CareFirst
Family of health care plans

Effective Dates, Current Procedural Terminology (CPT®) Codes and Policy Updates for December

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 effective dates for the policies listed below represent claims with date of service processed on and after that date.

Medical Policy and/or Procedure	Actions, Comments and Reporting Guidelines	Policy Status and Effective Date
1.01.013A – Coverage for Hair Prostheses	Updated Description section. Updated Benefit Applications section. Updated Provider Guidelines section. Report service using appropriate HCPCS and ICD-10 code. Updated Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details.	Revision. Effective 02/01/2024
1.04.001A – Prosthetics	Updated Benefit Applications section. Report service using appropriate HCPCS and ICD-10 code. Updated Cross References to Related Policies and Procedures section. Refer to policy for details.	Revision. Effective 02/01/2024
2.01.004 – Hyperbaric Oxygen Therapy	Updated Policy Guidelines section. Updated Benefit Applications section. Report service using appropriate Category I CPT®, HCPCS and ICD-10 code.	Revision. Effective 02/01/2024

Medical Policy and/or Procedure	Actions, Comments and Reporting Guidelines	Policy Status and Effective Date
2.01.045 - Continuous or Intermittent monitoring of Glucose in Interstitial Fluid	Updated Policy Guidelines section. Updated Provider Guidelines section. Updated CareFirst coverage decision to deny HCPCS A9276 and A9277 as unbundled when separately billed, as these devices are considered part of the "supplies" that comprise the monthly supply codes HCPCS A4238 and A4239. Report service using appropriate Category I CPT, HCPCS and ICD-10 code. Refer to policy for details.	Revision. Effective 02/01/2024
2.01.089 - Leva Pelvic Health System	New policy. Based on decision of medical directors at the Technology Assessment Committee on July 27, 2023 in which the Leva Pelvic Health System is considered experimental/investigational due to insufficient data regarding the efficacy of the technology.	New policy. Effective 02/01/2024
2.02.016 - Leadless Cardiac Pacemaker	Updated Description section. Updated Policy Guidelines section. Updated Benefit Applications section. Updated Provider Guidelines section. Report service using appropriate Category I CPT, HCPCS and ICD-10 code. Updated Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details.	Revision. Effective 02/01/2024
5.01.007 – ARCHIVED Botulinum Toxin (Botox)	Updated Title. Updated Description section. Updated Policy section. Updated Policy Guidelines section. Updated Benefit Applications section. Updated Provider Guidelines section. Report service using appropriate HCPCS code and ICD-10 code. Added Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details. Policy archived.	Periodic review and update. Effective 02/01/2024
5.01.020 - Xofigo (radium- Y 223 dichloride) Injection for Treatment of Prostate Cancer	Updated Description section. Updated Policy section. Updated Policy Guidelines section. Updated Benefit Applications section. Updated Provider Guidelines section. Report service using appropriate Category I CPT®, HCPCS and ICD-10 code. Added Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details.	Periodic review and update. Effective 02/01/2024

Medical Policy and/or Procedure	Actions, Comments and Reporting Guidelines	Policy Status and Effective Date
5.01.026 – ARCHIVED Colony Stimulating Factors (CVS)	Changed Title. Updated Description section. Updated Policy section. Updated Benefit Applications section. Updated Provider Guidelines section. Report service using appropriate HCPCS and ICD-10 code. Added Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details. Policy archived.	Periodic review and update. Effective 02/01/2024
5.01.037 – ARCHIVED Tesamorelin (Egrifta™) Injection for Lipodystrophy	Changed Title. Updated Description section. Updated Policy section. Updated Policy Guidelines section. Updated Benefit Applications section. Updated Provider Guidelines section. Report service using appropriate HCPCS code. Added Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details. Policy archived.	Periodic review and update. Effective 02/01/2024
5.01.040 – Intravenous Infusion of Ketamine for the Treatment of Chronic Pain and Major Depressive Disorder	Changed Title. Updated Description section. Updated Policy section. Updated Policy Guidelines section. Updated Benefit Applications section. Updated Provider Guidelines section. Report service using appropriate HCPCS code. Added Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details.	Periodic review and update. Effective 02/01/2024
6.01.043 (C) Stereotactic Radiosurgery Using Gamma Rays	Updated Description section. Updated Policy section. Updated Policy Guidelines section. Updated Benefit Applications section. Updated Provider Guidelines section. Report service using appropriate Category I CPT® and ICD-10 code. Updated Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details.	Periodic review and update. Effective 02/01/2024
7.01.025 - Spinal Cord and Deep Brain Stimulation	Updated Description section. Updated Policy section. Added Policy Guidelines section. Added Benefit Applications section. Added Provider Guidelines section. Report service using appropriate Category I CPT®, HCPCS and ICD-10 code. Updated Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details.	Periodic review and update. Effective 02/01/2024

