

## Medical Policy Updates and Effective Dates for July/August 2025

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.

**UPDATE:** Addendum to Medical Policy 8.01.011 A Habilitative Services (for Maryland and DC Mandates), update provided in our April and May 2025 policy communication: Habilitative policy had been updated to include additional diagnoses as part of the prior authorization process to ensure appropriate care and habilitative services; beginning September 1, 2025, (previously August 1) please ensure that these services are reported using the appropriate procedure code appended with modifier -96.

### Updated Policies

Medical Policy or Operating Procedure	Actions, Comments and Reporting Guidelines
2.01.002 (C) Dynamic Posturography	<ul style="list-style-type: none"> <li>■ Effective: 09/01/2025</li> <li>■ Important changes:               <ul style="list-style-type: none"> <li>• Under Policy Guidelines updated Rationale statements 1 through 3.</li> <li>• Rationale 1: updated to include Neurocom, a dynamic posturography device.</li> <li>• Rationale 2: Recent study (2024) from David and Shahnaz was included.</li> <li>• Rationale 3: added Alahmari et. al study evaluating the reliability and validity of a balance rehabilitation device, comparing the results with dynamic posturography.</li> <li>• Updated References to include those addressed in Rationale statements 1 through 3.</li> </ul> </li> </ul>

<p>2.01.006A Hypnosis / Hypnotherapy</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 10/1/2025</li> <li>■ Important changes: <ul style="list-style-type: none"> <li>• Under Benefit Applications section, 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.”</li> <li>• Update code tables to reflect standard formatting.</li> </ul> </li> </ul>
<p>2.01.021 Temporomandibular Joint (TMJ) Dysfunction</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 11/1/2025</li> <li>■ Important changes: <ul style="list-style-type: none"> <li>• Under Policy Guidelines updated Experimental/Investigational statement to standard statement: The term "experimental/investigational" describes services or supplies that are in the developmental stage and are in the process of human or animal testing. Services or supplies that do not meet all 5 of the criteria listed below adopted by the BlueCross BlueShield Association (BCBSA) Medical Policy Services (MPS) Assessment Criteria (formerly known as the Technology Evaluation Center (TEC) are deemed to be experimental/investigational: <ol style="list-style-type: none"> <li>1. The technology* must have final approval from the appropriate U.S.<sup>1</sup> government regulatory bodies; and</li> <li>2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes; and</li> <li>3. The technology must improve the net health outcome; and</li> <li>4. The technology must be as beneficial as any established alternatives; and</li> <li>5. The improvement must be attainable outside the investigational settings.</li> </ol> </li> </ul> </li> </ul> <p><i>* Technology includes drugs, devices, processes, systems, or techniques</i></p> <p><i><sup>1</sup>The BCBSA criteria indicates the technology must have final approval from the appropriate government regulatory bodies; however, CareFirst BlueCross BlueShield (“CareFirst”) requires the technology receives final approval from the appropriate U.S. government regulatory body.</i></p>

<p>2.01.023 Allergy Testing</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 11/1/2025</li> <li>■ Important changes: <ul style="list-style-type: none"> <li>• Under Policy removed “Rebuck skin window test” as it does not meet TEC criteria # 2 – 5.</li> <li>• Under Policy also removed the “not medically necessary” policy statement as this test (Passive transfer or r P-X (Prausnitz-Küstner) test (replaced by RAST)) is outdated and is no longer in use.</li> <li>• Policy Guidelines: <ul style="list-style-type: none"> <li>• Under TEC criteria #1, added and FDA, 2022 citation.</li> <li>• Under TEC criteria #2, removed MCG, 2021 citation as it is no longer relevant.</li> </ul> </li> <li>• Under cross references, added 6 additional policies that share common codes: 2.01.005, 11.01.003, 11.01.004, 11.01.010, 11.01.053,</li> <li>• 11.01.079; and removed policy 7.01.041 as it no longer shares any codes in common.</li> <li>• Under references, added FDA, 2022 reference and Cohen, 2004 reference to a landmark study regarding the outdated use of the P-X test.</li> </ul> </li> </ul>
<p>2.01.057 Exhaled Nitric Oxide Measurement for Diagnosis of Asthma</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 11/1/2025</li> <li>■ Important changes: <ul style="list-style-type: none"> <li>• Changed the title of the policy to Exhaled Nitric Oxide Measurement for Diagnosis of Asthma for better accuracy.</li> <li>• Under Policy Guidelines: <ul style="list-style-type: none"> <li>• TEC criteria #2 was removed due to more current studies which was added.</li> <li>• Updated TEC criteria #3 to state “The effects on health outcomes for FeNO have not been determined. Therefore, improvement of net health outcomes also cannot be determined.”</li> </ul> </li> </ul> </li> <li>■ Removed information under Benefit Applications and 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. Some services, devices, drugs, and places of service require prior authorization. Always check the member's contract for benefits.”</li> </ul>

