

## Medical Policy Updates and Effective Dates

Our Healthcare Policy department continuously reviews medical policies and operating procedures as new, evidence-based information becomes available regarding advances on new or emerging technologies, as well as current technologies, procedures and services.

The table below is designed to provide updates on changes to existing or new local policies and procedures during our review process. Each local policy or procedure listed includes a brief description of its status, select reporting instructions and effective dates. Policies from non-local accounts, such as NASCO and Federal Employee Program (FEP), may differ from our local determinations. Please verify member eligibility and benefits prior to rendering service through CareFirst on Call ([Professional](#) and [Institutional](#)) or [CareFirst Direct](#).

Note: The Medical Policy Committee meets monthly. The effective dates for the policies listed below represent claims with date of service processed on and after that date.

### Updated Policies

Medical Policy or Operating Procedure	Actions, Comments and Reporting Guidelines
3.01.018 (C) Treatment of PANS/PANDAS	<ul style="list-style-type: none"> <li>■ Effective Date: 04/01/2026</li> <li>■ Important changes:               <ul style="list-style-type: none"> <li>• Under this Policy Guidelines section, the 2026 update was added as followed: “A search of peer-reviewed literature was performed for the period of October 2024 through January 2026. Findings in the recent literature do not change the conclusion regarding the treatment of PANS PANDAS as being medically necessary for the indications in this policy. Therefore, the policy is unchanged.”</li> <li>• Under the Benefits Application section the following mandate language was added “In 2025, the Commonwealth of Virginia mandated that coverage be provided for the prophylaxis, diagnosis, and treatment of PANDAS and PANS. This includes, but is not limited to antimicrobials, medications to manage neuropsychiatric symptoms, behavioral therapies, immunomodulating medicines, plasma exchange and intravenous Immunoglobulin therapy. For plans subject to the laws of the Commonwealth of Virginia, this provision is effective January 1, 2026. For mor information please refer to Chapter 8 of the 2025 Virginia Acts of Assembly. “</li> <li>• Under the Provider Guidelines section that standard language was updated removing “Providers should submit preauthorization requests online at provider.carefirst.com or call 1-866-773-2884 (1-866-PRE-AUTH).” and adding “For Prior Authorization requirements please go to Prior Authorization Look-up tool</li> </ul> </li> </ul>

	<p>(PAL Tool) at <a href="https://provider.carefirst.com/providers/medical/in-network-precertification-authorization.page">https://provider.carefirst.com/providers/medical/in-network-precertification-authorization.page</a> or call 1-866-773-2884 (1-866-PRE-AUTH)."</p> <ul style="list-style-type: none"> <li>• The following language was added referencing payment policy "For professional billing of home infusion services please refer to CareFirst payment policy CO 010.02 Place of Service - Specialty Service- Professional and HIT."</li> <li>• Under the Reference section the following reference was added Va. Code Ann. § 38.23418.22 (2025).</li> </ul>
<p>4.01.010 (C) Lactation Consultations</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 04/01/2026</li> <li>■ Important changes: <ul style="list-style-type: none"> <li>• Formatting done throughout the document.</li> <li>• Under the Policy Guidelines section the 2026 update was added as follows: "A search of peer-reviewed literature was performed for the period of September 2024 through January 2026. In 2025 the U.S. Preventive Service Task Force (USPSTF) reaffirmed its grade B recommendation that all pregnant and postpartum persons should be provided with interventions or referrals for breastfeeding support. Findings in the recent literature do not change the conclusion lactation consultation. Therefore, the policy remains unchanged."</li> <li>• Under Cross References to Related Policies and Procedures added the word Retired to policy 4.01.005.</li> <li>• Under the Reference section a reference was added for USPSTF.</li> </ul> </li> </ul>
<p>7.01.147 (C) Periurethral Transperineal Adjustable Balloon Continence Device</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 06/01/2026</li> <li>■ Important changes: <ul style="list-style-type: none"> <li>• Minor formatting changes were made to the policy.</li> <li>• Under Policy Guidelines, a 2026 update was added stating no changes to the policy statement.</li> <li>• Under Benefit Applications, the standard language was added.</li> <li>• Under Provider Guidelines, the standard reference to the PAL Tool was added.</li> <li>• Under Cross References, removed 7.01.041 Treatments for Urinary Incontinence, Policy and added "There are no Related Policies for this Medical Policy."</li> <li>• References were updated to reflect research published from 2023 through 2025.</li> </ul> </li> </ul>

