



## **Sentara Health Plans Medical and Clinical Policy Updates**

**Effective August 1, 2026**

Sentara Health Plans would like to notify you of the following medical policy updates made since the last version of **Provider News**.

You can access all current Sentara Health Plans medical policies at [sentarahealthplans.com](https://sentarahealthplans.com).

You can link directly to Sentara Health Plans current Prior Authorization List (PAL) at [pal.sentarahealthplans.com](https://pal.sentarahealthplans.com).


For the most current, comprehensive review of the proceedings from Sentara Health Plans' pharmacy and therapeutics committee, please view the [Quarterly Pharmacy Changes](#) to see Formulary and Authorization updates.

### **Medical Policies**

The Medical Policy Committee (MPC) approved the following Medical Policies applicable to Sentara Health Plans. These medical policies take effect August 1, 2026.

<b>Policy Number</b>	<b>Policy Name</b>	<b>Status</b>	<b>Applicable Service Lines</b>
Surgical 10	Breast Procedures	Revised	Commercial and Medicaid
DME 14	High Frequency Chest Wall Compression	Revised	Commercial and Medicaid
Medical 173	Dry Needling	Revised	Commercial and Medicaid
Medical 336	Category III Codes	Revised	Commercial and Medicaid
Medical 351	Radiation Treatment for Nononcologic Indications	Revised	Commercial and Medicaid
Surgical 117	Cervical Fusion Procedures	Reviewed	Commercial and Medicaid
Surgical 235	Embolization Treatments	Revised	Commercial and Medicaid
DME 241	Negative Pressure Wound Vac	Reviewed	Commercial and Medicaid
BH 24	Mental Health Skill-Building (MHSS)	Reviewed	Medicaid
BH 28	Assertive Community Treatment (ACT)	Reviewed	Medicaid
BH 29	Mental Health Intensive Outpatient Services (MH-IOP)	Reviewed	Medicaid
BH 35	Multisystemic Therapy	Reviewed	Medicaid
BH 36	Functional Family Therapy	Reviewed	Medicaid
Medical 112	Mobile Cardiac Telemetry	Reviewed	Commercial and Medicaid


Medical 128	Apheresis	Archived	Commercial and Medicaid
BH 27	Sensory-Weighted Vest	Reviewed / Archived	Medicaid and Medicare Archive – Commercial
BH 18	Intensive in-Home Service for Youth	Reviewed	Medicaid
BH 19	Mental Health Peer Support Services	Reviewed	Medicaid
BH 20	Therapeutic Day Treatment (TDT) for Youth	Reviewed	Medicaid
BH 21	Psychosocial Rehabilitation	Reviewed	Medicaid
BH 22	Mental Health Case Management	Reviewed	Medicaid
BH 23	Mental Health Family Support Partners	Reviewed	Medicaid

Policy Number	Policy Name	Status	Applicable Service Lines
 Q2 Executive Summary <b>Avalon Policy Updates</b>			
F2019	Flow Cytometry (RTM)	Reviewed	Commercial and Medicaid
G2008	Prostate Specific Antigen (PSA) Testing (RTM)	Revised	Commercial and Medicaid
G2031	Allergen Testing (RTM)	Revised	Commercial and Medicaid
G2045	Thyroid Disease Testing (RTM)	Revised	Commercial and Medicaid

G2050	Cardiovascular Disease Risk Assessment (RTM)	Revised	Commercial and Medicaid
G2059	Epithelial Cell Cytology in Breast Cancer Risk Assessment (RTM)	Revised	Commercial and Medicaid
G2125	Urinary Tumor Markers for Bladder Cancer (RTM)	Reviewed	Commercial and Medicaid
G2138	Evaluation of Dry Eyes (RTM)	Reviewed	Commercial and Medicaid
G2164	Parathyroid Hormone, Phosphorus, Calcium, and Magnesium Testing (RTM)	Revised	Commercial and Medicaid
T2015	Prescription Medication and Illicit Drug Testing in the Outpatient Setting (RTM)	Revised	Commercial
G2181	Colorectal Cancer Screening (RTM)	Reviewed	Commercial and Medicaid
G2022	Biomarker Testing for Autoimmune Rheumatic Disease (RTM)	Reviewed	Commercial and Medicaid
G2036	Hepatitis Testing (RTM)	Revised	Commercial and Medicaid
G2099	Micronutrient Testing (Previously titled Intracellular Micronutrient Analysis) (RTM)	Revised	Commercial and Medicaid
G2124	Serum Tumor Markers for Malignancies (RTM)	Revised	Commercial and Medicaid
G2143	Lyme Disease Testing (RTM)	Revised	Commercial and Medicaid
G2153	Pancreatic Enzyme Testing for Acute Pancreatitis (RTM)	Revised	Commercial and Medicaid