<p>2.01.058 (C) Monitoring of Regional Cerebral Blood Flow Using Implanted Thermal Infusion Probe</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 9/1/2025</li> <li>■ Important changes: <ul style="list-style-type: none"> <li>● Under Description, wording and description revised. Added “All individuals diagnosed with subarachnoid hemorrhage (SAH) are initially administered the calcium channel blocker Nifedipine to prevent vasospasm, which generally occurs between Day 5 and Day 14 after initial bleed. Ongoing evaluation of vasospasm is performed throughout this timeframe to determine the necessity for further intervention. If vasospasm be identified, patients might receive "Triple H" therapy, which includes induced hypertension, hypervolemia with colloids, and hemodilution. In cases where vasospasm is significant, persistent, localized, or accompanied by neurological deficits, the patient may be subjected to angiography and angioplasty. Neurological decline serves as a critical clinical indicator of vasospasm; however, comatose and ventilated patients are not amendable to neurological exam. Therefore, clinicians must depend on a range of direct and indirect methods to detect critical changes in regional cerebral blood flow (rCBF) to accurately diagnose hemodynamically relevant asospasm (Vajkocszy et al., 2007). The bedside transcranial Doppler (TCD) is the most frequently used method for evaluating cerebral perfusion. However, this technique presents several challenges-it is technically difficult, may require more than an hour to complete, only visualizes a small number of vessels, and often cannot be performed if the temporal bone windows are dense.</li> <li>● Under Description also added a note stating: “This policy does not address insertion of a shunt for drainage.”</li> <li>● Under Policy Guidelines, Experimental/Investigational and TEC criteria standard statements were added. <ul style="list-style-type: none"> <li>● Under Rationale 2: Jaeger et al. study was included.</li> <li>● Under Rationale 4: The technology must be as beneficial as any established alternatives wording changed from effective to beneficial.</li> </ul> </li> <li>● Under Provider Guidelines, the statement “There are no provider guidelines for this medical policy” was included.</li> <li>● Under Cross References to Related Policies and Procedures, added "There are no Related Policies for this Medical Policy" and deleted "Transcranial Doppler Ultrasound 6.01.007."</li> </ul> </li> <li>■ Updated references</li> </ul>
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<p>6.01.014 Paranasal Sinuses Ultrasound</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 11/1/2025 <ul style="list-style-type: none"> <li>● Title of the policy Changed from “Ultrasound for the Evaluation of Paranasal Sinuses” to “Paranasal Sinuses Ultrasound” to be more concise.</li> </ul> </li> <li>■ Under the Benefit Applications section, standard language was added. <ul style="list-style-type: none"> <li>● Under Cross References removed 6.01.007 Transcranial Doppler Ultrasound policy and added statement “There are no cross references related to this medical policy” because there are no longer any shared codes.</li> </ul> </li> </ul>
<p>7.01.123 Gender Affirmation Services /Gender Dysphoria</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 11/1/2025</li> <li>■ Important changes: <ul style="list-style-type: none"> <li>● Throughout policy the term “gender reassignment” was replaced with “gender affirming” as it pertains to this 2025 update.</li> <li>● Under the Policy Guideline section, the 2025 update was added reading as follows: “A search of peer reviewed literature and evidence-based criteria was performed from April 2023 through June 2025. Findings in the literature do not change the conclusions regarding gender affirming services. However, notes were added pertaining to benefit applications. Please see the Benefits Application section of this policy for more details.</li> <li>● Under the Benefit Application section language was added to read as follows: For all Federal Employee Program Policies – FEP, FEHBP, PSHBP – confirm availability of benefits in the latest member brochure.</li> <li>● Under Cross References to Related Policies and Procedures section, policy 4.02.001 Assisted Reproduction Technology (ART) Procedures: In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and procedure 10.01.013A Medical Record Documentation Standards, was removed as it does not share any similar codes.</li> <li>● The following policies and or procedures were added as they share similar codes: 1.04.001A Prosthetics with Attached Companion Table, 2.01.021 Temporomandibular Joint (TMJ) Dysfunction, 2.01.025 Erectile Dysfunction with Attached Companion Table, 7.01.004 ARCHIVED Disorders of the Prostate, 7.01.070 ARCHIVED Transsexual Surgery, 7.01.071 RETIRED Prophylactic Mastectomy.</li> </ul> </li> <li>■ Under References a reference from the U.S. Office of Personnel Management was added.</li> </ul>