<p>11.01.068 The 4Kscore® Test for Cancer Risk Assessment of Prostate Cancer</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 06/01/2026</li> <li>■ Important changes: <ul style="list-style-type: none"> <li>• Several formatting updates made throughout the document.</li> <li>• Under Policy Guidelines, updated the TEC criteria statements to the standard language. Also added an updated 2025 rationale statement “An annual update and review was performed. There are no indications for a change in coverage at this time; therefore, no changes to the policy statement are being made”.</li> <li>• A Benefit Applications section was added and the standard language was added noting “The purpose of this Medical Policy Reference Manual is to provide clinical criteria and/or local, state, or federal coverage requirements for applicable services, devices, and drugs. Specific contract provisions, restrictions, and exclusions will take precedence over the clinical criteria, as the member contract supersedes clinical criteria adopted by CareFirst. Always check the member’s contract for benefits”.</li> <li>• A Provider Guidelines section was added, and the standard language was added noting “Some services, devices, drugs, and places of service may require prior authorization. Always check the member’s contract for benefits. For Prior Authorization requirements please go to Prior Authorization Look-up tool (PAL Tool) at <a href="https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page">https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page</a> or call 1-866-773-2884 (1-866-PRE-AUTH)”.</li> <li>• Under Cross References, removed policies 11.01.047, 11.01.058, and 11.01.064. The standard language was added noting “There are no Related Policies for this Medical Policy”.</li> <li>• Under references, the following references were added: National Comprehensive Cancer Network®. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Prostate Cancer Early Detection. (Version 1.2026). <a href="https://www.nccn.org/professionals/physician_gls/pdf/prostate_detection.pdf">https://www.nccn.org/professionals/physician_gls/pdf/prostate_detection.pdf</a> Nickel, J.C., Gorin, M.A., Partin, A.W. et al. (2025) and Hayes (2025).</li> </ul> </li> </ul>
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## Retired Policies

The policies below have been retired.

- 1.01.019A Air Cleaner/Purifier (Effective: 06/01/2026)
- 1.01.021A Bathroom Aids (Effective: 06/01/2026)
- 1.01.022A Bed Related Accessories (Effective: 06/01/2026)
- 1.01.025A Cervical Pillow (Effective: 06/01/2026)
- 1.01.027A Cold Pad/Cold Pressure Therapy (Effective: 06/01/2026)
- 1.01.029A Dehumidifier/Humidifier (Effective: 06/01/2026)
- 1.01.031 Fracture/Traction Frames and Associated Equipment (Effective: 06/01/2026)
- 1.01.032A Heating Pad (Effective: 06/01/2026)
- 1.01.035A Lumbar Roll Cushion (Effective: 06/01/2026)
- 1.01.036A Massage Devices (Effective: 06/01/2026)
- 1.01.047A Sphygmomanometer and Stethoscope (Effective: 04/01/2026)
- 1.01.049A Restraints (Effective: 04/01/2026)
- 10.01.010A Diagnosis: Family History of (Effective: 06/01/2026)

*Note: This medical policy has been retired. Coverage for prescription drugs is determined under the members pharmacy benefit and in accordance with applicable pharmacy clinical policies. Certain medications may require prior authorization and are subject to the terms of the member's specific health plan. Refer to <https://provider.carefirst.com/providers/pharmacy/pharmacy-forms.page> for current pharmacy coverage requirements, clinical policies, and prior authorization information.*