G2157	Diagnostic Testing of Common Sexually Transmitted Infections (RTM)	Revised	Commercial and Medicaid
M2057	Diagnosis of Vaginitis (RTM)	Revised	Commercial and Medicaid
M2116	Human Immunodeficiency Virus (HIV) (RTM)	Revised	Commercial and Medicaid
G2042	Pediatric Preventive Screening (RTM)	Reviewed	Commercial and Medicaid
G2044	Helicobacter Pylori Testing (RTM)	Reviewed	Commercial and Medicaid
G2154	Folate Testing (RTM)	Reviewed	Commercial and Medicaid
M2172	Onychomycosis Testing (RTM)	Reviewed	Commercial and Medicaid
G2120	Salivary Hormone Testing (RTM)	Reviewed	Commercial and Medicaid
M2024	Genetic Testing for Polyposis Syndromes (GTM)	Revised	Commercial and Medicaid
M2041	Venous and Arterial Thrombosis Risk Testing (GTM)	Revised	Commercial and Medicaid
M2101	Mutation Analysis in Myeloproliferative Neoplasm (GTM)	Revised	Commercial and Medicaid
M2171	Esophageal Pathology Testing (GTM)	Revised	Commercial and Medicaid
M2176	Testing for Developmental Delay (GTM)	Revised	Commercial and Medicaid

M2177	Fibromyalgia Testing (GTM)	Reviewed	Commercial and Medicaid
M2085	Genetic Testing of Mitochondrial Disorders (GTM)	Reviewed	Commercial and Medicaid
M2020	Molecular Diagnostics for Breast Cancer Prognosis (GTM)	Revised	Commercial and Medicaid
M2144	Genetic Testing for Connective Tissue Disorder (GTM)	Reviewed	Commercial and Medicaid
M2039	Pre-Implantation Genetic Testing (GTM)	Reviewed	Commercial and Medicaid
M2166	Gene Expression Profiling and Protein Biomarkers for Prostate Cancer (GTM)	Revised	Commercial and Medicaid
G2148	Genetic Testing for Hereditary Hearing Loss (GTM)	Reviewed	Commercial and Medicaid
M2021	Pharmacogenetic Testing (GTM)	Reviewed	Commercial and Medicaid
M2108	Molecular Markers in Fine Needle Aspirates of the Thyroid (GTM)	Reviewed	Commercial and Medicaid

RTM Policies		
Policy Title	Coding changes	Rationale of Coverage Criteria (CC) Changes with Enforcement Changes to Avalon Base Policy (please note that this document is intended for use as a summary; please refer to the base policy as the source of truth for all policy changes)
 Q2 2026 Executive Summary.docx Coverage criteria changes; no coding changes		
F2019 – Flow Cytometry	No CPT code Changes	N/A – See Avalon base policy for applicable literature and guideline updates. See redlined Avalon Base Policy for clarity and consistency edits.
G2008 – Prostate Specific Antigen (PSA) Testing	No CPT codes changes	<p>Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria: CC1 edited for clarity, added “initial”, now reads: “1) For average-risk individuals 45 years of age and older (see Note 1), initial screening for prostate cancer with the total prostate-specific antigen (PSA) test MEETS COVERAGE CRITERIA.”</p> <p>Based on NCCN guideline updates to recommendations for percent free PSA, updates made to CC4 and CC5:</p> <p>CC4 edited to remove percent free PSA as a standard follow up, and moved subcriteria into new Note 2.</p> <p>Now reads: “4) For individuals who have elevated PSA (see Note 2) or a suspicious DRE, a follow-up in 6-12 months with total PSA MEETS COVERAGE CRITERIA.”</p> <p>CC5, removed reference to “higher risk despite negative biopsy” and changed to “who had an initial negative biopsy”, now reads: “5) For</p>

