Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective July 15, 2025 (unless otherwise noted)

Note – Log-in is needed for policy update sections marked with an asterisk *. Use this link to log-in, Cigna for Health Care Professionals > Resources > Reimbursement and Payment Policies.

Medical Coverage Policy	New, Updated, or Retired?	Comments
Amplitude-Modulated Radiofrequency Electromagnetic Fields (AM RF-EMF) Therapy – (0581)	New	This is a NEW Coverage Policy **Posting 4/15/25, Effective 7/15/25.** • New CP addressing TheraBionic P1 medical device (HCPCS code E0767 Intrabuccal, systemic delivery of amplitude-modulated, radiofrequency electromagnetic field device, for cancer treatment, including all accessories)
Diaphragmatic/ Phrenic Nerve Stimulation – (0391)	Updated	Important **changes** in coverage criteria: • Removed noncoverage policy statements for the following indications because Diaphragmatic/phrenic (D/P) nerve stimulation is not clinically managed for those listed indications: ○ central sleep apnea ○ amyotrophic lateral sclerosis (ALS)

		○ temporary respiratory insufficiency ○ temporary use in difficult to wean individuals
Duplex Scan of Extracranial Arteries - (0542)	Updated	Important **changes** in coverage criteria: • Title change: Duplex Scan of Extracranial Arteries ~~to Evaluate for Carotid Artery Stenosis~~ • Adding specific bullet for neck trauma. • Clarifying malignancy/tumor criteria
Fetal Surgery – (0175)	Updated	Important **changes** in coverage criteria: • Removed coverage policy statements for the following because none of these procedures are clinically managed: ○ serial amnioreduction for twin-to-twin transfusion syndrome (TTTS) ○ fetoscopic occlusion of anastomotic vessels (e.g., laser photocoagulation, radiofrequency ablation, ligation) for twin reversed arterial perfusion (TRAP sequence) ○ fetal vesicoamniotic shunt procedures for bilateral fetal urinary-tract obstruction ○ in-utero needle access and open resection of sacrococcygeal teratoma ○ fetal thoracoamniotic shunt placement for ANY of the following indications
Heart, Lung and Heart-Lung Transplantation - (0129)	Updated	Important **changes** in coverage criteria: • Expanded coverage for lung transplant to individuals with a history of or current diagnosis of non-small cell lung cancer (NSCLC) Stage II or lower.
Nucleic Acid Pathogen Testing - (0530)	Updated	**Posting 7/15/25, Effective 10/15/25** Minor **changes** in coverage criteria/policy**:** • Added code 0531U • Added four new codes effective 7/1/2025 codes (0556U, 0557U, 0563U, 0564U)

		• No changes to policy statement wording
Phototherapy, Photochemotherapy, Excimer Laser, Dermabrasion and Chemical Peels for Dermatologic Conditions – (0505)	Updated	Important **changes** in coverage criteria: • Title change from "Phototherapy, Photochemotherapy, Excimer Laser, Dermabrasion and Chemical Peels for Dermatologic Conditions" to "Excimer Laser, Dermabrasion and Chemical Peels for Dermatologic Conditions" • Remove benefit coverage statement for the home phototherapy device • Remove and update benefit coverage statement dermabrasion/chemical peel treatment • Remove all policy statements associated with office-based phototherapy/photochemotherapy treatment session due to phototherapy and photochemotherapy codes no longer being managed. • Expanded coverage by removing excimer laser therapy treatment session limitation statement.
Site of Care: Outpatient Hospital Setting for Physical and Occupational Therapy - (0600)	New	Posting **7/1/2025; effective 10/1/2025** Important **changes** in coverage criteria: • New policy to address the medical necessity for outpatient hospital site of care for PT and OT services to direct patients to the most appropriate setting for PT and OT services.
Transcatheter Ablation for the Treatment of Supraventricular Tachycardia in Adults – (0529)	Updated	**Posting 4/15/2025; Effective 7/15/2025** Important **changes** in coverage criteria: • Title change from "Transcatheter Ablation for the Treatment of Supraventricular Tachycardia in Adults" to "Cardiac Ablation of Abnormal Electrical Rhythms in Adults". • Expanded the scope of the coverage policy by adding a medically necessary statement for 'ventricular arrhythmias' and 'PVCs'. • Limited coverage by adding an EIU statement for thoracoscopic epicardial ablation for the treatment of atrial flutter.

Transthoracic Echocardiography in Adults – (0510)	Updated	**Posting 4/15/25, Effective 7/15/25** Important **changes** in coverage criteria: • Updated the frequency policy statement
Ultrasound Guidance for Trigger Point Injections – (0139)	Updated	Minor **changes** in coverage criteria/policy: • Title changed from "Trigger Point Injections" to "Ultrasound Guidance for Trigger Point Injections" • Removed policy statements for diagnostic and therapeutic trigger point injections, as codes are not managed.
Athletic Pubalgia Surgery – (0522)	Updated	• No change in coverage.
Cardioverter-Defibrillator Devices – (0431)	Updated	• No change in coverage.
Gender Dysphoria Treatment – (0266)	Updated	**Effective 7/1/2025** • No change in coverage.
Head and Neck Ultrasound - (0549)	Updated	• No change in coverage.
Scrotal Ultrasound - (0548)	Updated	• No change in coverage.
Tests for the Evaluation of Preterm Labor and Premature Rupture of Membranes – (0099)	Updated	• No change in coverage.
Ultrasound in Pregnancy	Updated	• No change in coverage.

(including 3D, 4D and 5D Ultrasound) – (0142)		
Iron Testing in Adults – (0568)	Retired	• Retired 7/8/2025 • The policy was never posted or effective. The project and policy are tabled indefinitely.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Cognitive Rehabilitation– (CPG270)	Updated	• No change in coverage.
Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations– (CPG111)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore Gastrointestinal Endoscopic	Updated	Guideline retired **5/30/2025:** • Capsule Endoscopy

Procedure Guidelines		

Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Updated	Posted **4/1/2025**; Effective **7/1/2025**:
		
		Important **change** in coverage criteria:
		
		• One guideline was updated with a clinical change which will limit coverage:
		  ○ Breast Imaging
		  ▪ For breast MRI indications, added "40**" as age at which screening can start for members with BARD1, RAD51C, RAD51D mutation(s).

