

PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	POLICY NUMBER	CRITERIA CHANGE	MATERIAL AMEUREMENT	EFFECTIVE DATE	LINK TO FULL POLICY
Mammography-Based AI (Image-only) Risk Prediction Models	2026013	New policy developed: Use of mammography-based AI risk prediction software for individuals undergoing bilateral screening mammography to estimate their 5-year risk of developing breast cancer does not meet member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes and is not covered. For members with contracts without Primary Coverage Criteria, use of mammography-based AI risk prediction software for individuals undergoing bilateral screening mammography to estimate their 5-year risk of developing breast cancer is considered Not Medically Necessary or is investigational and is not covered. Not Medically Necessary or Investigational services are specific contract exclusions in most member benefit certificates of coverage.	Yes	1/1/2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2026013
Transcatheter Mitral Valve Repair or Replacement	2014017	Restricted coverage added for native TMVR and language updated (TMVR changed to M-TEER and TMViVR changed to ViV-TMVR): Mitral transcatheter edge-to-edge repair (M-TEER) with a device approved by the U.S. Food and Drug Administration (FDA) for use in mitral valve repair meets member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts without Primary Coverage Criteria is considered Medically Necessary and is covered for individuals with: - Heart failure AND moderate to severe symptomatic secondary mitral regurgitation despite the use of maximally tolerated guideline-directed medical therapy; OR - Symptomatic, primary mitral regurgitation who are considered at prohibitive risk for open surgery*.	Yes	1/1/2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2014017

		Native TMVR with a device approved by the U.S. Food and Drug Administration meets member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts without Primary Coverage Criteria is considered Medically Necessary and is covered for individuals with symptomatic mitral valve dysfunction associated with severe mitral annular calcification (MAC)* when one of the following conditions are met: • The individual has mitral stenosis, remains symptomatic despite medical management, and is inoperable or at prohibitive anatomical surgical risk*; OR • The individual has symptomatic severe MR, is at high or prohibitive surgical risk*, and M-TEER is expected to result in severe mitral stenosis. Valve-in-valve transcatheter mitral valve replacement (ViV-TMVR) with a device approved by the U.S. FDA meets member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts without Primary Coverage Criteria is considered Medically Necessary and is covered for individuals when ALL of the following conditions are present: • Failure (stenosed, insufficient, or combined) of a surgical bioprosthetic mitral valve; AND • New York Heart Association heart failure class II, III, or IV symptoms; AND • Individual is not an operable candidate for open surgery, as documented by at least 2 cardiovascular specialists (including a cardiac surgeon); OR individual is an operable candidate but is considered at an intermediate to prohibitive surgical risk for open surgery, as documented by at least 2 cardiac specialists (including a cardiac surgeon); OR individual is considered at an intermediate to prohibitive surgical risk for open surgery (e.g., repeat sternotomy) due			
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		to a history of congenital vascular anomalies AND/OR has a complex intrathoracic surgical history, as documented by at least 2 cardiovascular specialists (including a cardiac surgeon). *Definitions "Prohibitive risk" for open surgery may be determined based on: • Presence of a Society for Thoracic Surgeons predicted mortality risk of 12% or greater and/or • Presence of a logistic EuroSCORE of 20% or greater. The FDA definition of high risk for open surgery is: • Society of Thoracic Surgeons (STS) predicted operative risk score of 8% or higher; or • Judged by a heart team, which includes an experienced cardiac surgeon and a cardiologist, to have an expected mortality risk of 15% or higher for open surgery. The FDA definition of intermediate risk for open surgery is: • Society of Thoracic Surgeons (STS) predicted operative risk score of 4% or higher judged by a heart team. Moderate to severe or severe mitral regurgitation (MR) may be determined by: • Grade 3+ (moderate) or 4+ (severe) MR confirmed by echocardiography; • New York Heart Association (NYHA) functional class II, III, or IVa (ambulatory) despite the use of stable maximal doses of guideline-directed medical therapy and cardiac resynchronization therapy (if appropriate) administered in accordance with guidelines of professional societies. Severe mitral annular calcification (MAC) may be determined by cardiac CT demonstrating: • Calcium involving greater than or equal to 270 degrees of the mitral annular circumference; • Maximal annular calcium thickness greater than or equal to 10 mm; or			
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		Extension of calcium into both mitral leaflets, the anterior commissure, or the subvalvular apparatus. <u>Does Not Meet Primary Coverage Criteria Or Is Not Covered For Contracts Without Primary Coverage Criteria</u> Mitral transcatheter edge-to-edge repair (M-TEER) in all other situations does not meet member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes. For members with contracts without Primary Coverage Criteria, mitral transcatheter edge-to-edge repair (M-TEER) in all other situations is considered Not Medically Necessary or is investigational and is not covered. Not Medically Necessary or investigational services are specific contract exclusions in most member benefit certificates of coverage. Native TMVR for the treatment of MR in the absence of severe MAC and for all other indications does not meet member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes. For members with contracts without Primary Coverage Criteria, Native TMVR for the treatment of MR in the absence of severe MAC and for all other indications is considered Not Medically Necessary or is investigational and is not covered. Not Medically Necessary or investigational services are specific contract exclusions in most member benefit certificates of coverage. Valve-in-valve transcatheter mitral valve replacement (ViV-TMVR) for all other situations does not meet member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes.			
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Genetic Testing for Heterozygous Familial Hypercholesterolemia	2024005	Coverage updated to include Restricted coverage for adults and children who are close relatives of individual with FH and to confirm diagnosis of FH in individuals undergoing lipid-lowering therapy to establish proper treatment goals who meet criteria. Genetic testing to confirm a diagnosis of familial hypercholesterolemia (FH) meets member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts without Primary Coverage Criteria is considered Medically Necessary and is covered when a definitive diagnosis is required in individuals undergoing lipid-lowering therapy to establish proper treatment goals (i.e., eligibility for some specialty medications may require a definitive diagnosis of FH) and when all the following criteria are met: - Genetic testing is targeted to individuals who are in an uncertain category according to clinical criteria (personal and family history, physical exam, lipid levels) (see below examples of uncertain category); AND - Alternative treatment considerations are in place for individuals who have an uncertain diagnosis of FH and a negative genetic test. When FH is suspected and evaluated against standardized diagnostic criteria, it can be interpreted that the individual is in an “uncertain” category when criteria for a definitive diagnosis are not met. Here are some examples of certain criteria not being met: - Dutch Lipid Clinic Network Criteria. A score greater than 8 on the Dutch Lipid Clinic Network criteria is considered definitive FH.	No	12/1/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2024005

