

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 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
1.01.070A (C) Breast Pumps and Related Supplies	<ul style="list-style-type: none"> ■ Effective: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Formatting edits throughout. • Under Benefit Applications edited the information regarding the HRSA recommendations. • Under Provider Guidelines added standard language stating “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 https://provider.carefirst.com/providers/medical/in-network-precertificationpreauthorization.page or call 1-866-773-2884 (1-866-PRE-AUTH).” • Under Cross References to Related Policies and Procedures: <ul style="list-style-type: none"> ▪ Removed 1.02.024A Over-the-Counter Miscellaneous Supplies and Equipment, Procedure and 4.01.010 Lactation Consultations, Policy because they no longer share any CPT or HCPCS codes. ▪ Added “There are no cross references related to this medical policy operating procedure.”

<p>1.02.003 (C) Enteral Nutrition Therapy</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Under description, added additional information about Enteral Nutrition stating: “EN is recommended for individuals who cannot fulfill their caloric and metabolic requirements to sustain health through dietary modifications and/or oral supplementations (Ley et al., 2023).” • Under provider guidelines, added "For Prior Authorization requirements please go to Prior Authorization Look-up tool (PAL Tool) at https://provider.carefirst.com/prv/priorauth". • Under references, added: <ul style="list-style-type: none"> ▪ Ley, D., Austin, K., Wilson, K. A., & Saha, S. (2023). Tutorial on adult enteral tube feeding: Indications, placement, removal, complications, and ethics. JPEN. Journal of parenteral and enteral nutrition, 47(5), 677–685. https://doi.org/10.1002/jpen.2510 ▪ HB2177 - 2019 Regular Session LIS
<p>2.01.011 (C) Electrocorticography</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Formatting done throughout document. • Under Policy Guidelines, added a 2025 update stating “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.” • Under Benefit Applications, standard language was added stating: “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.” • Under Provider Guidelines, removed "There are no Provider Guidelines for this Medical Policy," and added "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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773-2884 (1-866-PRE-AUTH)."

	<ul style="list-style-type: none"> Under Cross References to Related Policies and Procedures deleted 2.01.081, 2.01.082, 7.01.036, 10.01.003A, 10.01.013A.
2.01.016 (C) Blood-Derived Growth Factors and Platelet Rich Plasma for Wound Healing	<ul style="list-style-type: none"> Effective Date: 3/1/2026 Important changes: <ul style="list-style-type: none"> Under Provider Guidelines: <ul style="list-style-type: none"> Deleted: There are no Provider Guidelines for this Medical Policy. Added, 'Some services, devices, drugs, and places of service require prior authorization. Always check the member's contract for benefits. Providers should submit preauthorization requests online at www.provider.carefirst.com or call 1-866-773-2884 (1-866- PRE-AUTH). For Prior Authorization requirements please go to Prior Authorization Look-up tool (PAL Tool) at https://provider.carefirst.com/prv/priorauth.
2.01.017 (C) Allergy Immunotherapy	<ul style="list-style-type: none"> Effective Date: 3/1/2026 Important changes: <ul style="list-style-type: none"> Formatting done throughout document. Under Policy Guidelines, added 2025 update stating: "A search of the peer-reviewed literature was performed from August 2023 through November 2025. Findings in the recent literature do not support any change in the medical necessity or experimental / investigational indications listed in this policy."
2.01.027 (C) Chelation Therapy	<ul style="list-style-type: none"> Effective Date: 3/1/2026 Important changes: <ul style="list-style-type: none"> Under Policy Guidelines added updated 2025 rationale statement stating "A search of the peer-reviewed literature was performed from the period of February 2023 through November 2025. Findings in the recent literature do not change the conclusions regarding the use of chelation therapy for the medically necessary indications listed within the policy statement. Therefore, the policy statement remains unchanged."

