

Medical Policy Updates and Effective Dates for October 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.

Updated Policies

Medical Policy or Operating Procedure	Actions, Comments and Reporting Guidelines
2.01.084 (C) Remote Patient Monitoring	<p>Effective: 12/01/2025</p> <p>Important changes:</p> <ul style="list-style-type: none"> • Formatting edits throughout. • Under Policy Guidelines, removed standard language “There are no Policy Guidelines for this Medical Policy.” • A 2025 updated rationale statement was added stating: “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 CPT, HCPCS, ICD-10 and other codes section, a medically necessary header was added to the code table.

<p>2.01.086 (C) Ambulatory Surgery Center - Site of Service</p>	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important changes: <ul style="list-style-type: none"> • Above the Description added standard Evicore language because as of 10/15/2025, Esophagogastroduodenoscopy (EGD) services will be reviewed by eviCore. • Removed all colonoscopy references/language as this policy will be reviewed by Evicore for EGD only. • Under Policy Guidelines added a 2025 update.
<p>5.01.045 Respiratory Syncytial Virus (RSV) Vaccines for Adults</p>	<ul style="list-style-type: none"> ■ Effective Date: 2/1/2026 ■ Important changes: <ul style="list-style-type: none"> • Formatting done throughout document. • Title of the policy was changed from Respiratory Syncytial Virus (RSV) Vaccines (Abrysvo™, Arexvy and mRESVIA®) for Adults to Respiratory Syncytial Virus (RSV) Vaccines for Adults. • Under Description added information to state: “July 8, 2025, the Center for Disease Control and Prevention (CDC) changed their recommendations for adults receiving a single dose vaccine for the prevention of RSV from ages 60-74 to 50-74 that are increased risk for RSV. However, as of June 12, 2025 the Food and Drug Administration (FDA) has granted approval for mRESVIA® for use in high-risk individuals between the ages of 18 to 49 for the prevention of lower respiratory tract disease caused by respiratory syncytial virus. On October 22, 2024, the FDA also approved the use of Abrysvo™ for use in high-risk individuals between the ages 18 to 59. It is important to note that Advisory Committee on Immunization Practices (ACIP) has not yet adopted the FDA’s recommendations for the age range of 18-49.” • Under the Policy section mRESVIA® was removed from experimental/investigational statement. • Under Policy Guidelines, added “Note: CareFirst has taken the progressive stance in adopting the FDA’s recommendations for the use of Abrysvo™ and mResvia® for the prevention of lower respiratory tract disease caused by respiratory syncytial virus in those individuals considered high risk in the age range of 18-74.” • TEC criteria #1 was revised to include the updated ACIP and FDA recommendations. • TEC criteria #2 was revised removing mRESVIA® information as well as updating the ages that were generally excluded from studies for Arexvy. • TEC criteria #3 information referring to mRESVIA® was deleted. • TEC criteria #5 mRESVIA® was deleted.

	<ul style="list-style-type: none"> • While CareFirst generally follows ACIP recommendations, this policy will adhere to the FDA’s approvals for Abrysvo™ and mRESVIA®. Therefore, the policy statement has changed, removing mRESVIA® from the experimental/ investigational statement. • Under the Cross References to Related Policies and Procedures the following policies were removed as they do not share any similar codes: 4.01.006A Global Maternity Care, 10.01.011A Emergency Services: Auto Codes. Replaced with the following standard language: “There are no related Policies for this Medical Policy.” • Under the References Section the following references were updated: <ul style="list-style-type: none"> ▪ Abrysvo. Prescribing Information. Pfizer Inc. Accessed November 15, 2023. https://www.fda.gov/media/168889/download?attachment; Arexvy. Prescribing Information. GlaxoSmithKline Biologicals. Accessed November 15, 2023. https://www.fda.gov/media/167805/download#:~:text=AREXVY ▪ Pfizer. (2025). ABRYSVO (respiratory syncytial virus vaccine, adjuvanted) prescribing information [Package insert]. U.S. Food and Drug Administration. Retrieved August 31, 2025, from https://www.fda.gov/media/168889/download?attachment” ▪ GlaxoSmithKline. (2025). AREXVY (respiratory syncytial virus vaccine, adjuvanted) prescribing information [Package insert]. U.S. Food and Drug Administration. Retrieved August 31, 2025, from https://www.fda.gov/media/167805/download?attachment. ▪ The references from Moderna prescribing information (2025), FDA approval letters for Abrysvo™; mRESVIA® and the CDC Vaccine Guidance for Adults was added.
<p>5.01.046 (C) Nirsevimab-alip (Beyfortus™) for Immune Prophylaxis for Pediatric Respiratory Syncytial Virus (RSV)</p>	<ul style="list-style-type: none"> ■ Effective Date: 11/1/2025 ■ Important changes: <ul style="list-style-type: none"> • The title of the policy was changed from “Nirsevimab-alip (Beyfortus™) for Immune Prophylaxis for Pediatric Respiratory Syncytial Virus (RSV)” to “Respiratory Syncytial Virus (RSV) Prophylaxis for Pediatrics • Under Description added FDA information to state: On June 9, 2025, the US. Food and Drug Administration (FDA) approved clesrovimab-cfor (Enflonsia™) for the prevention of RSV in neonates (first 28 days of life) and infants that are 8 months or younger who are either born or entering their first RSV season. The mechanism of action involves conferring passive immunity via monoclonal antibody directed against the RSV fusion (F) protein. This binding inhibits viral entry into host cells, preventing replication and spreading within the respiratory tract. Enflonsia™ is administered intramuscularly as a single 105mg dose. • Under the Policy Statement Enflonsia™ was added as Medically Necessary if meeting criteria outlined in the Policy Guidelines. Enflonsia™ was also added to the Experimental and Investigational statement.