<p>11.01.079 Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 10/1/2025</li> <li>■ Important changes:           <ul style="list-style-type: none"> <li>• Under Description deleted American College of Radiology (ACR) and Systemic Lupus International Collaboration Clinics (SLICC) classification criteria.</li> <li>• Updated code tables to reflect deleted codes.</li> <li>• Under Cross References to Related Policies and Procedures deleted 11.01.015, 11.01.029, 11.01.074 because the policies no longer share codes with this policy.</li> <li>• Under References added Alexander et al. (2022); Kernder et al. (2021); Oglesby et al. (2014); O'Malley et al. (2022); Ramsey-Goldman et al. (2020); Ramsey-Goldman et al. (2021); Wallace and Gladman (2025).</li> </ul> </li> </ul>
<p>2.01.078 Amniotic Membrane and Amniotic Fluid Grafts and Injections</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 11/1/2025</li> <li>■ Important Changes:           <ul style="list-style-type: none"> <li>• Code Table updated to include newly added codes to the medically necessary table (codes effective 4/1/2025).</li> <li>• Code Table updated to include newly added codes to the experimental/investigational code tables (codes effective 7/1/2025)</li> </ul> </li> </ul>
<p>1.02.022A Contraceptive Supplies</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 10/1/2025</li> <li>■ Important changes:           <ul style="list-style-type: none"> <li>■ Under Benefit Applications, added the following statement to align with the preventive contraceptive mandate: "For information regarding condoms as a federal preventative service, please review CareFirst preventive service guidelines <a href="https://provider.carefirst.com/providers/care-management/preventive-service-guidelines.page">https://provider.carefirst.com/providers/care-management/preventive-service-guidelines.page</a>."</li> </ul> </li> </ul>
<p>2.01.051 (C) Extracorporeal Photopheresis</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 10/1/2025</li> <li>■ Important Changes:           <ul style="list-style-type: none"> <li>• Updated Rationale Statement under Policy guidelines to state: "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> </ul> </li> </ul>

