular therapy drug Breyanzi® (lisocabtagene maraleucel) is considered established when criteria are met, effective Dec. 4, 2025. Breyanzi is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the

	treatment of adult patients with relapsed or refractory marginal zone lymphoma, or MZL, who have received at least two prior lines of systemic therapy. **Dosage and administration** For autologous use only. For intravenous use only For CLL/SLL, FL, MCL and MZL the dose is 90 to 110 × 10^6 CAR-positive viable T cells.

None of the information included in this article is intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with all applicable state and federal laws and regulations.