August 2024

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	
J9177	**Basic benefit and medical policy** **Padcev® (enfortumab vedotin-ejfv)** Effective Dec. 15, 2023, the following usage statement has been removed from the metastatic urothelial cancer indication for Padcev (enfortumab vedotin-ejfv): Adult patients who aren't eligible for cisplatin-containing chemotherapy.
POLICY CLARIFICATIONS	
36836, 36837	**Basic benefit and medical policy** **Percutaneous arteriovenous fistula** The use of an endovascular percutaneous device for the creation of an arteriovenous fistula, or pAVF, for hemodialysis, or HD, access is considered established

	when criteria are met. Procedure codes *36836 and *36837 were added as payable, effective May 1, 2024. **WavelinQ inclusions:** All the following must be met: • Individuals with ESRD • Life expectancy greater than one year • Individuals who aren't candidates for a distal surgical AVF • Adult (age ≥ 18 years old) • Procedural access vessels ≥ 2 mm in diameter • Perforator vein ≥ 2 mm in diameter • Ulnar artery and paired ulnar vein **or** radial artery and paired radial vein ≥ 2 mm in diameter at the fistula creation site • Less than 2.0 mm separation between the artery and vein at the fistula creation site **WavelinQ exclusions:** • When above criteria aren't met • Known central venous stenosis or central vein narrowing > 50% based on imaging on the same side as the planned endoAVF creation • Upper extremity venous occlusion or vessel abnormality on the same side as the planned endoAVF creation that precludes endoAVF creation • New York Heart Association class III or IV heart failure despite optimal therapy • Hypercoagulable state **Ellipsys inclusions:** All the following must be met: • Individuals with ESRD • Life expectancy greater than one year • Individuals who aren't candidates for a distal surgical AVF • Adult (age ≥ 18 years old) • Proximal radial artery and adjacent perforating vein with a minimum vessel diameter of 2.0 mm • Distance between the artery and vein at the fistula creation site <1.5 mm **Ellipsys exclusions:** • When above criteria aren't met • Known central venous stenosis or central vein

	narrowing > 50% based on imaging on the same side as the planned endoAVF creation • Upper extremity venous occlusion or vessel abnormality on the same side as the planned endoAVF creation that precludes endoAVF creation • Hypercoagulable state • New York Heart Association class III or IV heart failure despite optimal therapy
37242, 37244	**Basic benefit and medical policy** **Prostatic arterial embolization for BPH** Prostatic arterial embolization, or PAE, for benign prostatic hyperplasia, or BPH, is established, effective May 1, 2024. It may be considered a useful therapeutic option when criteria are met. Prostatic artery embolization for treatment of hematuria of prostatic origin is established. It may be considered a useful option when criteria are met. **Inclusions:** PAE for BPH may be considered established when **all** the following are met: • Selection is done by a multidisciplinary team involving both a urologist and an interventional radiologist • Gland size is 50 grams or greater • Preserved bladder function **And one** of the following is met: • Moderate to severe lower urinary tract symptoms, or LUTS, by International Prostate Symptoms Score, or IPSS,[a] refractory to medical management[b] • Moderate to severe LUTS in individuals who are poor surgical candidates (e.g., advanced age, multiple comorbidities, or inability to stop anticoagulation or antiplatelet therapy) • Acute or chronic urinary retention, requiring urinary catheter use PAE for hematuria of prostatic origin may be considered medically necessary when one of the following are met: • 5-alpha reductase inhibitor,[c] or ARI, therapy has failed • Acute bleeding that is uncontrolled with conservative measures • Recurrent bleeding that is uncontrolled with conservative measures [a] IPSS is a reproducible, validated index designed to