<p>2.01.061 (C) Ocular Photostreening by Primary Physicians to Detect Amblyogenic Disorders</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 12/1/2025</li> <li>■ Important changes: <ul style="list-style-type: none"> <li>• Under Policy Guidelines added 2025 rationale statement “Findings in the literature do not change the medically necessary indication for ocular photostreening in the primary care physician’s office to detect amblyogenic disorders.”</li> <li>• Under Benefit Applications section: <ul style="list-style-type: none"> <li>• Deleted note stating: “NOTE: For FEP business, check the member's contract for benefits.”</li> <li>• Added standard statement: 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> </ul> </li> </ul> </li> </ul>
<p>2.01.066 (C) Digital Pulse Wave Analysis Assessment of Arterial Elasticity</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 10/1/2025</li> <li>■ Important Changes: <ul style="list-style-type: none"> <li>• Updated Rationale Statement under Policy guidelines to state: “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> </ul> </li> </ul>
<p>2.01.067 (C) Pulsed Radiofrequency Therapy for Chronic Pain</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 10/1/2025</li> <li>■ Important Changes: <ul style="list-style-type: none"> <li>• Under Description, updated to add more detailed information regarding Radiofrequency (RF) and pulsed radiofrequency (PRF) ablation techniques.</li> <li>• Under Policy Guidelines added standard Experimental/Investigation statement and TEC criteria language.</li> <li>• Under Benefit Applications included standard verbiage.</li> <li>• Under Cross References related policies and procedures, deleted 7.01.120 Peripheral Field Neurostimulation for Chronic Pain and added “There are no related policies to this Medical Policy.”</li> <li>• Updated References.</li> </ul> </li> </ul>

<p>4.01.006A (C) Global Maternity Care</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 10/1/2025</li> <li>■ Important Changes: <ul style="list-style-type: none"> <li>● Under Benefit Applications, removed the following statement “Benefits are not provided for doula services” to align with the Maternal Health Benefits Expansion and added a statement referring to Payment Policy ‘PP CO 080.01 Global Obstetrical Services – Professional’ for billing of multiple births.</li> <li>● Update code table to remove termed codes</li> </ul> </li> </ul>
<p>6.01.002 Bone Mineral Density Studies</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 10/1/2025</li> <li>■ Important Changes: <ul style="list-style-type: none"> <li>● Under Description added information related to the Fracture Risk Assessment (FRAX) tool.</li> <li>● Under Policy removed “screening” due to the Maryland mandate allowing the use of Bone Mineral Density for diagnostic studies</li> <li>● Under Benefit Applications added information from Maryland Insurance Code §15-823, please review Benefit Applications section for expanded details.</li> <li>● Under References added (Maryland Insurance Code §15-823).</li> </ul> </li> </ul>
<p>7.01.113 (C) Saturation Biopsy of the Prostate</p>	<ul style="list-style-type: none"> <li>■ Effective Date: 10/1/2025</li> <li>■ Important Changes: <ul style="list-style-type: none"> <li>● Under the Benefits Applications section 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.”</li> <li>● Under the Provider Guidelines section standard language was 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 <a href="http://www.provider.carefirst.com">www.provider.carefirst.com</a> or call 1-866-773-2884 (1-866-PRE-AUTH).”</li> <li>● Under the Cross References to Related Policies and Procedures the following policy was removed “7.01.133 Free-handed Transperineal Biopsy of the Prostate with a Transperineal Access System (PrecisionPoint™), policy” as it does not share any similar CPT or HCPCS codes. The standard language was added “There are no Related Policies for this Medical Policy.”</li> </ul> </li> </ul>

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|  | <ul style="list-style-type: none"><li>• Under the Reference section NCCN 2025 Guideline for Prostate Cancer Early Detection was added.</li></ul> |
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TriClip	<ul style="list-style-type: none"> <li>■ Effective Date: 11/1/2025</li> <li>■ Important Changes: <ul style="list-style-type: none"> <li>• At the Technology Assessment Committee (TAC) meeting on May 22, 2025 a decision was made to follow MCG Care Guidelines® for TriClip.</li> <li>• CareFirst has adopted the position of MCG Care Guidelines®, along with its proprietary clinical criteria, for medical necessity. Please navigate to <a href="https://carefirst.access.mcg.com/index">https://carefirst.access.mcg.com/index</a>.</li> </ul> </li> </ul>
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### Retired Policies