		<p>individuals who have elevated total PSA and who had an initial negative biopsy, follow-up testing (no more often than follow-up total PSA) with percent free PSA MEETS COVERAGE CRITERIA.”</p> <p>For clarity, CC7.b. was divided and complexed PSA is now in CC7.c., now reads: “7) The following testing DOES NOT MEET COVERAGE CRITERIA:</p> <ul style="list-style-type: none"> <li>a) Percent free PSA as a first-line screening test for prostate cancer.</li> <li>b) Percent free PSA or free-to-total PSA ratio for the routine screening of prostate cancer.</li> <li>c) Complexed PSA testing.”</li> </ul> <p>New Note 2 to define elevated PSA.</p>
G2031 – Allergen Testing	No CPT code changes	<p>Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria:</p> <p>New CC4: “4) When performed on the same day as skin prick testing, specific IgE in-vitro allergy testing DOES NOT MEET COVERAGE CRITERIA”</p>
G2045 – Thyroid Disease Testing	No CPT code changes	<p>Reviewed and Updated: Updated background, guidelines, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria:</p> <p>CC1: Edited and divided into multiple criteria to create a cascade approach for TSH vs fT4/fT3/TT3. All situations and conditions for which TSH is appropriate as the first line test remain in CC1 with indicated frequency of testing.</p> <p>New CC2 (follow up testing for abnormal TSH results), new CC3 (monitoring of TSH and fT4 when conditions allow for initial monitoring</p>

		<p>of fT4 without requiring abnormal TSH), and new CC4 (monitoring of fT4 without additional measurement of TSH for secondary hypothyroidism) Former CC2 is now CC3.a. Former CC3, now CC5, edited for clarity Former CC4, now CC6, added “who have not been diagnosed with autoimmune thyroid disease (e.g., Hashimoto disease, Graves disease)” Former CC6, now CC8, edited to only include TBG, TRH, and reverse T3 intake, which never meet CC. Now reads: “8) Testing for thyroxine-binding globulin (TBG), thyrotropin-releasing hormone (TRH), reverse T3, or T3 uptake DOES NOT MEET COVERAGE CRITERIA.” Former CC8, CC9, and CC10 combined and edited into new CC9, which summarizes that thyroid markers already addressed within the policy are not allowed for indications already addressed. CC9 now reads: “9) For all other situations not mentioned above, testing for any thyroid function markers discussed in this policy (e.g., testing for thyroid dysfunction during a general exam without abnormal findings) DOES NOT MEET COVERAGE CRITERIA.”</p>
G2050 – Cardiovascular Disease Risk Assessment	No CPT code Changes	<p>Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review necessitated the following changes to coverage criteria: As risk factors (not general screening) are age dependent, “For individuals 18 years of age or older” removed from CC1. CC1.a.i. Changed “Every 4 years” to “Every 5 years” based on NLA updates CC1.a.ii., for clarity, added “10-year ASCVD risk cannot be calculated for individuals 39 years of age or younger.” Moved CC1.d. into CC1.b. annual testing based on elevated risk of dyslipidemia, as the long-term drug therapy is elevating their risk of dyslipidemia. 2025 NLA update</p>

		<p>results in addition of CC1.b.xiii., 1.b.xiv., and 1.b.xv.: “xiii) Family history of elevated lipids xiv) Premature heart disease xv) History of stroke” CC1.c., added “therapy (i.e., individuals with hyperlipidemia, transplant patients)” CC1.c.iii, annual recommendation changed to “iii) Every three to twelve months as clinically indicated.” based on 2025 NLA updates CC2, added “(no more than once every four weeks)” frequency based on 2024 NLA guideline. Removed CC4 allowing hs-CRP, as 2025 VA/DoD guideline update recommending against its general use, along with statements from USPSTF and weaker general support for hs-CRP. Removal of CC4 results in changes to former CC5, now CC4, now reads: “4) For cardiovascular disease risk assessment, CRP testing (conventional measurement or high-sensitivity measurement) DOES NOT MEET COVERAGE CRITERIA.”</p> <p>Former CC8, now CC7, added “myeloperoxidase” CC10, Lp-PLA2 is never supported, resulting in removal of “For CVD risk assessment”, as this test should never approve.</p>
G2059 - Epithelial Cell Cytology in Breast Cancer Risk Assessment	No CPT code changes	<p>Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review necessitated the following changes to coverage criteria: Edits made to CC1 for clarity on the situations where epithelial cell cytology is not supported, CC1 now reads: “1) Cytologic analysis of epithelial cells (e.g., nipple aspiration, fine-needle aspiration [FNA]) to diagnose, to screen for, or to assess risk of developing breast cancer DOES NOT MEET COVERAGE CRITERIA.”</p>
G2125 – Urinary Tumor Markers	No CPT code changes	<p>N/A – See Avalon base policy for applicable literature and guideline updates. See redlined Avalon Base Policy for clarity and consistency edits.</p>