Cobranded Cigna-EviCore Laboratory Management Clinical Guidelines	Updated	Posted **4/1/2025**; Effective **7/1/2025**:
		
		Important **changes** in coverage criteria.
		
		• One new guideline:
		  ○ Primary Ciliary Dyskinesia Genetic Testing
		• Four guidelines were updated with clinical changes which will expand coverage:
		  ○ Liquid Biopsy Testing
		  ○ Somatic Mutation Testing
		  ○ Mitochondrial Disorders Genetic Testing
		  ○ Polymerase Gamma (POLG) Related Disorders Genetic Testing
		• One guideline was updated with clinical changes which may limit coverage:
		  ○ Cardiomyopathy and Arrhythmia Genetic Testing
		• One guideline was retired:
		  ○ BCR-ABL Negative Myeloproliferative Neoplasm Testing
		• The remaining guidelines had no clinically impactful changes.
		
		Please see the Cigna-EviCore Cobranded Guidelines Homepage for updates.

Cobranded Cigna-EviCore Musculoskeletal Management Guidelines	Updated	Posted **4/1/2025**; Effective **7/1/2025**:
		
		Minor **change**:
		
		• One guideline was updated with minor clinical changes which may impact coverage:
		  ○ CMM-318: Shoulder Arthroplasty/ Replacement/ Resurfacing/ Revision/ Arthrodesis
		• The remaining guidelines had no clinically impactful changes:
		  ○ Preface to the Comprehensive Musculoskeletal Management (CMM) Guidelines
		  ○ CMM-200: Epidural Steroid Injections
		  ○ CMM-203: Sacroiliac Joint Procedures
		  ○ CMM-208: Ablations/Denervations of Facet Joints and Peripheral Nerves
		  ○ CMM-210: Implantable Intrathecal Drug Delivery Systems
		  ○ CMM-211: Spinal Cord and Dorsal Root Ganglion Stimulation
		  ○ CMM-311: Knee Replacement/Arthroplasty
		  ○ CMM-312: Knee Surgery - Arthroscopic and Open Procedures
		  ○ CMM-313: Hip Replacement/Arthroplasty
		  ○ CMM-314: Hip Surgery-Arthroscopic and Open Procedures
		  ○ CMM-315: Shoulder Surgery-Arthroscopic and Open Procedures
		  ○ CMM-201: Facet Joint Injections/Medial Branch Blocks
		  ○ CMM-204: Prolotherapy
		  ○ CMM-207: Epidural Adhesiolysis
		  ○ CMM-209: Regional Sympathetic Blocks

Cobranded Cigna-EviCore Radiation Oncology Guidelines	Updated	Posted **6/1/2025**; Effective **7/15/2025** Important **changes** in coverage criteria: • One guideline was updated with clinical changes to expand coverage: ○ Pluvicto

		▪ Added indication for use in individuals for whom a delay in taxane-based chemotherapy has been deemed appropriate. • The remaining guidelines had no clinical changes. Posted/Effective **7/16/2025** Important **changes** in coverage criteria: • Ten guidelines were updated with clinical changes which will expand coverage: o Breast Cancer o Cervical Cancer o Esophageal Cancer o Image-Guided Radiation Therapy (IGRT) o Multiple Myeloma and Solitary Plasmacytomas o Non-Small Cell Lung Cancer o Pancreatic Cancer o Prostate Cancer o Skin Cancer - Melanoma o Skin Cancer - Non-Melanoma • Four guidelines will be retired: o Azedra® (iobenguane I-131) o Hyperthermia o Other Cancers o Zevalin® • The remaining guidelines had no clinical changes.
Cobranded Cigna-EviCore Spine Surgery Guidelines	Update	Posted **4/1/2025**; Effective **7/1/2025**: Important **changes** in coverage criteria.

		• Two guidelines were updated with clinical changes which will expand coverage:
		  ○ CMM-608: Lumbar Decompression
		  ○ CMM-609: Lumbar Fusion (Arthrodesis)
		• One guideline was updated with clinical changes which will limit coverage:
		  ○ CMM-611: Sacroiliac Joint Fusion and Stabilization
		• The remaining guidelines had no clinically impactful changes:
		  ○ CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy)
		  ○ CMM-308: Intradiscal Procedures
		  ○ CMM 401: Discography
		  ○ CMM-600: Preface to Spine Surgery Guidelines
		  ○ CMM-601: Anterior Cervical Discectomy and Fusion
		  ○ CMM-602: Cervical Total Disc Arthroplasty
		  ○ CMM-603: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty)
		  ○ CMM-604: Posterior Cervical Fusion
		  ○ CMM-605: Cervical Microdiscectomy
		  ○ CMM-607: Primary Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) and Sacroplasty
		  ○ CMM-610: Lumbar Total Disc Arthroplasty
		  ○ CMM-612: Grafts
		  ○ CMM-613: Thoracic Decompression/Discectomy
		  ○ CMM-614: Thoracic / Thoracolumbar Fusion (Arthrodesis)
		  ○ CMM-615: Electrical and Low Frequency Ultrasound Bone Growth Stimulation (Spine)
		  ○ CMM-616: Vertebral Body Tethering for Adolescent Idiopathic Scoliosis

Cobranded Cigna-EviCore Vascular Intervention Guidelines	Update	Posted **7/1/2025**; Effective **10/1/2025**: Important **changes** in coverage criteria.

		• Cerebrovascular Intervention
		  ○ Added indications for venous sinus stenting in treatment of idiopathic, intracranial hypertension (IIH) for specific conditions.
		• Peripheral Vascular Intervention
		  ○ Guideline was updated with several clinical changes which will expand and limit coverage.