<p>2.01.070 (C) Fecal Microbiota Transplantation</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> ● Updated formatting throughout policy. ● Under the Policy section, the policy statement changed from experimental/investigational (E/I) to not medically necessary. ● Under policy guidelines: <ul style="list-style-type: none"> ▪ Updated TEC criteria paragraph to standard language. ▪ Added updated 2025 rationale statement “An annual update and review were performed. There are no indications for a change in coverage at this time; therefore, no changes to the policy statement are being made”. ● Under Provider Guidelines, the standard language was added “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 https://provider.carefirst.com/providers/medical/in-network-precertification-authorization.page or call 1-866-773-2884 (1-866-PRE-AUTH)”.
<p>2.01.082 (C) Comprehensive Weight Reduction and Obesity Management Policy</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> ● Updated formatting throughout policy. ● Under Benefit Applications: <ul style="list-style-type: none"> ▪ Deleted 'Some services, devices, drugs, and places of service require prior authorization'. ▪ Added Section 2713 of the ACA requires most health plans to cover certain preventive services without cost-sharing (no copay, coinsurance, or deductible). <ul style="list-style-type: none"> ● For obesity, this includes: <ul style="list-style-type: none"> ○ Screening for obesity in adults and children. ○ Intensive behavioral counseling for adults with a BMI \geq 30 kg/m². ○ These services are based on USPSTF (U.S. Preventive Services Task Force) recommendations rated A or B. ● Under Provider guidelines, added: Please refer to Payment Policy PP 002.01 Claims Editing All Provider and Facility Types for proper billing.

	<ul style="list-style-type: none"> • Under Cross References to Related Policies and Procedures deleted 7.01.036 Surgical Treatment of Obesity and Morbid Obesity, Policy; 10.01.003A Preventive Services, Procedure; 10.01.013A Medical Record Documentation Standards, Procedure. • Under reference, added: <ul style="list-style-type: none"> ▪ CareFirst- BlueCross BlueShield (2025). Claims Editing – All Provider and Facility Types. Retrieved from ViewUploadedFile.aspx ▪ Published Recommendations, U.S. Preventive Services Task Force: Recommendation: High Body Mass Index in Children and Adolescents: Interventions United States Preventive Services Taskforce ▪ Published Recommendations, U.S. Preventive Services Task Force: Retrieved from https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/obesity-in-adults-interventions
<p>2.01.083 (C) Compression Stockings for Non-lymphedema Indications</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Under Policy Guidelines, a 2025 updated rationale statement was added stating: "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." • Under Provider Guidelines, added "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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773-2884 (1-866-PRE-AUTH)."
<p>2.01.085 (C) Orthopedic Applications of Stem Cell Therapy</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy Guidelines, a 2025 updated rationale statement was added stating: "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."

	<ul style="list-style-type: none"> Under Provider Guidelines, added "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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773-2884 (1-866-PRE-AUTH)."
2.01.089 (C) Leva Pelvic Health System	<ul style="list-style-type: none"> Effective Date: 3/1/2026 Important changes: <ul style="list-style-type: none"> Updated formatting throughout policy. Under Policy Guidelines: <ul style="list-style-type: none"> Updated TEC criteria to standard language. Added an updated 2025 rationale statement noting "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". Under provider guidelines, the standard language was added "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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773-2884 (1-866-PRE-AUTH)". Under CPT, HCPCS, ICD-10 and other codes section, added an experimental/investigational header to the code table. Under cross references, removed policy 7.01.041 as it no longer shares any codes in common. Added the standard language "There are no Related Policies for this Medical Policy."
2.02.015 (C) Implanted Pulmonary Artery Pressure Monitor for Congestive Heart Failure	<ul style="list-style-type: none"> Effective Date: 3/1/2026 Important changes: <ul style="list-style-type: none"> Updated formatting throughout policy. Under Policy Guidelines, updated rationale statement was added. Under provider guidelines: <ul style="list-style-type: none"> Deleted "There are no Provider Guidelines for this Medical Policy." Added, 'Some services, devices, drugs, and places of service require prior authorization. Always check the member's contract for benefits. Providers should submit preauthorization requests

	<p>online at www.provider.carefirst.com or call 1-866-773-2884 (1-866-PRE-AUTH). For Prior Authorization requirements please go to Prior Authorization Look-up tool (PAL Tool) at https://provider.carefirst.com/prv/priorauth.'</p> <ul style="list-style-type: none"> • Under references, added: Centers for Disease Control and Prevention / About Heart Failure(2024): About Heart Failure Heart Disease CDC
<p>2.02.016 (C) Leadless Cardiac Pacemaker</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy: <ul style="list-style-type: none"> ▪ Updated statement to “FDA-approved single chamber transcatheter pacing systems (e.g., Micra Transcatheter Pacing System, Aveir Transcatheter Pacing System) may be considered medically necessary...” ▪ Deleted statements that were specific for Micra or Aveir. • Under Policy Guidelines added 2025 update statement: “: A search of the peer-reviewed literature was performed from May 2023 through November 2025. Findings in the recent literature do not change the conclusions on the use of leadless cardiac pacemaker. Therefore, the policy statement remains unchanged.”
<p>2.02.017 (C) Myocardial Strain Imaging</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Under Policy Guidelines, added rationale statement 2025: “A search of peer-reviewed literature and evidence-based criteria was performed from February 2024 through November 2025. Findings in the recent literature do not change the conclusions on the use of myocardial strain imaging for conditions other than the medically necessary indications listed within the Policy section of this document. Therefore, the policy statement is unchanged.”