for Bladder Cancer		
G2138 – Evaluation of Dry Eyes	No CPT code changes	N/A – See Avalon base policy for applicable literature and guideline updates. See redlined Avalon Base Policy for clarity and consistency edits.
G2164 – Parathyroid Hormone, Phosphorus, Calcium, and Magnesium Testing	No CPT code changes	Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria: CC1 added “hormone” to “serum intact parathyroid hormone” CC1.b. edited for clarity and consistency CC1 subcriteria reordered so that testing frequencies are grouped together. Results in the following changes: Former CC1.e. becomes CC1.g.; Former CC1.g. becomes CC1.h.; Former CC1.h. becomes CC1.f. Former CC1.g., now CC1.h., frequency changed from “one time testing” to “annual testing” based on NCCN guidance. CC2 removed “parathyroid” as the PTH initialism has already been defined. Edited to clarify that PTH testing is not allowed for any conditions not described in CC1 (asymptomatic or otherwise). Removed CC3.e. as PTH’s inclusion in CC3 becomes redundant with changes to CC2 language.
T2015 – Prescription Medication and Illicit Drug Testing in the Outpatient Setting	No CPT code changes	Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review did not necessitate any modifications to coverage criteria. The following changes were made for clarity and consistency: Added “(no more than 24 times per year)” to CC1 and CC2 for clarity and transparency on the number of tests allowed in a year to align with the clinical guidance further laid out within the criteria
No coverage criteria changes; coding changes		

G2181 – Colorectal Cancer Screening	Added 87626	N/A – See Avalon base policy for applicable literature and guideline updates.
Coverage criteria changes; coding changes		
G2022 – Biomarker Testing for Autoimmune Rheumatic Disease	Added PLA code 0522U	N/A – See Avalon base policy for applicable literature and guideline updates. See redlined Avalon Base Policy for clarity and consistency edits.
G2036 – Hepatitis Testing	Removing CPT code 87799	<p>Reviewed and Updated: Updated background, guidelines, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria:</p> <p>While the CDC refers to measurement of HBsAg, anti-HBs, and anti-HBc testing as “triple panel testing”, this language is not common and could potentially cause confusion. Results in changes to CC1 and CC2.b., removing broad “triple panel testing” language and just specifying that HBsAg, anti-HBs, and anti-HBc testing are the primary three biomarkers used for most HBV antibody screening.</p> <p>Update to CDC recommendations for PrEP include Hep B screening; moving from the STI policy to the hepatitis policy for consistency in management. Results in new CC2.b.xv: “xv) For individuals who are about to begin or who are receiving pre-exposure prophylaxis (PrEP).”</p> <p>For consistency in management, moving prenatal hepatitis testing recommendations from the prenatal policy to the hepatitis policy, results in new CC3 and CC10: “3)For pregnant individuals, HBsAg, anti-HBs, and anti-HBc testing for HBV MEETS COVERAGE CRITERIA.” New</p>