	determine disease severity and response to therapy. Scores range from 0 to 35. Mild (≤7), moderate (8-19), or severe (20-35). [b]Documented failure (no clinical improvement after three months of therapy), inability to tolerate, or undesirable side effects or pharmacologic intervention for BPH [c]Examples consist of finasteride and dutasteride (brand names Proscar, Propecia, Avodart and Jalyn) **Note:** Procedure should only be done by an interventional radiologist with specific training and expertise in prostatic artery embolization. **Exclusions:** • Bladder cancer • Catheter dependence over 12 months • Detrusor or bladder dysfunction • Gland size < 50 grams • High-grade prostate cancer/Gleason Score >7 • Large bladder diverticula • Neurogenic lower urinary tract dysfunction or neurogenic bladder • Repeat PAE for BPH treatment • Uncorrectable coagulopathy **Note:** Procedure code *37242, previously not payable for BPH, will have the diagnostic exclusions removed, effective May 1, 2024.
81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217, 81301, 81307, 81308, 81408, 81432, 81479, 0037U, 0172U, 0239U** **Experimental** **0129U** ****Unlisted procedure code**	**Basic benefit and medical policy** **Germline and somatic biomarker testing for targeted treatment in prostate cancer** Germline *BRCA1/2* variant analysis for individuals with metastatic castrate-resistant prostate cancer, or mCRPC, to select treatment with FDA-approved targeted therapies is considered medically necessary. All other uses of germline *BRCA1/2* variant analysis to guide prostate cancer targeted therapy are considered experimental. Somatic testing using tissue biopsy or circulating tumor DNA testing (liquid biopsy) for homologous recombination repair, or HRR, gene alterations (*BRCA1*, *BRCA2*, *ATM*, *BARD1*, *BRIP1*, *CDK12*, *CHEK 1*, *CHEK2*, *FANCL*, *PALB2*, *RAD51B*, *RAD51C*, *RAD51*

	D and *RAD54L*) to select treatment for mCRPC with FDA-approved targeted therapies is considered medically necessary. All other uses of somatic testing using tissue biopsy or circulating tumor DNA (liquid biopsy) for HRR gene alterations to guide prostate cancer targeted therapy are considered experimental. Somatic testing using circulating tumor DNA testing (liquid biopsy) for *BRCA1*, *BRCA2* and *ATM* alterations to select treatment for mCRPC with FDA-approved targeted therapies is considered medically necessary. All other uses of somatic testing using circulating tumor DNA testing (liquid biopsy) to guide prostate cancer targeted therapy are considered experimental. Simultaneous testing using liquid and tumor biopsies (outside of paired or concurrent somatic-germline testing) to guide treatment in individuals with prostate cancer is considered experimental. The medical policy statement and inclusionary criteria have been updated, effective July 1, 2024. **Inclusions:** The clinical utility of germline and somatic biomarker testing using tumor tissue or circulating tumor DNA (liquid biopsy) for targeted treatment in prostate cancer (*BRCA1/2,* homologous recombination repair gene alterations) has been established when any of the following criteria are met: • Germline BRCA1/2 variant analysis for individuals with advanced for metastatic castrate-resistant prostate cancer, or mCRPC, with FDA-approved targeted therapies. • Somatic BRCA1/2 variant analysis using tumor tissue for individuals with advanced for mCRPC with FDA-approved targeted therapies. • Somatic testing using tissue biopsy or circulating tumor DNA testing (liquid biopsy) for homologous recombination repair, or HRR, gene alterations (*BRCA1*, *BRCA2*, *ATM*, *BARD1*, *BRIP1*, *CDK12*, *CHEK1*, *CHEK2*, *FANCL*, *PALB2*, *RAD51B*, *RAD51C*, *RAD51D* and *RAD54L*) to select treatment for mCRPC with FDA-approved targeted therapies. • Somatic testing using circulating tumor DNA testing (liquid biopsy) for *BRCA1*, *BRCA2* and *ATM* alterations to select treatment for mCRPC with FDA-approved targeted therapies.

	Exclusions: • All other uses of germline *BRCA1/2* variant analysis to guide prostate cancer targeted therapy are considered experimental. • All other uses of somatic testing using tissue biopsy for HRR gene alterations to guide prostate cancer targeted therapy are considered experimental. • All other uses of somatic testing using circulating tumor DNA testing (liquid biopsy) to guide prostate cancer targeted therapy are considered experimental. • Simultaneous testing using liquid and tumor biopsies (outside of paired or concurrent somatic-germline testing) to guide treatment in individuals with prostate cancer is considered experimental.
81528	**Basic benefit and medical policy** **Analysis of human FIT-DNA (Cologuard) for colorectal screening** The safety and effectiveness of FIT-DNA (in other words, Cologuard®) analysis of stool samples, using FDA-approved tests, is considered established as a screening technique for colorectal cancer for individuals at average risk who are 45 years of age and older. FIT-DNA (Cologuard) analysis of stool samples for all other indications is considered experimental. The title, medical policy statement and exclusionary criteria have been updated, effective July 1, 2024. **Inclusions:** Screening of members who are 45 to 75 years old must meet **both** of the following criteria: • At average risk for colon cancer • Asymptomatic (no signs or symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in the stools, positive guaiac fecal occult blood test or fecal immunochemical test) The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history.