<p>3.01.011A (C) Autism Spectrum Disorders (Virginia Mandate)</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy Guidelines the 2025 update was added noting no change in this medical policy operating procedure. • Under the Benefits Application section the following standard language was added “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.” • Under the Provider Guidelines section: <ul style="list-style-type: none"> ▪ The following was removed “Preauthorization may be required by the Plan to determine appropriateness and medical necessity for treatment. CareFirst uses MCG Care Guidelines. Providers should submit preauthorization requests online at www.provider.carefirst.com or call 1-866-773-2884 (1-866-PRE-AUTH).” ▪ The following updated standard language was added “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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773-2884 (1-866-PRE-AUTH).” • Under the Cross References to Related Policies and Procedures section the following 3 procedures were removed as they no longer share CPT® or HCPCS codes “1.01.015A Augmentative Communication Devices, 2.01.048A ARCHIVED Acupuncture, Procedure, and 9.01.001A ARCHIVED Anesthesia Services, Procedure.” The following policies were updated with the word retired: 2.01.028, 2.01.047, 3.01.006, and 3.01.014.
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<p>3.01.015 (C) Autism Spectrum Disorder (ASD)</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy Guidelines, added rationale statement 2025: “A search of the peer-reviewed literature was performed for the period of January 2024 through December 2025. There are no indications for a change in coverage at this time; therefore, no changes to the policy statement are being made.” • Under the Benefits Application section: <ul style="list-style-type: none"> ▪ Standard language was added: 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. ▪ Also added statement “Coverage for this service may be subject to state specific mandates. For the state of Maryland, please refer to 2024 Maryland Statutes Insurance Title 15 - Health Insurance Subtitle 8 - Required Health Insurance Benefits Section 15- 835 - Required Coverage for Habilitative Services for additional details regarding mandated coverage.” For the District of Columbia please refer to § 31–3272. Coverage, Notice, Applicability, and Regulations for additional details regarding mandated coverage.” • Under Provider Guidelines added, “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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773- 2884 (1-866-PRE-AUTH).”
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<p>5.01.016 (C) Zoster Vaccine - Shingrix®</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy Guidelines: Update 2025 was added stating no change in coverage. • Under Cross references to related policies and procedures: <ul style="list-style-type: none"> ▪ Deleted 10.01.003A Preventive Services ▪ Added, 'There are no Related Policies for this Medical Policy'. • Under references, added Zoster Vaccine. Presentation to ACIP, Sep 2024. ACIP Evidence to Recommendations Framework for Use of Recombinant Zoster Vaccine in Immunocompromised Adults Aged ≥19 Years ACIP CDC
<p>6.01.007 (C) Transcranial Doppler Ultrasound</p>	<ul style="list-style-type: none"> ■ Effective Date: 5/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy Guidelines, updated with the current standard Experimental/Investigational statement and added a 2025 update for the rationale stating no change in coverage. • Under Benefit Applications, the standard language was added: 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. • Under Provider Guidelines, the standard language was added: 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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773- 2884 (1-866-PRE-AUTH). • Under Cross References to Related Policies and Procedures, removed 6.01.014 Ultrasound for the Evaluation of Paranasal Sinuses, Policy and replaced with "There are no Related Policies for this Medical Policy." • Under References, updated MCG to 29th edition.

<p>6.01.049A (C) Breast Density Screening and Notification Amendment Act of 2018 (District of Columbia [D.C.] Mandate)</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy.
<p>7.01.015 (C) Meniscal Allograft Transplantation</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy Guidelines added a 2025 update stating no change in coverage. • Under Provider Guidelines added standard language stating: Some services, devices, drugs, and places of service may require prior authorization. Always check the member's contract for benefits. Providers should submit preauthorization requests online at www.provider.carefirst.com or call 1-866-773-2884 (1-866-PRE-AUTH).
<p>7.01.023 (C) Percutaneous Electrical Nerve Stimulation</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy Guidelines added a 2025 update stating there is no change in coverage. • Under Provider Guidelines removed information “There are no Provider Guidelines for this Medical Policy and added standard language stating: Some services, devices, drugs, and places of service may require prior authorization. Always check the member's contract for benefits. Providers should submit preauthorization requests online at www.provider.carefirst.com or call 1-866-773-2884 (1-866-PRE-AUTH).