		CC10: “10) For pregnant individuals, antibody testing for HCV MEETS COVERAGE CRITERIA.”
G2099 – Micronutrient Testing (Previously titled Intracellular Micronutrient Analysis)	Removed CPT code 82607,82652, 82725, 82746, 84999, 86353, 88348	Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review did not necessitate any modifications to coverage criteria. The following changes were made for clarity and consistency: Title changed from “Intracellular Micronutrient Analysis” to “Micronutrient Testing” New CC1 to align with enforcement of micronutrient codes within policy: “1) Serum micronutrient testing as a general screen for nutritional disorders DOES NOT MEET COVERAGE CRITERIA.”
G2124 - Serum Tumor Markers for Malignancies	Remove CPT code 81479, 81599, 83789, 84078, 84080, 84703, 84999	Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Based on guidance from the National Comprehensive Cancer Network’s Biomarker’s Compendium, the following coverage additions and removals were made: Clinical recommendations for almost all indications for almost all biomarkers were adjusted to reflect current recommendations in NCCN guidelines (e.g., for ALP testing for bone neoplasms, added “for osteosarcoma”) For BNP/NT-proBNP, added SLCA indications for testing based on NCCN compendium updates For calcitonin, CEA, and inhibin, removed “occult primary” recommendations, as the NCCN recommends these as an IHC marker for occult primary, not as a serum biomarker. For CA-125, removed “peritoneal mesothelioma” and “Lynch syndrome”, as the NCCN no longer includes it as a recommended biomarker in the compendium
G2143 – Lyme Disease Testing	Added PLA code 0615U (effective date 4/1/2026)	Reviewed and Updated: Updated background, guidelines, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria:

		<p>Combined the contents of CC1 (symptomatic for Lyme disease) into CC2 (extreme conditions potentially caused by undiagnosed Lyme), results in addition of new a. and b. subcriteria to former CC2, now CC1: “a) For individuals with early signs and symptoms of untreated Lyme disease (see Note 1) who have a known tick exposure or a known environmental exposure (e.g., outdoor activities, contact with wildlife). b) For individuals with later signs and symptoms of untreated Lyme disease (see Note 1) who may or may not have a known tick exposure.” New CC2: “2) When symptoms persist for individuals who tested negative by serologic testing, repeat serologic testing (no sooner than four weeks after previous test) MEETS COVERAGE CRITERIA.” CC3.a. replaced reference to endemic regions with “(see Note 1). CC3.b., changed “patients” to “individuals” for consistency and removed “living in endemic areas” as no asymptomatic individuals should be screened for Lyme disease. Removed former subcriteria 3.c. (testing for nonspecific symptoms), as signs and symptoms and when nonspecific symptoms can be used are now defined in CC1 and new Note 1. Former subcriteria 3.d-h are now subcriteria beneath new CC4.c. “c) For individuals presenting solely with one of the following without additional signs or symptoms of Lyme disease:” New Note 1 to define signs/symptoms of early and late untreated Lyme disease and note that individuals presenting with EM should be clinical diagnosed and treated without a need for laboratory testing.</p>
G2153 – Pancreatic Enzyme Testing	Added CPT code 86141	Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature

for Acute Pancreatitis		<p>review did not necessitate any modifications to coverage criteria. The following edits were made for clarity:</p> <p>CC2.a. and CC2.c. are repetitious with former CC7, now CC5, and frequency of testing can be addressed in CC1. Results in removal of CC2 and addition of “(no more than one test per day in the outpatient setting)” to CC1. Now reads: “1) For individuals presenting with signs and symptoms of acute pancreatitis (see Note 1), measurement of serum lipase (no more than one test per day in the outpatient setting) MEETS COVERAGE CRITERIA.”</p> <p>Former CC3, now CC2, removed “serum”, as this contradicts the intent of measuring amylase from the pancreatic cyst fluid. With this change, all other types of amylase testing, including urinary, are DNMCC, which results in the removal of former CC6.</p>
G2157 – Diagnostic Testing of Common Sexually Transmitted Infections	<p>Added CPT code 87140, 87270, 87285, 87320, 87660, 87810</p> <p>Remove CPT code 86704, 86706, 87340, G0499</p>	<p>Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review necessitated the following changes to coverage criteria: Moving prenatal STI screening from the Prenatal Screening policy into this policy. Results in the addition of CC2.a., 5.e., 6.a., and 10.a.; change to 5.d. 2.a.: “a) For pregnant individuals as part of the first prenatal visit.” 5.d.: added “for non-pregnant individuals” 5.e.: “e) At least four weeks after initial chlamydial diagnosis as a TOC for pregnant individuals.” 6.a.: “a) For pregnant individuals 24 years of age or younger as part of the first prenatal visit.” 10.a.: “a) For pregnant individuals 24 years of age or younger as part of the first prenatal visit.”</p> <p>New CC3: “3) For individuals who are currently diagnosed with a syphilis infection or who have a past history of a syphilis infection, treponemal Ig testing DOES NOT MEET COVERAGE CRITERIA.” Former CC3, now CC4:</p>