Administrative Policy	**New, Updated, or Retired?**	**Comments**
		• No updates for July 2025
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Allergen Immunotherapy – Palforzia - (IP0141)	Updated	Effective: **7/15/2025** • Peanut allergy: Criteria were updated to require a patient to have either a positive skin prick test response to peanut or a positive *in vitro* test (i.e., a blood test) for immunoglobulin E (IgE) to peanut. Previously, a patient was required either have a positive skin prick test response to peanut with a wheal diameter ≥ 3 mm larger than the negative control and a positive *in vitro* test (i.e., a blood test) for peanut-specific IgE with a level ≥ 0.35 kU_A/L; OR have either a positive skin prick test response to peanut with a wheal diameter ≥ 8 mm larger than the negative control or have a positive *in vitro* test (i.e., a blood test) for peanut-specific IgE with a level ≥ 14 kU_A/L. • Added "documentation provided that" language to criterion 1C.

Antiseizure Medications - (IP0031)	Updated	Effective date remains **3/15/2024** • Replaced coverage for migraine prophylaxis for Trokendi
Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Employer Group Plans - (IP0477)	Updated	Effective **7/1/2025** Vyvanse capsules • Updated the preferred product requirements to multi-source brand criteria. • Extended the preferred product criteria to the Standard, Performance and Legacy formularies. Vyvanse chewable tablets • Updated the preferred product requirements to multi-source brand criteria. • Extended the preferred product criteria to the Standard, Performance and Legacy formularies. • Updated the preferred product requirements for Adderall, Adderall XR, Adhansia XR, Adzenys XR-ODT, Aptensio XR, Concerta, Cotempla XR ODT, Desoxyn, Dexedrine, Dyanavel XR, Evekeo, Evekeo ODT, Focalin, Focalin XR, Jornay PM, Methylin, Mydayis, Ritalin, Ritalin LA, Xelstrym and Zenzedi.
Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Individual and Family Plans – (IP0584)	Updated	Effective **7/1/2025** • For Metadate CD, methylphenidate extended-release 45mg, 63mg, 72 mg tablets, and Relexxii: Removed methylphenidate extended-release capsules (generic for Aptensio XR) from the list of alternatives in the preferred product criteria.
Botulinum Toxins – Botox - (IP0637)	New	Effective: **7/15/2025** • New policy

Botulinum Toxins – Daxxify - (IP0588)	Updated	Effective: **7/15/2025** • Policy Title Updated from "DaxibotulinumtoxinA-lanm" to "Botulinum Toxins – Daxxify". Cervical Dystonia • Updated cervical dystonia criteria for approval to require a screen patient is at least 18 years of age, documentation for diagnosis, documentation of head torsion with limited range of motion, specialist requirement. • Updated dosing for use of Daxxify to treat *cervical dystonia* from "Dosing. Up to a maximum dose of 300 units, administered not more frequently than once every 3 months" to "Dosing. Approve up to a maximum dose of 250 units, administered not more frequently than once every 3 months." Conditions Not Covered • Updated to only include cosmetic uses. Coding Information: • Added CPT code 64616
Botulinum Toxins – Dysport - (IP0638)	New	Effective: **7/15/2025** • New policy
Botulinum Toxins – Myobloc - (IP0509)	Updated	Effective: **7/15/2025** • Policy Title Updated from "RimabotulinumtoxinB" to "Botulinum Toxins – Myobloc". Cervical Dystonia • Updated *cervical dystonia* criteria for approval to require a screen patient is at least 18 years of age, documentation for diagnosis, documentation of head torsion with limited range of motion, specialist requirement.

		• Updated dosing for use of Myobloc to treat *cervical dystonia* from "Dosing. The recommended dose for Cervical Dystonia is up to a maximum dose of 10,000 units, administered not more frequently than once every 12 weeks" to "Dosing. Approve up to a maximum dose of 5,000 units, administered not more frequently than once every 12 weeks". Chronic Sialorrhea • Updated criteria to screen for age only. Limb Spasticity • Updated criteria to screen for age only. Conditions Not Covered • Updated *conditions not covered* to only screen for cosmetic uses; no other uses listed to be excluded from coverage for *conditions not covered*. Coding Information: • Added CPT coding tables for the following codes: 64616, 64611, 64642, 64643, 64644, 64645, 64646, 64647
Botulinum Toxins – Xeomin - (IP0639)	New	Effective: **7/15/2025** • New policy
Brands with Bioequivalent Generics - (IP0011)	Updated	Effective **7/1/2025** Added for Employer Plans: • Alinia tablets, Azilect, BromSite, Celebrex, Desowen cream, Estrogel, Evoxac, Femara, Gastrocrom, Imuran, Levbid, Levsin SL, Norvasc, Plavix, Prevident 5000 Plus, Pulmicort respules, Pyridium, Spiriva Handihaler, Singulair, Taclonex suspension, Uroxatral, Vytorin, Zetia.

		Added for Individual and Family Plans: • Azilect, Celebrex, Desowen cream, Evoxac, Femara, Gastrocrom, Imuran, Levbid, Levsin SL, Norvasc, Plavix, Pulmicort respules, Pyridium, Singulair, Uroxatral, Vytorin, Zetia. Removed for Employer Plans: • Differin 0.1% cream, Differin 0.3% gel pump, Retin-A cream (0.025%, 0.05%, 0.1%), Retin-A gel (0.025%, 0.01%), Retin-A Micro gel (0.04% & 0.1%), Retin-A Micro Pump gel (0.04%, 0.08%, 0.1%).
Chenodiol Products - (IP0203)	Updated	Effective **7/15/2025** • The policy name was changed from "Chenodiol" to "Chenodiol Products," with the addition of Ctexli tablets to the policy. Also, divided criteria based on specific agent intended for approval. • Individual and Family Plans added to the policy. Chenodal – Gallstones: • Added an exception for a patient currently receiving an ursodiol product. Chenodal: Removed condition of approval for cerebrotendinous xanthomatosis (CTX). Ctexli: Added new condition of approval for cerebrotendinous xanthomatosis (CTX). Conditions Not Covered • "Total Treatment Duration Exceeding 24 months for Gallstones" removed from the not medically necessary list.

