

Medical Policy Updates and Effective Dates for June

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
1.01.018 - Neuromuscular Electrical Stimulation (NMES) Devices	Updated Policy section to indicate "Neuromuscular electrical stimulation devices for all other indications, and neuromuscular electrical stimulation devices for home use, are considered experimental/ investigational, as it does not meet TEC criteria # 2 - 5." Updated Policy Guidelines section. Report service using the appropriate 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 08/01/2024
2.01.066 - Digital Pulse Wave Analysis Assessment of Arterial Elasticity	Updated Description section. Updated Policy Guidelines section by adding the TEC criteria to support the experimental/investigational coverage decision. Added Benefit Applications section. Added Provider Guidelines section. Report service using appropriate category I CPT®, HCPCS and ICD-10 code. Updated References section. Refer to policy for details.	Periodic review and update Effective 08/01/2024
2.01.070 - Fecal Microbiota Transplantation	Updated Description section. Updated Policy section to indicate "Fecal microbiota transplantation is considered experimental/investigational for all other conditions as it does not meet TEC criteria #2-5." Updated Policy Guidelines 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.	Periodic review and update Effective 08/01/2024

Medical Policy and/or Procedure	Actions, Comments and Reporting Guidelines	Policy Status and Effective Date
2.02.009 – ARCHIVED Electrocardiographic Body Surface Mapping	Updated Policy Title. Updated Description section. Updated Policy section. Updated Policy Guidelines section by adding the TEC criteria to support the experimental/investigational coverage decision. Updated Benefit Applications section. Added 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. The medical policy is archived.	Periodic review and update Effective 08/01/2024
2.02.015 - Implanted Pulmonary Artery Pressure Monitor for Congestive Heart Failure	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.	Periodic review and update Effective 08/01/2024
3.01.016 - Dialectical Behavior Therapy	Updated Policy section. Updated Policy Guidelines section. Added Benefit Applications section. Added Provider Guidelines section. Report service using appropriate category I CPT®, HCPCS and ICD-10 code. The policy revision resulted in the inclusion of psychotherapy services (CPT® codes 90791, 90832, 90837, 90846, 90847, 90849 and 90853) that, if criteria is not met, will be deemed not medically necessary. Added Cross References to Related Policies and Procedures section. Refer to policy for details.	Periodic review and update Effective 08/01/2024
7.01.023 - Percutaneous Electrical Nerve Stimulation	Updated Description section. Updated Policy 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 08/01/2024
7.01.111 - Transanal Endoscopic Microsurgery (TEM)	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.	Periodic review and update Effective 08/01/2024

7.01.126 - Power Morcellation for Hysterectomy and Myomectomy	Updated Description section. Updated Policy section to indicate "Laparoscopic power morcellation for hysterectomy and myomectomy is considered experimental/investigational as it does not meet TEC criteria # 2-5." 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.	Periodic review and update Effective 08/01/2024
7.01.146 - Genicular Nerve Block for Treatment of Chronic Pain from Knee Osteoarthritis	Updated Policy Guidelines section. Updated Benefit Applications 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 08/01/2024

PRD1178 (6/24)

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc., CareFirst Advantage DSNP, Inc., CareFirst Community Partners, Inc., CareFirst BlueCross BlueShield Community Health Plan District of Columbia, CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.