		Scores between 3 and 8 are considered “possible” or “probable” FH. The latter 2 categories can be considered to represent “uncertain” FH. • Simon-Broome Register Criteria. A definitive diagnosis of FH is made based on a total cholesterol level greater than 290 mg/dL in adults (or low-density lipoprotein [LDL] greater than 190 mg/dL), together with either positive physical exam findings or a positive genetic test. Probable FH, which can be interpreted as “uncertain” FH, is diagnosed using the same cholesterol levels, plus family history of premature myocardial infarction or total cholesterol of at least 290 mg/dL in a first- or a second-degree relative. • Make Early Diagnosis Prevent Early Death (MEDPED) Diagnostic Criteria. These criteria provide a yes/no answer for whether an individual has FH, based on family history, age, and cholesterol levels. An individual who meets criteria for FH can be considered to have definitive FH; however, there is no “possible” or “probable” category that allows assignment of an “uncertain” category. Genetic testing of adults or children who are close relatives (first- and second-degree relatives, i.e., siblings, offspring, parents, grandparents, aunts, uncles) of individuals with FH to determine future risk of disease meets member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes or for members with contracts without Primary Coverage Criteria is considered Medically Necessary and is covered. <u>Does Not Meet Primary Coverage Criteria Or Is Not Covered For Contracts Without Primary Coverage Criteria</u> Genetic testing to confirm a diagnosis of FH does not meet member benefit certificate Primary Coverage Criteria that there be scientific evidence of effectiveness in improving health outcomes in all other situations.			
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Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon	2002008	Artificial intelligence assisted reading tools for suspected small bowel bleeding added as noncovered.:	Yes	1/1/2027	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2002008