Complement Inhibitors – Fabhalta - (IP0614)	Updated	Effective **7/1/2025** Primary Immunoglobulin A Nephropathy. • Added documentation requirements.
Complement Inhibitors – PiaSky - (IP0694)	Updated	Effective: **7/1/2025** • Preferencing Table. • Added eculizumab product (Bkemv, Epysqli) • Added "Note: All of the eculizumab products would count as one alternative (Soliris, Bkemv, Epysqli)."
Contraceptives - (IP0036)	Updated	Effective **7/1/2025** Employer Plans Preferred Product Table: • Added preferred product requirement criteria for Annovera, Loestrin 1.5/30, Loestrin 1.5/30 FE, and Tyblume for Employer plans. • Removed preferred product requirement criteria for Phexxi for Employer plans. • Updated preferred product requirement criteria for Balcoltra, Beyaz, Depo Provera, Femlyv, Generess FE, Layolis FE, Loestrin, Loestrin FE, Lo Loestrin FE, Minastrin 24 FE, Mircette 28 day, Natazia, Nextstellis, Nuvaring, Quartette, Safyral, Seasonique, Slynd, Twirla, Taytulla, Yasmin 28, and Yaz for Employer plans.
Contraceptives – Phexxi - (IP0729)	New	Effective **7/1/2025** • New policy.
Cushing's – Mifepristone - (IP0092)	Updated	Effective **7/1/2025** • Reworded the Conditions Not Covered statement.

Diabetes – Diabetic Supplies - (IP0272)	Updated	Effective **7/1/2025** • Updated the policy title. • Updated the Employer Plans pen needle preferred product from "BD Pen Beedles" to "BD/Embecta Pen Needles". • Added Syringes to the policy, for Employer Plans. • Added Lancing Devices to the policy, for Individual and Family Plans.
Drugs Requiring Medical Necessity Review for Employer Plans – (1602)	Updated	Effective **7/1/2025** • Added preferred product step requirement for the following products: Journavx, metronidazole 125 mg tablets, Lybalvi, metformin immediate-release 750 mg tablets, Estring, Gabarone, Glucagon Emergency Kit, GlucaGen HypoKit, Gvoke HypoPen Auto-Injector, Kit, or Prefilled Syringe, Zegalogue, Otrexup, Rasuvo, Fenopron, Alrex, Zerviate, TobraDex ST, Zylet, Acuvail, Flarex, Inveltys, Lotemax, Lotemax SM, Cetraxal, Cipro HC Otic Suspension, and ferric citrate tablets. • Updated preferred product step requirement for the following products: Neffy, ArmonAir DigiHaler, Arnuity Ellipta, Flovent Diskus, Flovent HFA, fluticasone propionate Diskus (authorized generic of Flovent Diskus), fluticasone propionate HFA (authorized generic of Flovent HFA), Pulmicort Flexhaler, Ohtuvayre, and Tudorza Pressair. • Removed preferred product requirements for Iluvien
Drugs Requiring Medical Necessity Review for Employer Plans – (1602)	Updated	Effective: **7/15/2025** • Added preferred product step requirement for Fulvicin P/G • Updated preferred product step requirement for the following products: ○ Kristalose, lactulose packet, and Gemtesa

Growth Disorders – Ngenla - (IP0577)	Updated	Effective **7/1/2025** • Updated the Employer Plans preferred product requirements. • Updated the conditions not covered statement.
Growth Disorders – Skytrofa - (IP0375)	Updated	Effective **7/1/2025** • Updated the Employer Plans preferred product requirements.
Hemophilia – Alhemo - (IP0730)	Updated	Effective **7/15/2025** • Added documentation requirements throughout the policy. • Preferred Product Criteria – Employer Plans: ○ Updated preferred product criteria
Hemophilia – Hemlibra - (IP0121)	Updated	Effective **7/15/2025** • Added documentation requirements throughout policy.
Hemophilia – Hympavzi - (IP0731)	Updated	Effective **7/15/2025** • Preferred Product Criteria – Employer Plans: • Updated preferred product criteria • Removed "Approve if, according to the prescriber, there is concern for a drug-drug interaction (e.g., drug interaction with Hemlibra and Feiba" • Added documentation requirements throughout the policy.
Hemophilia – Qfitlia - (IP0742)	New	Effective **7/15/2025** • New policy
Hepatitis C – Harvoni Prior	New	Effective **7/1/2025**

Authorization Policy - (IP0735)		• New policy – replaces Ledipasvir/Sofosbuvir – (IP0186), which is being retired.
Hepatitis C – Vosevi Prior Authorization Policy - (IP0736)	New	Effective **7/1/2025** • New policy – replaces Sofosbuvir/Velpatasvir/Voxilaprevir – (IP0188), which is being retired.
Hepatitis C – Mavyret Prior Authorization for Preferred Specialty Management Policy - (IP0737)	New	Effective **7/1/2025** • New policy – replaces Glecaprevir/Pibrentasvir – (IP0187), which is being retired.
Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for Employer Plans - (PSM025)	New	Effective **7/1/2025** • New policy
Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for Individual and Family Plans - (PSM026)	New	Effective **7/1/2025** • New policy
Hepatitis C – Epclusa Prior Authorization	Updated	Effective **7/1/2025** • Added the following note to the policy, "NOTE: This product also requires the use of preferred products before approval of the requested product. Refer to

Policy - (IP0184)		the Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for Employer Plans (PSM025) for additional preferred product criteria requirements and exceptions." • For Employer Plans: removed and relocated the preferred product criteria to the *Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for Employer Plans* – (PSM025).
Hepatitis C – Sovaldi Prior Authorization Policy - (IP0157)	Updated	Effective **7/1/2025** • For Employer Plans: Added the following note to the policy, "NOTE: This product also requires the use of preferred products before approval of the requested product. Refer to the *Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for Employer Plans (PSM025)* for additional preferred product criteria requirements and exceptions".
Hepatitis C – Zepatier Prior Authorization Policy - (IP0158)	Updated	Effective **7/1/2025** • Added the following note to the policy: "NOTE: This product also requires the use of preferred products before approval of the requested product. Refer to the Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for Individual and Family Plans (PSM026) for additional preferred product criteria requirements and exceptions." • For Employer Plans: removed preferred product criteria requirements. • For Individual and Family Plans: relocated the preferred product related criteria to *Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for Individual and Family Plans – (PSM026).*
Hyperlipidemia – Nexletol - (IP0248)	Updated	Effective **7/15/2025** • Heterozygous Familial Hypercholesterolemia: For Initial Therapy, the phrase "phenotypic confirmation of heterozygous familial hypercholesterolemia" was