Medical Policy or Operating Procedure	Actions, Comments and Reporting Guidelines
2.01.009 (C) Tilt Table Test	<ul style="list-style-type: none"> <li>■ Effective Date: 11/1/2025</li> <li>■ Important Changes: <ul style="list-style-type: none"> <li>• CareFirst has adopted the position of MCG Care Guidelines®, along with its proprietary clinical criteria, for medical necessity. Please navigate to <a href="https://carefirst.access.mcg.com/index">https://carefirst.access.mcg.com/index</a>.</li> </ul> </li> </ul>
2.01.054A (C) Total Body Photography for Melanoma Risk Monitoring	<ul style="list-style-type: none"> <li>■ Effective Date: 8/1/2025</li> <li>■ Important changes: <ul style="list-style-type: none"> <li>• CareFirst has adopted the position of MCG Care Guidelines®, along with its proprietary clinical criteria, for medical necessity. Please navigate to <a href="https://carefirst.access.mcg.com/index">https://carefirst.access.mcg.com/index</a>.</li> </ul> </li> </ul>
2.01.060 (C) Electromagnetic and Electrical Stimulation for the Care of Chronic Wounds	<ul style="list-style-type: none"> <li>■ Effective Date: 11/1/2025</li> <li>■ Important changes: <ul style="list-style-type: none"> <li>• CareFirst has adopted the position of MCG Care Guidelines®, along with its proprietary clinical criteria, for medical necessity. Please navigate to <a href="https://carefirst.access.mcg.com/index">https://carefirst.access.mcg.com/index</a>.</li> </ul> </li> </ul>
6.01.034 Magnetic Resonance Spectroscopy	<ul style="list-style-type: none"> <li>■ Effective Date: 11/1/2025</li> </ul>

- CareFirst has adopted the position of MCG Care Guidelines®, along with its proprietary clinical criteria, for medical necessity. Please navigate to <https://carefirst.access.mcg.com/index>.

7.01.092 Interspinous Vertebral Decompression Implantation for Spinal Stenosis	<ul style="list-style-type: none"> <li>■ Effective Date: 11/1/2025</li> <li>• Changed title to align with MCG Care Guidelines®. Title changed from Interspinous Vertebral Decompression Implantation for Spinal Stenosis to Spinal Distraction Devices.</li> <li>• CareFirst has adopted the position of MCG Care Guidelines®, along with its proprietary clinical criteria, for medical necessity. Please navigate to <a href="https://carefirst.access.mcg.com/index">https://carefirst.access.mcg.com/index</a>.</li> </ul>
9.01.001A Anesthesia Services	<ul style="list-style-type: none"> <li>■ Effective Date: 9/1/2025</li> <li>■ Important Changes: <ul style="list-style-type: none"> <li>• CareFirst has adopted the position of MCG Care Guidelines®, along with its proprietary clinical criteria, for medical necessity. Please navigate to <a href="https://carefirst.access.mcg.com/index">https://carefirst.access.mcg.com/index</a>.</li> </ul> </li> </ul>
7.01.005 Cochlear Implantation	<ul style="list-style-type: none"> <li>■ Effective Date: 12/1/2025</li> <li>■ Important Changes: <ul style="list-style-type: none"> <li>• CareFirst has adopted the position of MCG Care Guidelines®, along with its proprietary clinical criteria, for medical necessity. Please navigate to <a href="https://carefirst.access.mcg.com/index">https://carefirst.access.mcg.com/index</a>.</li> </ul> </li> </ul>
7.01.095 Endoscopic Therapies for Gastroesophageal Reflux (GERD)	<ul style="list-style-type: none"> <li>■ Effective Date: 12/1/2025</li> <li>■ Important Changes: <ul style="list-style-type: none"> <li>• CareFirst has adopted the position of MCG Care Guidelines®, along with its proprietary clinical criteria, for medical necessity. Please navigate to <a href="https://carefirst.access.mcg.com/index">https://carefirst.access.mcg.com/index</a>.</li> </ul> </li> </ul>