<p>7.01.036 Surgical Treatment of Obesity and Morbid Obesity</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Description, added Single-anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S) description. • Under Policy added SADI-S as procedure that may be considered medically necessary when criteria are met. • Under Policy Guidelines, added 2025 rationale update statement stating the SADI-S procedure has been determined to be medically necessary. This procedure has been endorsed by the American Society for Metabolic and Bariatric Surgery. • Under CPT, HCPCS, ICD-10 and Other Codes deleted E65 and E66.8. Added E66.811, E66.812, E66.813, E66.89. • Under References added Balamurugan et al. (2023), Code of Virginia (2025), MD Insurance Code, and Verhoeff et al. (2022).
<p>7.01.111 (C) Transanal Endoscopic Microsurgery (TEM)</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy Guidelines added a 2025 update stating there is no change in coverage. • Under Provider Guidelines added standard language “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 Lookup tool (PAL Tool) at https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization_page_or_call_1-866-773-2884 (1-866-PRE-AUTH).
<p>7.01.122 (C) Percutaneous Left Ventricular Assist Device (pLVAD)</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under the Policy Guidelines section: <ul style="list-style-type: none"> ▪ The experimental/investigational standard language was updated. ▪ The 2025 update was added noting no changes to the policy statement.

	<ul style="list-style-type: none"> • Under Benefits Application section the following sentence was removed from the paragraph: “Some services, devices, drugs, and places of service require prior authorization. Always check the member's contract for benefits.” • Under the Provider Guidelines section, the following sentence was removed “There are no Provider Guidelines for this Medical Policy.” This was replaced with the updated standard language as follows: “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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773-2884 (1-866-PRE-AUTH).” • Under Cross References to Related Policies and Procedures policy 7.03.011 Ventricular Assist Devices and Related Services was removed as it no longer shares any CPT or HCPCS codes. The standard language noting no related policies was added.
7.01.137 (C) Oral-Facial Pathology with Attached Companion Table	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under policy, deleted the “NOTE: Services covered may vary according to the member's contract. When benefits are provided under the member's contract, mandated benefits are provided for habilitative services for certain individuals with pervasive developmental disorders (autism and autism spectrum disorders). For information on these benefits, refer to Medical Policy Operating Procedure 8.01.011A - Habilitative Services (Maryland and DC Mandates), Medical Policy Operating Procedure 3.01.011A - Autism Spectrum Disorders (Virginia Mandate), and Medical Policy 3.01.006 - Pervasive Developmental Disorders. For Anesthesia Services, see Medical Policy 9.01.001A.” • Under Policy Guidelines, added 2025 update to state that there is no change in coverage. • Under Benefit applications: <ul style="list-style-type: none"> ▪ Added standard language: 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.

	<ul style="list-style-type: none"> ▪ Added "Coverage is mandated for children under 19 years of age including those diagnosed with autism or pervasive developmental disorders. "Habilitative services means services and devices, including occupational therapy, physical therapy, and speech therapy, that help a child keep, learn, or improve skills and functioning for daily living." The age limit was extended to include "insureds and enrollees who are children until at least the end of the month in which the insured or enrollee turns 19 years old." ▪ Added: For Anesthesia Services, please refer to PP CO 014.02 Consultation Services-Professional. ▪ Added: Services not specifically identified by this Policy for the treatment of oral-facial trauma are not considered related to this policy. Other services or procedures may be reviewed for medical necessity to determine benefit applicability. ▪ Deleted year 2016 and 2000 statements and well as "NOTE" statement. • Under cross references to related policies and procedures: <ul style="list-style-type: none"> ▪ Added-6.01.051A (C) Breast Cancer Screening (Maryland Mandate), 7.01.136 (C) Oral-Facial Trauma/Accidental Injury ▪ Deleted 3.01.006(C) Retired Pervasive Developmental Disorders. • Under references added: Code of Virginia § § 38.2-3411. Coverage of newborn children (2013).
<p>7.01.140 (C) Intraosseous Basivertebral Nerve Ablation</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy Guidelines, a 2025 update was added stating no change in coverage. • Under Provider Guidelines, added the standard language: 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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773- 2884 (1-866-PRE-AUTH).