		replaced with "The diagnosis has been confirmed by genetic testing". Also, "apo B" was changed to "APOB".
Hyperlipidemia – Nexlizet - (IP0249)	Updated	Effective **7/15/2025** • Heterozygous Familial Hypercholesterolemia (HeFH): For Initial Therapy, the phrase "phenotypic confirmation of heterozygous familial hypercholesterolemia" was replaced with "The diagnosis has been confirmed by genetic testing". Also, "apo B" was changed to "APOB".
Immune Globulin - (IP5026)	Updated	Effective **7/1/2025** • Multiple Myeloma. ○ Updated criteria for use in recurrent infection ○ Added the following option for approval in initial therapy as an alternative to infection status 1) Patient will be starting, has taken, or is currently receiving chimeric antigen receptor (CAR)-T cell therapy OR bispecific antibody therapy. Note: Examples of CAR-T cell therapy includes: Abecma (idecabtagene vicleucel intravenous infusion), Carvykti (ciltacabtagene autoleucel intravenous infusion). Note: Examples of bispecific antibody therapy includes: Elrexfio (elranatamab-bcmm subcutaneous injection), Tecvayli (teclistamab-cqyv subcutaneous injection), Talvey (talquetamab-tgvs subcutaneous injection). ○ Added Dosing
Immunologicals – Cinqair - (IP0423)	Updated	Effective: **7/15/2025** • Asthma: Eosinophil level requirements were clarified to require a level ≥ 400 cells/microliter either within the previous 6 weeks OR prior to treatment with a monoclonal antibody that may alter eosinophil levels. Previously, criteria required a level ≥ 400 cells/microliter either within the previous 6 weeks OR

		within 6 weeks prior to treatment with a monoclonal antibody that may lower eosinophil levels. • Throughout the policy, Ebglyss (lebrikizumab-lbkz subcutaneous injection) and Nemluvio (nemolizumab-ilto subcutaneous injection) were added to notes as examples of monoclonal antibody therapies. • Added Ebglyss and Nemluvio as options/ examples of monoclonal antibody therapies that may alter blood eosinophil levels to "Notes" throughout policy.
Immunologicals – Dupixent - (IP0453)	Updated	Effective: **7/15/2025** • Chronic Spontaneous Urticaria (Chronic Idiopathic Urticaria): This condition and criteria for approval were added to the policy. New approval criteria for this indication were added that include an age requirement, a duration of symptom requirement, a trial of H_1 antihistamine therapy, and specialist involvement. • Conditions Not Covered, Peanut Allergy: Peanut allergy was added to the "Conditions Not Covered" section. • Added HCPCS Coding • Added C9399, J3490 and J3590
Immunologicals – Fasenra - (IP0421)	Updated	Effective: **7/15/2025** • Asthma. • Removed Ebglyss and Nemluvio as examples from monoclonal antibody therapies for asthma. • Conditions Not Recommended. • Chronic spontaneous urticaria was added as a Condition Not Recommended for Approval.
Immunologicals – Xolair - (IP0487)	Updated	Effective: **7/15/2025**

		• Chronic Spontaneous Urticaria (Chronic Idiopathic Urticaria): Approval condition was updated to "Chronic Spontaneous Urticaria (Chronic Idiopathic Urticaria)". Previously, this approval condition was listed as "Chronic Idiopathic Urticaria (Chronic Spontaneous Urticaria). The approval duration for this condition was changed from 4 months to 6 months. Criteria for a patient currently receiving Xolair was updated to apply to a patient who has already received at least 6 months of therapy with Xolair. Previously, these criteria applied to a patient who had received at least 4 months of therapy with Xolair. Criteria for a patient currently receiving Xolair was also updated to require that the patient has experienced a beneficial clinical response, defined as either decreased itch severity, decreased number of hives, or decreased size of hives. Previously, these criteria required the patient to have responded to therapy as determined by the prescriber.
Infectious Disease – Livtencity – (IP0394)	Updated	Effective **7/1/2025** • Cytomegalovirus Infection – Treatment: Approval for 2 months was added for a patient currently receiving Livtencity, if, according to the prescriber, the patient has responded to Livtencity, as demonstrated by cytomegalovirus polymerase chain DNA laboratory results within the past 4 weeks, demonstrating improvement in cytomegalovirus levels.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans - (PSM003)	Updated	Effective **7/15/2025** • For the Non-Preferred products, Abrilada, Amjevita, Hadlima, Hulio/ adalimumab-fkjp, Hyrimoz, Idacio/adalimumab-aacf, Yuflyma/adalimumab-aaty, Yusimry, removed "Patient is currently taking the requested adalimumab product for ≥ 120 days." • Adalimumab-adaz was moved from a Preferred Product to a Non-Preferred product. A patient is directed to a trial of Preferred Products with documentation requirements. Documentation is also required to support the requirement that formulation difference(s) in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or

		serious adverse reaction. Patients who are currently taking adalimumab-adaz are allowed an exception to the preferred product requirement.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy: Standard/ Performance, Value/Advantage, and Total Savings Prescription Drug Lists - (PSM013)	Updated	Effective **7/15/2025** • Adalimumab-adaz was moved from a Preferred Product to a Non-Preferred product. A patient is directed to a trial of Preferred Products with documentation requirements. Documentation is also required to support the requirement that formulation difference(s) in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Patients who are currently taking adalimumab-adaz are allowed an exception to the preferred product requirement.
Inflammatory Conditions – Cosentyx Subcutaneous Drug Quantity Management Policy – Per Days - (DQM002)	New	Effective **7/1/2025** • New policy.
Maralixibat - (IP0341)	Update	Effective **7/15/2025** • Progressive Familial Intrahepatic Cholestasis: • The criterion for age was changed from ≥ 12 years to ≥ 12 months of age to align with FDA indication expansion for age. • Added oral tablets to coverage policy. • Added "documentation required" as noted in criteria.