	• Adults in this age group who have never been screened for colorectal cancer are more likely to benefit.
	• Screening would be most appropriate among adults who meet **both** of the following indications:
	  ○ Are healthy enough to undergo treatment if colorectal cancer is detected.
	  ○ Don't have comorbid conditions that would significantly limit their life expectancy.
	
	Repeat studies are appropriate at three-year intervals in individuals who remain at average risk and meet all the above requirements.
	
	Exclusions:
	
	The test isn't indicated in the following (list may not be all inclusive):
	
	• Symptomatic individuals
	• Personal history of adenomatous polyps
	• Personal history of colorectal cancer
	• History of inflammatory bowel disease
	• Family history of colorectal cancer or adenomatous polyps in a parent or other first-degree relative, particularly when the age of cancer onset is 45 years or less.
	• Familial adenomatous polyposis.
	• Lynch syndrome.
	
	Because colonoscopy offers specific advantages as a colon cancer screening tool, health care providers should ideally discuss this as one of the options for screening with their patients, so an informed decision can be made.

95249, 95250, 95251, A4238, A4239, A9276, A9277, A9278, A9279, E2102, E2103, 0446T, 0447T, 0448T **Non-covered:** **99091, S1030, S1031**	**Basic benefit and medical policy** **Invasive continuous glucose monitoring** The safety and effectiveness of FDA-approved continuous glucose monitoring systems have been established. They may be considered useful therapeutic devices for patients meeting the relevant patient selection criteria. Inclusionary criteria have been updated, effective July 1, 2024. **Inclusions:** Continuous (long-term) monitoring of glucose levels in

	interstitial fluid, including real-time monitoring, as a technique in diabetic monitoring may be considered established for **all** individuals who require insulin.
	
	Or
	
	Continuous (long-term) monitoring of glucose levels in interstitial fluid, including real-time monitoring, as a technique in diabetic monitoring may be considered established for **all** individuals who don't require insulin (not on insulin therapy) **and**:
	
	• The individual has a history of problematic hypoglycemia with documentation of at least one of the following:
	  ○ Recurrent (more than one) level 2** hypoglycemic events (glucose <54mg/dL [3.0mmol/L]) that persist despite multiple (more than one) attempts to adjust medications or modify the diabetes treatment plan.
	  ○ A history of one level 3** hypoglycemic event (glucose <54mg/dL [3.0mmol/L]) characterized by altered mental or physical state requiring third-party assistance for treatment of hypoglycemia.
	Or
	
	Continuous (long-term) monitoring of glucose levels in interstitial fluid, including real-time monitoring, as a technique in diabetic monitoring may be considered established for pregnant individuals who don't require insulin (not on insulin therapy) **and** who experience postprandial hyperglycemia (as defined by the American College of Obstetricians and Gynecologists).
	
	**Level 1 hypoglycemia is defined as a measurable glucose concentration <70 mg/dL (3.9 mmol/L) but ≥54 mg/dL (3.0 mmol/L).
	Level 2 hypoglycemia (defined as a blood glucose concentration <54 mg/dL [3.0 mmol/L]).
	Level 3 hypoglycemia is defined as a severe event characterized by altered mental or physical functioning that requires assistance from another person for recovery.
	
	Note: Patients with clinical conditions or lifestyle-based risks who exhibit intermittent hyperglycemia may benefit from continuous glucose monitors within the context of a Provider-Delivered Care Management program or Collaborative Quality Initiative focused on improving quality outcomes for members with a diagnosis of diabetes. The selection of these patients may not be consistent with the inclusion criteria presented above.