		<p>Addition of antigen testing, now reads: “4) Polymerase chain reaction (PCR) testing, nucleic acid amplification testing (NAAT), and antigen testing for syphilis DO NOT MEET COVERAGE CRITERIA.” Former CC6, now CC7: Addition of culture testing, changing “serology” to “antibody and antigen testing”, now reads: “7) Culture testing, antibody testing, and antigen testing for chlamydia or LGV DO NOT MEET COVERAGE CRITERIA.” Former CC7.c., now CC8.c., replaced “As a TOC for treatment” with “c) At least three months after initial gonorrhea diagnosis as a TOC.” Former CC12, now CC13, fixed reference to note with M. genitalium symptoms (typo indicated Note 8, fixed to reference Note 9). Former CC13, now CC14, removed reference to note, as symptoms are addressed in CC13 and don’t need addressed here in CC14 Reordered former CC16 and CC17 so HSV criteria that MCC are first, followed by the HSV CC that DNMCC. CC17 changed “serologic” to “antibody” for clarity Former CC16, now CC18, replaced “immunoassay” with “antibody and antigen” for clarity on HSV-1 testing and added “antigen testing for HSV-2”, now reads: “18) Antibody and antigen testing for HSV-1 and and/or herpes simplex (non-specific type test) and antigen testing for HSV-2 DO NOT MEET COVERAGE CRITERIA.”</p> <p>Removed former CC21, as Hepatitis B testing for those being considered for PrEP is now addressed in the Hepatitis policy. CC24, removed HPV, as ordering of HPV testing is no longer defined by direct/amplified/quantitative and instead just by HPV type. Changes to the vaginitis policy result in all targeted Trich testing being managed by the STI policy, results in addition of CC24.f: “f) Trichomonas vaginalis”</p>
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M2057 – Diagnosis of Vaginitis	Removed CPT code 87660	Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review did not necessitate any modifications to coverage criteria. The following updates were made for clarity and consistency: Direct probe testing to detect vaginitis is only appropriate when part of a multi-pathogen panel. All individual testing for Trichomonas should now be in the STI policy (G2157). Results in the following changes to CC2, CC4, and CC8: CC2: added “a multi-pathogen panel testing using”, as individual direct probe testing provides minimal information and use of direct probe testing should be restricted to the multi-pathogen panel test (e.g., BD Affirm VPIII) and should not be billed individually. CC4: changed qualitative PCR to NAAT, as individual Candida testing should be amplified probe testing, not direct probe testing CC8: changing NAAT to “nucleic acid testing (NAT)”, adding “direct probe testing, conditions not addressed above” to Candida and adding “or Gardnerella (e.g., direct probe testing).
M2116 – Human Immunodeficiency Virus (HIV)	Removed CPT code 86689	Reviewed and Updated: Updated background, guidelines, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria: Antibody testing that does not provide rapid results and does not incorporate antigen testing is outdated methodology and should no longer be used as part of initial HIV screening. Addition of new CC9: “9) Screening for HIV-1 and HIV-2 using an antibody test that does not provide rapid results and does not incorporate antigen testing DOES NOT MEET COVERAGE CRITERIA.”
No coverage criteria changes; no coding changes		

G2042 – Pediatric Preventive Screening	No CPT code Changes	N/A – See Avalon base policy for applicable literature and guideline updates.
G2044 – Helicobacter Pylori Testing	No CPT code changes	N/A – See Avalon base policy for applicable literature and guideline updates.
G2120 – Salivary Hormone Testing	No CPT code Changes	N/A – See Avalon base policy for applicable literature and guideline updates.
G2154 – Folate Testing	No CPT code Changes	N/A – See Avalon base policy for applicable literature and guideline updates.
M2172 – Onychomycosis Testing	No CPT code changes	N/A – See Avalon base policy for applicable literature and guideline updates.