Methotrexate Injection Step Therapy Standard / Performance Drug List Plans - (ST0001)	New	Effective **7/1/2025** • New coverage policy.
Migraine – Reyvow - (IP0114)	Updated	Effective **7/1/2025** • Updated coverage policy title from L*asmiditan* to *Migraine – Reyvow*. • Relocated the triptan prerequisite requirements to preferred product boxes. • Added steps through Nurtec ODT and Ubrelvy to the Value/Advantage, Total Savings and Legacy Drug List Plans.
Migraine – Zavzpret - (IP0573)	Updated	Effective **7/1/2025** • Relocated the triptan prerequisite requirements to preferred product boxes. • Added steps through Nurtec ODT and Ubrelvy to the Standard/Performance Drug List Plans.
Nephrology – Filspari - (IP0565)	Updated	Effective **7/1/2025** • Primary Immunoglobulin A Nephropathy. • Added documentation requirements.
Nephrology – Tarpeyo - (IP0413)	Updated	Effective **7/1/2025** • Primary Immunoglobulin A Nephropathy. • Added documentation requirements. • Updated the conditions not covered statement.
Nephrology – Vanrafia - (IP0740)	New	Effective **7/1/2025**

		• New policy.
Neurology – Edaravone - (IP0176)	Updated	Effective: **7/1/2025** • Amyotrophic Lateral Sclerosis (ALS): The requirement that patients have been diagnosed with ALS for ≤ 2 years was removed. The requirement that "patient has a percent-predicted forced vital capacity (FVC) ≥ 80% (i.e., has normal respiratory function)" was changed to "according to the prescriber, patient has adequate respiratory function and does not require invasive ventilation." Dosing information for IV product only added.
Nonsteroidal Anti-inflammatory Drugs - (IP0457)	Updated	Effective **7/15/2025** • Removed Vimovo, naproxen/esomeprazole, Duexis, and ibuprofen/famotidine from policy.
Odactra - (IP0516)	Updated	Effective: **7/1/2025** • House Dust Mite-Induced Allergic Rhinitis. Criteria were updated to require the patient to be ≥ 5 years of age. Previously, criteria required the patient be ≥ 12 years of age. • Removed documentation from failure, contraindication or intolerance to covered alternatives criterion.
Oncology Medications - (1403)	Updated	Effective: 7/1/2025 Danziten. • Updated from "Patient meets ONE of the following: Patient is at risk of bleeding Note: An example of a patient with an increased risk of bleeding as if a patient has thrombocytopenia or is receiving a medication that inhibits platelet function or anticoagulants; Patient has a prolonged QT interval or is at risk of developing QT interval prolongation" to "Patient meets ONE of the following: Patient has a history of serious, chronic lung disease or has had or is at risk of

		pleural effusion; OR Note: Examples of lung disease are pulmonary arterial hypertension and interstitial pneumonitis; Patient is at risk of bleeding; OR Note: An example of a patient with an increased risk of bleeding is a patient with thrombocytopenia or with medication use that inhibits platelet function or anticoagulants." Opdivo Qvantig. • Added Opdivo Qvantig criteria Rituxan. • Removed "Currently receiving Rituxan" Ziihera. • Added 'may require prior authorization' to: trastuzumab plus Perjeta, trastuzumab plus Tukysa Effective: **7/15/2025** Anktiva. • Removed Anktiva criteria. Alymsys. • Removed "Currently receiving Alymsys" Avastin. • Removed "Currently receiving Avastin" Vegzelma • Removed "Currently receiving Vegzelma"

Oncology (Intravesicular) – Adstiladrin - (IP0579)	Updated	Effective: **7/15/2025** • Updated title from "Oncology (Other) – Adstiladrin" to "Oncology (Intravesicular) – Adstiladrin • Non-Muscle Invasive Bladder Cancer: For the requirement that the patient has carcinoma in situ, removed "with or without high-grade papillary Ta/T1tumors".
Ophthalmology - Gene Therapy - Encelto (IP0744)	New	Effective: **7/15/2025** • New policy
Pain – Journavx Drug Quantity Management Policy – Per Days (DQM004)	New	Effective **7/1/2025** • New policy
Pharmacy and Medical Prior Authorization (1407)	Updated	Effective: **7/1/2025** • Added Individual and Family Plan product-specificmedical necessity criteria: Angeliq, Duavee, Premphase, Prempro, Veltassa, Onapgo, Xromi, GlucaGen, GlucaGen Hypokit, Gvoke, Zegalogue, Twiist, Fulvicin P/G, griseofulvin ultramicrosize 165mg, Journavx, Tezruly, metaxolone, clobetasol propionate cream, Zunveyl, Inzirqo, meclizine, ferric citrate, Auryxia, Raldesy, Auranofin, Ridaura, Aptiom, Briviact, carbamazepine chewable, Elepsia XR, Eprontia, Fycompa, Motpoly XR, Oxtellar XR, oxcarbazepine ER, Spritam, topiramate, Trokendi XR, Zonisade, Kristalose, lactulose, halcinonide, • Updated Individual and Family Plan product-specific medical necessity criteria: Furoscix, Bijuva, Xcopri

Prader-Willi Syndrome – Vykat XR (IP0741)	New	Effective **7/1/2025** • New policy
Quantity Limitations - (1201)	Updated	Effective **7/1/2025** • Removed Cosentyx from the policy.
Rituximab for Non-Oncology Indications - (IP0319)	Updated	Effective: **7/1/2025** Preferencing Product Table. • Removed "Individual has previously started on or is currently receiving Rituxan (rituximab)
Somapacitan - (IP0576)	Updated	Effective **7/1/2025** • Updated the Employer Plans preferred product requirements.
Somatostatin Analogs – Octreotide Immediate-Release Products - (IP0490)	Updated	Effective **7/15/2025** • Added a note to provide examples of Grade 3 or Grade 4 diarrhea.
Somatostatin Analogs – Octreotide Long-Acting Products - (IP0489)	Updated	Effective **7/15/2025** • Added a note to provide examples of Grade 3 or Grade 4 diarrhea.
Somatropin - (IP0452)	Updated	Effective **7/15/2025** • Removed Zorbtive from the policy (obsolete).