	Exclusions: • Patients who haven't demonstrated an understanding of the technology. • Patients not capable of using the device to recognize alerts and alarms. • Patients not expected to adhere to a comprehensive diabetes treatment plan. • Use of a continuous glucose monitoring device for convenience purposes such as (but not limited to) lifestyle or employment circumstances. • All other uses of diabetic monitoring for insulin and non-insulin requiring individuals that haven't met the above criteria. **Replacement:** Replacement of a CGMS may be considered when: • The transmitter is out of warranty, **or** • The transmitter is malfunctioning; and replacement parts are unavailable, **and** • There is documented evidence of patient compliance provided, if no evidence of compliance is provided or if the member isn't compliant, benefit of CGMS may be withdrawn. **Continuation:** Continuation of sensor use after one year may be considered when both the following apply: • The CGMS has been previously approved by the health plan or the CGMS is in use before the user enrolling in the health plan. • There is documented evidence of patient compliance provided, if no evidence of compliance is provided or if the member isn't compliant, benefit of CGMS may be withdrawn. All covered supplies must be compatible with the CGMS.
J0689	**Basic benefit and medical policy** **Cefazolin (cefazolin sodium)** Cefazolin (cefazolin sodium) is considered established when criteria are met, effective Feb. 1, 2024. Cefazolin injection is a cephalosporin antibacterial indicated for perioperative prophylaxis in adults and

	pediatric patients aged 10 to 17 years old for whom appropriate dosing with this formulation can be achieved. **Dosage and administration:** Recommended dosing schedule in pediatric patients with CLcr greater than or equal to 70 mL/min. Site and type of infection: Moderate to severe infections Dose: 25 to 50 mg per kg Frequency: Divided into three or four equal doses Site and type of infection: Severe infections Dose: May increase to 100 mg per kg Frequency: Divided into three or four equal doses
J1556	**Basic benefit and medical policy** **Bivigam (immune globulin intravenous, human)** Bivigam® (immune globulin intravenous, human) is considered established when criteria are met, effective Dec. 26, 2023. Bivigam (immune globulin intravenous, human) is payable for adults and pediatric patients 2 years of age and older with primary humoral immunodeficiency.
J2777	**Basic benefit and medical policy** **Vabysmo® (faricimab-svoa)** Effective Oct. 26, 2023, Vabysmo® (faricimab-svoa) is payable for the updated FDA-approved indications below. Vabysmo (faricimab-svoa) is a vascular endothelial growth factor, or VEGF, and angiopoietin-2, or Ang-2, inhibitor indicated for the treatment of patients with macular edema following retinal vein occlusion, or RVO. **Dosage and adminstration:** • For intravitreal injection • Macular edema following RVO: The recommended dose for Vabysmo (faricimab-svoa) is 6 mg (0.05 mL of 120 mg/mL) administered by intravitreal injection every four weeks (approximately every 28 ± 7 days, monthly) for six months.
J3262	**Basic benefit and medical policy**

	Actemra® (tocilizumab) Actemra® (tocilizumab) is covered for the following updated FDA-approved indication, effective May 22, 2017. Giant cell arteritis, or GCA: Adult patients with giant cell arteritis.
J3490, J3590	**Basic benefit and medical policy** **Defencath™ (taurolidine and heparin)** Defencath™ (taurolidine and heparin) is considered established when criteria are met, effective Nov. 15, 2023. Defencath is a combination of taurolidine, a thiadiazinane antimicrobial, and heparin, an anti-coagulant, indicated to reduce the incidence of catheter-related bloodstream infections, or CRBSI, in adult patients with kidney failure receiving chronic hemodialysis, or HD, through a central venous catheter, or CVC. This drug is indicated for use in a limited and specific population of patients. **Limitations of use:** The safety and effectiveness of Defencath haven't been established for use in populations other than adult patients with kidney failure receiving chronic HD through a CVC. **Dosage and administration:** • Defencath is for instillation into CVCs only. • Defencath isn't intended for systemic administration. • Don't use Defencath as a catheter lock flush product. • Withdraw a sufficient volume of Defencath catheter lock solution, or CLS, from the vial using a sterile needle and syringe to fill the catheter lumens. • Use 3 mL or 5 mL single-dose vial (depending on the volume of the catheter lumens) to instill Defencath into each catheter lumen at the conclusion of each HD session. • Defencath must be aspirated from the catheter and discarded before the initiation of the next HD session. • Discard any unused portion of Defencath remaining in the vial. **Dosage forms and strengths:**