<b>GTM Policies</b>		
<b>Policy Title</b>	<b>Coding changes</b>	<b>Rationale of Coverage Criteria (CC) Changes with Enforcement Changes to Avalon Base Policy (please note that this document is intended for use as a summary; please refer to the base policy as the source of truth for all policy changes)</b>
Coverage criteria changes; no coding changes		
M2024 – Genetic Testing for Polyposis Syndromes	No CPT code changes	Reviewed and Updated: Updated background, guidelines, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria:

		<p>For clarity and consistency, “pathogenic” was changed to “pathogenic/likely pathogenic (P/LP)” throughout criteria and “mutation” was changed to variant throughout criteria.</p> <p>NCCN updates necessitated updates to polyposis testing criteria.</p> <p>CC3: Removed CC3.a. and moved CC3.a.i. into former CC3.b., now CC3.a., number remains CC3.a.i. Removed CC3.b.iii. Primary brain tumor (e.g., medulloblastoma)., CC3.b.vi. Osteomas, and CC3.b.vii.</p> <p>Supernumerary teeth, as these conditions are no longer included in the genetic testing workflow provided by the NCCN.</p> <p>Added new CC3.b. and CC3.c.: “b) For individuals who meet criteria for serrated polyposis syndrome (see Note 4) with at least some of the qualifying polyps being adenomas.</p> <p>c) For individuals who were diagnosed with any cancer before 30 years of age and for whom an APC P/LP variant was found on tumor-only genomic testing.”</p> <p>New CC5.d.: “d) For individuals for whom a BMPR1A or SMAD4 P/LP variant was detected on any tumor type by tumor genomic profiling in the absence of germline mutation testing.”</p> <p>New CC6.d.: “d) For individuals for whom an STK11 P/LP variant was detected on any tumor type by tumor genomic profiling in the absence of germline mutation testing.”</p> <p>New Note 4 defining serrated polyposis syndrome.</p>
M2041 – Venous and Arterial Thrombosis Risk Testing	No CPT code changes	<p>Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria:</p> <p>Update to ACMG guidelines results in removal of CC1.f., as it is no longer included as a recommended condition for thrombophilia risk</p>

		testing. Former CC1.d. edited for clarity. Update to ACMG guideline and additional analysis of ASH, Thrombosis Canada, and The Endocrine Society results in changes to CC3. Now reads: “3) For individuals who are contemplating estrogen use (OCs or hormone replacement therapy) and who have a first-degree relative (see Note 2) with a known Factor V Leiden or prothrombin gene G20210A mutation, genetic testing for the known familial mutation MEETS COVERAGE CRITERIA.” For clarity, removed “Assays for clotting inhibitors amount and function should be performed prior to any molecular testing.” from Note 1.
M2101 – Mutation Analysis in Myeloproliferative Neoplasms	No CPT code changes	Reviewed and Updated: Updated background, guidelines, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria: CC1: Based on NCCN updates, changed “or” to “and”, as testing for all three driver mutations at once is now recommended. Now reads: “1) For the diagnosis of individuals presenting with clinical, laboratory, or pathological findings suggesting classic forms of myeloproliferative neoplasms (MPN) (e.g., polycythemia vera [PV], essential thrombocythemia [ET], or primary myelofibrosis [PMF]), JAK2, CALR, and MPL mutation testing MEETS COVERAGE CRITERIA in any of the following situations:”
M2171 – Esophageal Pathology Testing	No CPT code changes	Reviewed and Updated: Updated background, guidelines, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria: CC4a: Alphabetized, added repotrectinib as indicated medication, changed “NTRK gene fusion” to “NTRK1/2/3 gene fusion” to align with NCCN wording CC7: replaced “BarreGEN test” with “TissueCypher® Barrett's Esophagus Assay”, as BarreGEN is no longer available on the market

M2176 – Testing for Developmental Delay	No CPT code changes	Off-cycle Review: CC2 updated for clarity. Additional review was not performed; policy will be reviewed in total during its next annual review. CC2 now reads: “2) For the diagnosis of autism spectrum disorder (ASD) or developmental delay, all other genetic testing (e.g., multi-gene panels of 50 or more genes) not discussed above* DOES NOT MEET COVERAGE CRITERIA.”
M2177 – Fibromyalgia Testing	No CPT code changes	N/A – See Avalon base policy for applicable literature and guideline updates
No coverage criteria changes; coding changes		
M2039 – Pre-Implantation Genetic Testing	Fixed typo in code description for CPT code 81229	N/A – See Avalon base policy for applicable literature and guideline updates.
M2085 – Genetic Testing of Mitochondrial Disorders	Added PLA code 0537U (effective date 7/1/2025)	Off-cycle coding modifications only. Policy document updated with 7/1/2025 effective date PLA code that was mapped to policy but missing from document table.
Coverage criteria changes; coding changes		
M2020 – Molecular Diagnostics for Breast Cancer Prognosis	Added PLA code 0630U (effective date 4/1/2026)	Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review did not necessitate any modifications to coverage criteria. The following changes were made for clarity and consistency: CC2: Added “who have completed staging” for clarity. CC3 and CC4: added reference to Note 1 CC5: added “on a surgically excised sample” Note 1 edited for clarity on when the molecular diagnostic tests from CC2, CC3, and CC4 can be run on a CNB sample (CNB sample submitted for