Medical Policy and/or Procedure	Actions, Comments and Reporting Guidelines	Policy Status and Effective Date
7.01.040 – ARCHIVED Cavernous Nerve Stimulation Device	Changed Title. Updated Description section. Updated Policy Guidelines section. Updated Benefit Applications section. Report service using appropriate category I CPT® and ICD-10 code. Updated References section. Refer to policy for details. Policy archived.	Periodic review and update. Effective 02/01/2024
7.01.062 – ARCHIVED Lung Volume Reduction Surgery for Palliation of Severe Emphysema	Updated Description section. Updated Policy section. Updated Policy Guidelines section. Added Benefit Applications section. Updated Provider Guidelines section. Report service using appropriate Category I CPT® and ICD-10 code. Updated Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details. Policy Archived.	Periodic review and update. Effective 02/01/2024
7.01.079 – ARCHIVED Laryngeal Denervation and Reinnervation for Laryngeal Dystonia	Changed Title. Updated Description section. Updated Policy section. Added Policy Guidelines section. Added Benefit Applications section. Added Provider Guidelines section. Report service using appropriate Category I CPT® and ICD-10 code. Updated Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details. Policy archived.	Periodic review and update. Effective 02/01/2024
7.01.087 - Insertion of Automatic Implantable Cardioverter Defibrillator (AICD)	Report service using appropriate Category I CPT® and ICD-10 code. Refer to policy for details.	Revision. Effective 02/01/2024
7.01.093 - Total Ankle Arthroplasty / Replacement	Updated Policy Guidelines section. Report service using appropriate Category I CPT® and ICD-10 code. Refer to policy for details.	Revision. Effective 02/01/2024
7.01.095 – Endoscopic Therapies for Gastroesophageal Reflux (GERD)	Updated Policy Guidelines section. Added Benefit Applications section. Added Provider Guidelines section. Report service using appropriate Category I CPT® and ICD-10 code. Refer to policy for details.	Revision. Effective 02/01/2024

Medical Policy and/or Procedure	Actions, Comments and Reporting Guidelines	Policy Status and Effective Date
7.01.122 – Percutaneous Left Ventricular Assist Device (pLVAD)	Updated Policy Guidelines section. Updated Benefit Applications section. Added Provider Guidelines section. Report service using appropriate Category I CPT® and ICD-10 code. Refer to policy for details.	Revision. Effective 02/01/2024
7.01.141 – Intraoperative Neurophysiologic Monitoring	Report service using appropriate Category I CPT® and ICD-10 code. Refer to policy for details.	Revision. Effective 02/01/2024
7.01.142 – Waterjet Tissue Ablation of the Prostate	Report service using appropriate Category I CPT® and ICD-10 code. Refer to policy for details.	Revision. Effective 02/01/2024
7.03.002 – Hematopoietic Stem Cell Transplant (HSCT) - Autologous	Changed Title. Updated Description section. Updated Policy section. Updated Policy Guidelines section. Updated Benefit Applications section. Updated Provider Guidelines section. Report service using appropriate Category I CPT® and ICD-10 code. Updated References section. Refer to policy for details.	Periodic review and update. Effective 02/01/2024
7.03.003 – Hematopoietic Stem Cell Transplant - Allogenic	Changed Title. Updated Description section. Updated Policy section. Updated Policy Guidelines section. Updated Benefit Applications section. Updated Provider Guidelines section. Report service using appropriate Category I CPT® and ICD-10 code. Updated Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details.	Periodic review and update. Effective 02/01/2024
7.03.011 – Ventricular Assist Devices and Associated Services	Report service using appropriate Category I CPT® and ICD-10 code. Refer to policy for details.	Revision. Effective 02/01/2024

Medical Policy and/or Procedure	Actions, Comments and Reporting Guidelines	Policy Status and Effective Date
11.01.019 - ARCHIVED In Vitro Chemotherapeutic Drug Assays	Changed Title. Updated Description section. Updated Policy Guidelines section. Added Benefit Applications section. Added Provider Guidelines section. Report service using appropriate Category I CPT® and ICD-10 code. Added Cross References to Related Policies and Procedures section. Updated References section. Refer to policy for details. Policy archived.	Periodic review and update. Effective 02/01/2024

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