- Under the Policy Guidelines section the following was added:
 - “Enflonsia™ is considered medically necessary to protect against respiratory syncytial virus (RSV) disease in neonates and infants who: are younger than 8 months old, born during or entering their first RSV season.”
 - An additional note was added as the following: “Note: For infants undergoing cardiac surgery with cardiopulmonary bypass during or entering their first RSV season, an additional 105 mg dose is recommended as soon as the infant is stable after surgery.”
- Under TEC criteria #1 the following was added “On June 9, 2025 the Food and Drug Administration approved the use of Enflonsia™ in neonates and infants 8 months or younger that are either born in or entering into their first RSV season. CareFirst follows ACIP’s treatment recommendation.”
- Under TEC criteria #2 the following was added: “Existing research provides insufficient evidence to confirm that Enflonsia™ is an effective treatment for infants beyond the age of eight months. The available data is sparse and does not offer strong support for its use in the older infant group. Therefore, its benefits for patients in this age range cannot be reliably established without further, more comprehensive studies.”
- Under TEC criteria #3 the following was added: “Clinical evidence for the effectiveness of Enflonsia™ is primarily limited to younger infants, with insufficient data available to support its efficacy in infants older than 8 months. More extensive research is needed to evaluate its impact on the older age group. Therefore, it cannot be determined if Enflonsia™ improves the net health outcomes in older infants.”
- For TEC criteria #4 the following was added: “Enflonsia™ demonstrates comparable efficacy to establish alternatives, Beyfortus™ and Synagis®, establishing it as a viable prophylactic option for neonates and infants under 8 months of age who are entering their first RSV season. However, the evidence is scarce regarding its efficacy in use of infants over the age of 8 months.”
- Under TEC criteria #5 Enflonsia™ was included after Beyfortus™.
- The following 2025 update was added: Update 2025: A search of the peer reviewed literature was performed from January 2024 through August 2025. Findings in the recent literature has caused the adoption of the new ACIP guidelines for Enflonsia™ in the prevention of RSV in neonates and infants that are 8 months and younger who are either born or entering their first RSV season. The conclusion regarding Beyfortus™ remains unchanged for the prophylactic treatment of neonates and infants born during or entering their first RSV season and children up to 24 months of age who remain vulnerable to severe RSV. Therefore, the policy statement has changed to include Enflonsia™ as medically necessary in the prevention of RSV in neonates and infants that are 8 months and younger who are either born or entering their first RSV season and experimental/investigational for all other indications.