		molecular diagnostic testing will be allowed so long as the tumor has been appropriately staged).
M2144 – Genetic Testing for Connective Tissue Disorder	Added CPT code 81406	N/A – See Avalon base policy for applicable literature and guideline updates.
M2166 – Gene Expression Profiling and Protein Biomarkers for Prostate Cancer	Added PLA code 0376U	<p>Reviewed and Updated: Updated background, guidelines, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria: ArteraAI Prostate was approved by the CAB, resulting in former CC1 and CC2 being combined into a single CC and ArteraAI being added as an allowed tumor-based assay. CC1 now reads: “1) For individuals who have prostate cancer, who have no significant co-morbidities, including advanced age, to suggest they have an estimated life expectancy of less than ten years, and for whom pathological examination showed localized adenocarcinoma of the prostate with no clinical evidence of metastasis or lymph node involvement, the one-time use of one of the following tumor-based assays to guide the management of prostate cancer MEET COVERAGE CRITERIA: a) For individuals with low-risk or favorable intermediate-risk disease, as defined by the NCCN (see Note 1): Prolaris®, Genomic Prostate Score®, or Decipher®. b) For individuals with intermediate-risk disease, as defined by the NCCN (see Note 1): ArteraAI Prostate. c) For individuals with unfavorable intermediate-risk and high-risk disease, as defined by the NCCN (see Note 1), the one-time use of Prolaris® or Decipher®.” CC5, added PHI initialism.</p> <p>Addition of new CC6 and new CC7: “6) For individuals for whom a tumor-based assay to guide the management of prostate cancer (i.e.,</p>

		ArteraAI Prostate, Decipher®, Genomic Prostate Score®, Prolaris®) has already been ordered, the use of a different approved tumor-based assay DOES NOT MEET COVERAGE CRITERIA. 7) For individuals for whom a non-invasive test designed to assess the probability of prostate cancer and inform the need for prostate biopsy (i.e., EPI, 4Kscore, IsoPSA, PHI) has already been ordered, the use of a different approved non-invasive test DOES NOT MEET COVERAGE CRITERIA.”
No coverage criteria changes; no coding changes		
G2148 – Genetic Testing for Hereditary Hearing Loss	No CPT code changes	N/A – See Avalon base policy for applicable literature and guideline updates.
M2021 – Pharmacogenetic Testing	No CPT code changes	N/A – See Avalon base policy for applicable literature and guideline updates.
M2108 – Molecular Markers in Fine Needle Aspirates of the Thyroid	No CPT code changes	N/A – See Avalon base policy for applicable literature and guideline updates.

**REMINDER OF PRIOR NOTIFICATION (CODE CHANGES OCCURRING IN BETWEEN CAB POLICY REVIEW):**

G2124: Effective date 10/1/2025- Added PLA code 0599U

G2143: Effective date 10/1/2025- Added PLA code 0580U

G2157: Effective date 1/1/2026- Added CPT code 87494

G2181: Effective date 1/1/2025- Removed CPT code 0500T (deleted code), updated code description for CPT code 87624

Effective date 1/1/2026- Updated code description for PLA code 0537U

T2015: Effective date 1/1/2026- Added PLA code 0603U

Updated code description for PLA code 0517U

M2021: Effective date 1/1/2026- Removed PLA code 0033U (deleted code), updated code descriptor for PLA code 0533U (wrong descriptor in previously published document)

M2039: Effective date 7/1/2025- Added PLA code 0552U, 0553U, 0554U, 0555U

M2085: Effective date 4/1/2025- Added PLA code 0532U

M2166: Effective date 10/1/2025- Added PLA code 0591U

Effective date 1/1/2026- Added PLA code 0609U, removed PLA code 0550U