		• Non-Growth Hormone Deficient Short Stature (Idiopathic Short Stature) in a Child or Adolescent: A criterion was added for initial therapy that the medication has been prescribed by or in consultation with an endocrinologist. • Growth Hormone Deficiency in Adult or Transition Adolescent: The criterion "Patient (adult onset or transition adolescent) has three or more of the following pituitary hormone deficiencies:." was updated to "Patient (adult onset or transition adolescent) has or had three or more of the following pituitary hormone deficiencies prior to hormone replacement therapy (if hormone therapy if required)". The criterion "The age and gender adjusted serum insulin-like growth factor-1 is below the lower limit of the normal reference range for the reporting laboratory" was updated to "The age and gender adjusted serum insulin-like growth factor-1 is or was below the lower limit of the normal reference range for the reporting laboratory (…), prior to growth hormone therapy". • Noonan Syndrome in a Child or Adolescent: The criterion "Noonan syndrome has been confirmed with genetic testing" was updated to "Noonan syndrome has been confirmed by a heterozygous pathogenic variant in BRAF, KRAS, MAP2K1, MRAS, NRAS, PTPN11, RAF1, RASA2, RIT1, RRAS2, SOS1, or SOS2 OR by either a heterozygous variant or biallelic pathogenic variants in LZTR1." • Prader-Willi Syndrome: The criterion "The diagnosis of Prader-Willi syndrome has been confirmed by genetic testing" was updated to "The diagnosis of Prader-Willi syndrome has been established by identification of abnormal DNA methylation of chromosome 15q11.2-q13." • Human Immunodeficiency Virus Infection with Wasting or Cachexia in an Adult: Removed the criterion "If the patient has previously received treatment with Serostim for this use, patient has been off Serostim therapy for at least 1 month." • Updated the wording of "buffalo hump" was updated to "dorsocervical fat pad." • Updated the conditions not covered statement.

Step Therapy Individual and Family Plan - (1603)	Updated	Effective **7/1/2025** • Added Insulin Aspart Pro Mix 70-30 Pen as an Insulin, short-acting Step 2 product.
Teriparatide - (IP0330)	Updated	Effective 7**/1/2025** Chronic Hypoparathyroidism**:** • This condition of approval was removed.
Thrombocytopenia – Eltrombopag Products - (IP0153)	Updated	Effective **7/15/2025** Thrombocytopenia in a Patient Due to Immune Checkpoint Inhibitor Therapy: • This condition and criteria for approval were added to the policy for Promacta and Alvaiz. It was noted in the policy that Promacta (both tablets and oral suspension) are available as generics. Also, the following change was made Thrombocytopenia in a Patient Post-Allogeneic Transplantation: • For Alvaiz, for initial approval, the duration of therapy was changed from 6 months to 3 months.
Thrombocytopenia – Nplate - (IP0155)	Updated	Effective **7/15/2025** Thrombocytopenia in a Patient Due to Immune Checkpoint Inhibitor Therapy: • This condition and criteria for approval were added to the policy for Nplate, as well as Dosing.
Weight Loss – Appetite Suppressants and Orlistat - (IP0420)	Updated	Effective **7/1/2025** • Lomaira added to the policy.

		Phentermine Preferred Product Table • Added criteria for Lomaira.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 30 - (IP0206)	Updated	Effective **7/1/2025** • Policy title changed from" Weight Loss – Glucagon-Like Peptide-1 Agonists" to "Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 30" • The Conditions Not Covered statement was reworded.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 32 - (IP0621)	Updated	Effective **7/1/2025** • Policy title changed from" Weight Loss – Glucagon-Like Peptide-1 Agonists Benefit Exclusion Overrides Policy" to "Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 32" • The Conditions Not Covered statement was reworded.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ - 35 – IP0739	New	Effective **7/1/2025** • New policy
Antiseizure Medications – Fintepla - (IP0042)	Updated	Effective: **7/15/2025** • No change in coverage
Antiseizure Medications – Vigabatrin - (IP0049)	Updated	Effective: **7/15/2025** • No change in coverage
Cushing's – Recorlev - (IP0389)	Updated	Effective: **7/1/2025** • No change in coverage

Cushing's - Signifor - (IP0482)	Updated	Effective: **7/1/2025** • No change in coverage
Cystic Fibrosis – Pulmozyme - (IP0483)	Updated	Effective: **7/1/2025** • No change in coverage
Cystic Fibrosis Transmembrane – Conductance Regulator – Trikafta - (IP0434)	Updated	Effective: **7/15/2025** • No change in coverage
Eliglustat - (IP0441)	Updated	Effective **7/15/2025** • No change in coverage
Enspryng - (IP0078)	Updated	Effective: **7/1/2025** • No change in coverage
Enzyme Replacement Therapy – Aldurazyme (IP0445)	Updated	Effective: **7/15/2025** • No change in coverage
Enzyme Replacement Therapy – Elaprase (IP0444)	Updated	Effective: **7/15/2025** • No change in coverage
Enzyme Replacement	Updated	Effective: **7/15/2025**

Therapy – Fabrazyme (IP0406)		• No change in coverage
Enzyme Replacement Therapy – Kanuma (IP0448)	Updated	Effective: **7/15/2025** • No change in coverage
Enzyme Replacement Therapy – Mepsevii - (IP0449)	Updated	Effective: **7/15/2025** • No change in coverage
Enzyme Replacement Therapy – Naglazyme - (IP0443)	Updated	Effective: **7/15/2025** • No change in coverage
Enzyme Replacement Therapy – Sucraid - (IP0447)	Updated	Effective: **7/15/2025** • No change in coverage
Enzyme Replacement Therapy – Vimizim - (IP0442)	Updated	Effective: **7/15/2025** • No change in coverage
Gastroenterology – Gimoti - (IP0085)	Updated	Effective: **7/1/2025** • No change in coverage
Gaucher Disease – Substrate Reduction Therapy – Miglustat - (IP0446)	Updated	Effective: **7/15/2025** • No change in coverage
Gonadotropin-Releasing Hormone	Updated	Effective: **7/15/2025**