	Defencath is a sterile catheter lock solution available in single-dose vials in the following strengths: • 3 mL containing taurolidine 40.5 mg/3 mL (13.5 mg/mL) and heparin 3,000 USP units/3 mL (1,000 USP units/mL) • 5 mL containing taurolidine 67.5 mg/5 mL (13.5 mg/mL) and heparin 5,000 USP units/5 mL (1,000 USP units/mL) Defencath (taurolidine and heparin) isn't a benefit for URMBT.
J3490, J3590	**Basic benefit and medical policy** **Zynrelef® (bupivacaine and meloxicam)** Effective Jan. 23, 2024, Zynrelef® (bupivacaine and meloxicam) is covered for the following FDA-approved indications: Zynrelef is indicated in adults for postsurgical analgesia for up to 72 hours after: • Soft tissue surgical procedures. • Orthopedic surgical procedures. • Foot and ankle procedures. • Other orthopedic surgical procedures (for example, total joint arthroplasty) in which direct exposure to articular cartilage is avoided. **Dosage and administration:** Zynrelef is intended for single-dose administration only. Administer Zynrelef via instillation only.
J3490, J3590	**Basic benefit and medical policy** **iDose® TR (travoprost intracameral implant)** iDose® TR (travoprost intracameral implant) is considered established, effective Dec. 13, 2023. iDose TR (travoprost intracameral implant) is a prostaglandin analog indicated for the reduction of intraocular pressure, or IOP, in patients with open-angle glaucoma, or OAG, or ocular hypertension, or OHT. **Dosage and administration:** • For ophthalmic intracameral administration. • The intracameral administration should be carried

	out under standard aseptic conditions. **Dosage forms and strengths:** Intracameral implant containing 75 mcg travoprost, pre-loaded in a single-dose inserter. This drug isn't a benefit for URMBT.
J7183	**Basic benefit and medical policy** **Wilate® (von Willebrand factor/coagulation factor VIII complex [human])** Wilate® (von Willebrand factor/coagulation factor VIII complex [human]) is considered established when criteria are met, effective Dec. 5, 2023. Wilate is also indicated in adolescents and adults with hemophilia A for routine prophylaxis to reduce the frequency of bleeding episodes and for on-demand treatment and control of bleeding episodes.
J9061	**Basic benefit and medical policy** **Rybrevant® (amivantamab-vmjw)** Effective March 1, 2024, Rybrevant® (amivantamab-vmjw) is covered for the FDA-approved indications listed below. Rybrevant is a bispecific EGF receptor-directed and MET receptor-directed antibody indicated in combination with carboplatin and pemetrexed for the first-line treatment of adult patients with locally advanced or metastatic non-small cell lung cancer, or NSCLC, with epidermal growth factor receptor, or EGFR, exon 20 insertion mutations, as detected by an FDA-approved test. **Dosage and administration:** Rybrevant in combination with carboplatin and pemetrexed: • **Body weight at baseline** = less than 80 kg – during weeks 1 through 4, recommended dose is 1,400 mg • **Body weight at baseline =** less than 80 kg – from week 7 onwards, recommended dose is 1,750 mg • **Body weight at baseline =** greater than or equal to 80 kg – during weeks 1 through 4, recommended dose is 1,750 mg • **Body weight at baseline =** greater than or equal to

	80 kg – from week 7 onwards, recommended dose is 2,100 mg.
J9228	**Basic benefit and medical policy** **Yervoy® (ipilimumab)** Blue Cross Blue Shield of Michigan has approved payment for the off-label use of Yervoy® (ipilimumab) for the treatment of mesothelioma of peritoneum. URMBT is excluded from this change.
J9299	**Basic benefit and medical policy** **Opdivo® (nivolumab)** Blue Cross Blue Shield of Michigan has approved payment for the off-label use of Opdivo® (nivolumab) for the treatment of mesothelioma of peritoneum. URMBT is excluded from this change. Opdivo (nivolumab) is covered for the updated FDA-approved indication below, effective Oct. 13, 2023. For the adjuvant treatment of adult and pediatric patients 12 years and older with completely resected Stage IIB, Stage IIC, Stage III or Stage IV melanoma.
J9312, Q5115, Q5119, Q5123	**Basic benefit and medical policy** **Rituxan® (rituximab), Truxima® (rituximab-abbs), Ruxience® (rituximab-pvvr), Riabni® (rituximab-arrx)** Blue Cross Blue Shield of Michigan has approved payment for the off-label use of Rituxan® (rituximab), Truxima® (rituximab-abbs), Ruxience® (rituximab-pvvr) and Riabni® (rituximab-arrx) for the treatment of stiff person syndrome. URMBT is excluded from this change.

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.