<p>7.01.141 (C) Intraoperative Neurophysiologic Monitoring</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under the Policy section, added the TEC criteria numbers were to the correlating experimental/investigational statements. • Under the Policy Guidelines section: <ul style="list-style-type: none"> ▪ Updated the Experimental/ Investigational standard language. ▪ Updated the rationale information for statements numbered 1, 2, 3, 4, and 5. • Under Benefit Applications section, added standard language: 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. • Under Provider Guidelines, added the standard language: 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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773- 2884 (1-866-PRE-AUTH). • Under the Reference section a reference from Hemmer & Rabai 2025 was added.
<p>7.03.001 (C) Human Organ Transplants</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy Guidelines added a 2025 update stating no change in coverage. • Under Provider Guidelines, added the standard language: 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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773- 2884 (1-866-PRE-AUTH).

<p>7.03.003 (C) Hematopoietic Stem Cell Transplantation (HSCT) - Allogenic</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy: <ul style="list-style-type: none"> ▪ Alphabetized all indications (for organization and readability). ▪ Added AML and multiple myeloma to the medically necessary statement to align with the National Comprehensive Cancer Network (NCCN). . • Under Policy Guidelines: <ul style="list-style-type: none"> ▪ Edited TEC criteria 2 regarding multiple myeloma. ▪ Added a 2025 update stating “National Comprehensive Cancer Network (NCCN) guidelines and UpToDate (Deej & Sandmaier, 2025) support allogenic HSCT for AML (NCCN, 2025a) and multiple myeloma (NCCN, 2025b). The policy statement was updated.” • Updated Benefit Applications section to state: 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. • Under Provider Guidelines, added the standard language: 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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization_page or call 1-866-773- 2884 (1-866-PRE-AUTH). • Under CPT HCPCS ICD 10 CM and Other Codes added C90.00-C90.02 Multiple myeloma to align with BCBSA and NCCN. • Under Cross References removed 7.03.001 Human Organ Transplants, Policy 10.01.001A because they no longer share any CPT or HCPCS codes. • Under References added (Deej & Sandmaier, 2025), (NCCN, 2025a), (NCCN, 2025b).
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<p>7.03.011 (C) Ventricular Assist Devices and Associated Services</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Description, updated information to add information about left ventricular assist device (LVAD). • Under Policy Guidelines add 2025 update to state no change in coverage. • Under Provider Guidelines, added the standard language: 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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773- 2884 (1-866-PRE-AUTH).
<p>11.01.083 (C) Gene Expression Profiling for Melanoma</p>	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • Under Policy Guidelines add 2025 update to state no change in coverage. • Under Benefit Applications section, added statement: Coverage for this service may be subject to state specific mandates. For the state of Maryland, please refer to 2024 Maryland Statutes Insurance Title 15 - Health Insurance Subtitle 8 - Required Health Insurance Benefits Section 15- 859 - Coverage for Biomarker Testing for additional details regarding mandated coverage. • Under Provider Guidelines, added the standard language: 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 https://provider.carefirst.com/providers/medical/in-network-precertification-preauthorization.page or call 1-866-773- 2884 (1-866-PRE-AUTH).

Retired Policies

The policies below have been retired.

- 5.01.020 (C) Xofigo (radium-223 dichloride) Injection for Treatment of Prostate Cancer (effective 3/1/2026)
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.

CareFirst has adopted the position of MCG Care Guidelines®, along with its proprietary clinical criteria, for medical necessity, for the following policies:

- 1.03.002 (C) Adjustable Cranial Orthoses for Positional Plagiocephaly and for Craniosynostosis (effective 3/1/2026)
- 2.01.003 (C) Gait Analysis (effective 3/1/2026)
- 2.01.075 (C) High-Intensity Focused Ultrasound for Treatment of Localized Prostate Cancer (effective 3/1/2026)
- 4.01.008 (C) Uterine Artery Embolization (effective 3/1/2026)
- 6.01.010 (C) Stereotactic Radiosurgery and Stereotactic Body Radiotherapy with 3-D Conformal Radiation Therapy (effective 4/1/2026)
- 6.01.027 (C) Computed Tomography as a Screening Test for Lung Cancer (effective 3/1/2026)
- 7.01.093 (C) Total Ankle Arthroplasty / Replacement (effective 3/1/2026)

More information available at <https://carefirst.access.mcg.com/index>