Antagonists – Myfembree- (IP0205)		• No change in coverage
Gonadotropin-Releasing Hormone Antagonists – Oriahnn - (IP0087)	Updated	Effective: **7/15/2025** • No change in coverage
Gonadotropin-Releasing Hormone Antagonists – Orilissa (IP0196)	Updated	Effective: **7/15/2025** • No change in coverage
Hyperhidrosis – Sofdra - (IP0703)	Updated	Effective: **7/15/2025** • No change in coverage
Immunologicals – Nucala - (IP0422)	Updated	Effective: **7/15/2025** • No change in coverage
Inflammatory Conditions – Ilumya Prior Authorization Policy – (IP0659)	Updated	Effective: **7/1/2025** • No change in coverage
Inflammatory Conditions – Otezla Prior Authorization Policy – (IP0666)	Updated	Effective: **7/15/2025** • No change in coverage
Inflammatory Conditions – Siliq Prior Authorization Policy – (IP0685)	Updated	Effective: **7/1/2025** • No change in coverage

Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy – (IP0667)	Updated	Effective: **7/1/2025** • No change in coverage
Inflammatory Conditions – Taltz Prior Authorization Policy – (IP0688)	Updated	Effective: **7/1/2025** • No change in coverage
Interferon – Actimmune - (IP0201)	Updated	Effective: **7/15/2025** • No change in coverage
Metabolic Disorders – Nulibry - (IP0142)	Updated	Effective: **7/1/2025** • No change in coverage
Methotrexate for Injection - (IP0411)	Updated	Effective: **7/1/2025** • No change in coverage
Migraine – Calcitonin Gene-Related Peptide Inhibitors – Aimovig – (IP0503)	Updated	Effective: **7/1/2025** • No change in coverage
Migraine – Calcitonin Gene-Related Peptide Inhibitors – Ajovy – (IP0504)	Updated	Effective: **7/1/2025** • No change in coverage

Migraine – Calcitonin Gene-Related Peptide Inhibitors – Emgality – (IP0505)	Updated	Effective: **7/1/2025** • No change in coverage
Migraine – Calcitonin Gene-Related Peptide Inhibitors – Vyepti - (IP0506)	Updated	Effective: **7/1/2025** • No change in c • overage
Migraine – Elyxyb - (IP0640)	Updated	Effective: **7/1/2025** • No change in coverage
Muscular Dystrophy – Duvyzat – (IP0651)	Updated	Effective: **7/1/2025** • No change in coverage
Mycapssa - (IP0491)	Updated	Effective: **7/15/2025** • No change in coverage
Neurology – Brineura – (IP0175)	Updated	Effective: **7/1/2025** • No change in coverage
Neurology – Lyrica CR - (IP0183)	Updated	Effective: **7/1/2025** • No change in coverage

Neurology – Skyclarys – (IP0566)	Updated	Effective: **7/1/2025** • No change in coverage
Ophthalmology – Dry Eye Disease – Tyrvaya for Individual and Family Plans - (IP0395)	Updated	Effective: **7/15/2025** • No change in coverage
Ophthalmology – Dry Eye Disease – Xiidra for Individual and Family Plans – (IP0644)	Updated	Effective: **7/15/2025** • No change in coverage
Pompe Disease – Enzyme Replacement Therapy – Lumizyme - (IP0440)	Updated	Effective: **7/15/2025** • No change in coverage
Pompe Disease – Enzyme Replacement Therapy – Nexviazyme - (IP0279)	Updated	Effective: **7/15/2025** • No change in coverage
Repository Corticotropin – Acthar Gel - (IP0178)	Updated	Effective: **7/15/2025** • No change in coverage
Repository Corticotropin -	Updated	Effective: **7/15/2025**

Cortrophin Gel - (IP0374)		• No change in coverage
Somatostatin Analogs – Signifor LAR – (IP0165)	Updated	Effective: **7/15/2025** • No criteria change.
Vijoice - (IP0481)	Updated	Effective: **7/15/2025** • No criteria change.
Botulinum Toxins - (IP1106)	Retired	Effective: **7/15/2025** • Botox supported in IP0637; Dysport supported in IP0638; Xeomin supported in IP0639
Glucagon Products - (IP0039)	Retired	Policy retired effective **7/1/2025** • Glucagon Emergency Kit, GlucaGen HypoKit, Gvoke HypoPen Auto-Injector, Kit, or Prefilled Syringe, and Zegalogue relocated to CP #1602 - Drugs Requiring Medical Necessity Review for Employer Plans
Lybalvi - (IP0368)	Retired	Policy retired effective **7/1/2025**
Methotrexate for Injection - (IP0411)	Retired	Policy retired effective **7/1/2025**
Otic Antibiotics - (IP0366)	Retired	Policy retired effective **7/1/2025** • Cetraxal relocated to CP #1602 - Drugs Requiring Medical Necessity Review for Employer Plans
CareAllies Medical Necessity Guideline	**New, Updated,**	**Comments**

	or Retired?	
		• All above updates apply
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
Precertification Policies	Updates	**Effective 1/1/25** • 58 New Codes released by CMS/AMA were added to precertification.
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Ambulance Services - (R18)	Updated	• Notification: **Effective 10/11/2025** Cigna will Align with the Center of Medicare and Medicaid Services (CMS) for reporting requirements for ambulance services.
Evaluation and Management Coding and Accuracy - (R49)	New	• Notification: **Effective 10/01/2025** Cigna has developed a new reimbursement policy, Cigna may adjust the E/M CPT® code 99204- 99205, 99214-99215, 99244-99245 to a single level lower when the encounter criteria on the claim does not support the higher level E/M CPT® code reported.
Facility Services, Supplies, and Equipment - (R12)	Updated	• Notification: **Effective 10/01/2025**, language removed that pertains to claim reporting and/or billing errors as it is duplicative to existing language in the Coding and Billing Accuracy (R46) reimbursement policy.
DRG Readmission - (R35)	Updated	• Effective date **07/01/2025** for readmission timeline update from 72 hours to 30 days,

		• Removed notification banner and clarified language related to the admitting and principal diagnosis.
Precertification - (R21)	Update	• Policy was reviewed and clarifying language added.
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No updates for July 2025
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
Code Editing Policy and Guidelines	Updated	• Changes made to the Code Editing Policy and Guidelines July 11, 2025.