	<ul style="list-style-type: none"> • Under the Provider Guidelines section recommendations for administering Enflonsia™ were added • Under the CPT®, HCPCS, ICD-10 and Other Codes section updated codes. • Under References section the following references were added: American Academy of Pediatrics 8/19/2025, Center for Disease Control and Prevention 6/25/2025; 8/18/2025, and the U.S. Food and Drug Administration 8/18/2025.
7.01.025 (C) Spinal Cord, Deep Brain, and Responsive Cortical Stimulation	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important changes: <ul style="list-style-type: none"> • Code update. • Under CPT, HCPCS, ICD-10 and Other Codes added four codes that were effective 1/1/2024.
7.01.047 (C) Functional Neuromuscular Stimulation	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important changes: <ul style="list-style-type: none"> • Under Policy Guidelines: <ul style="list-style-type: none"> ▪ Updated edited TEC criteria #2 with updated research and added a 2025 update. ▪ Added 2025 rationale statement. • Under Provider Guidelines added standard language: “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).” • Under Cross References to Related Policies and Procedures updated policies due to shared codes: <ul style="list-style-type: none"> ▪ Added 2.01.047 (C) RETIRED Electrical Stimulation of the Pelvic Floor for Stress Urinary Incontinence. ▪ Added 7.01.025 Spinal Cord, Deep Brain, and Responsive Cortical Stimulation. ▪ Added 7.01.037 RETIRED Phrenic Nerve Stimulator for Chronic Respiratory Insufficiency. ▪ Added 7.01.041 Treatments for Urinary Incontinence. ▪ Added 7.01.075 (C) RETIRED Vagus Nerve Stimulation.
8.01.007A (C) Work Hardening Programs	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. ■ Under Cross References to Related Policies and Procedures deleted 8.01.001 Physical Therapy, 8.01.003 Chiropractic Care Including Spinal Manipulation, 8.01.004 Occupational Therapy.

<p>10.01.001A (C) Clinical Trial Mandates, Maryland and Virginia</p>	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important changes: <ul style="list-style-type: none"> • Updated formatting throughout policy. • 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. ▪ The following language was removed: “Drugs or devices which have been approved for sale by the FDA, but which may not have been approved for a patient’s condition (e.g., an off-label application) are covered under this benefit if the drug or device is not being paid for by the manufacturer, distributor, or provider” as it does not apply to the Commonwealth of Virginia Mandate. ▪ The following note regarding mandate language was added under the Maryland section: “Note: Subject to the provisions of subsection (d), this plan shall provide coverage for expenses incurred by a member for drugs and devices that have received approval from the U.S. Food and Drug Administration (FDA). Such coverage is required irrespective of whether the product is prescribed for the FDA approved indications. This benefit is contingent upon the costs of the product not being otherwise paid for or provided by the manufacturer, distributor, or any provider of service.” ▪ Under the Virginia section, the following mandate language was added: “The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise” along with “Note: Coverage for patient costs during cancer treatment clinical trials is shall be provided for treatments provided in phase II, III, or IV studies, while treatment administered in phase one trials may be eligible for coverage on a case by case basis.” • Under the Cross References to related Policies and Procedures the following policy was removed as it does not share any similar codes: 5.01.001 Off-label Drug and Orphan Drug Use and the following standard language was added: “There are no Related Policies for this Medical Policy Operating Procedure.” • Under the Reference section the Virginia Code subsection was corrected from 38.2-3418 to 38.2-3418.8. A reference from Code of Virginia § 38.2-3453 was added. Maryland §15- 827 was updated from 1999 to 2015.
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Retired Policies

Medical Policy or Operating Procedure	Actions, Comments and Reporting Guidelines
1.01.002 (C) Air Fluidized Beds	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important Changes: <ul style="list-style-type: none"> • 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.
1.01.007 (C) Home Apnea Monitoring for Infants	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important changes: <ul style="list-style-type: none"> • 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.
1.01.077A (C) Automated Blood Pressure Monitoring for Home Use	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important changes: <ul style="list-style-type: none"> • CareFirst has retired this policy. For specific details regarding your benefits, please refer to the members' contract.
3.01.013 Transcranial Magnetic Stimulation for Treatment of Depression and Other Psychiatric / Neurologic Disorders	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important Changes: <ul style="list-style-type: none"> • 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.
7.01.112 (C) Collagen Meniscus Implant	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important Changes: <ul style="list-style-type: none"> • 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.
7.01.115 (C) Shoulder Resurfacing Arthroplasty	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important Changes: <ul style="list-style-type: none"> • 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.

7.01.118 (C) Minimally Invasive Interventions for Fecal Incontinence	<ul style="list-style-type: none"> ■ Effective Date: 3/1/2026 ■ Important Changes: ■ 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.
7.01.131 (C) Esophageal Brush Biopsy (WATS3D®)	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important Changes: ■ This policy is retired and is no longer in effect.
7.01.146 RETIRED Genicular Nerve Block for Treatment of Knee Osteoarthritis	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important Changes: ■ 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.
10.01.009A (C) Global Surgical Care Rules	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important Changes: <ul style="list-style-type: none"> • This policy is retired and is no longer in effect. Please refer to Payment Policy CO 070.03 Global Surgical Services https://provider.carefirst.com/providers/medical/payment-policy.page
11.01.005 (C) Cathepsin-D	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important Changes: ■ This medical policy is retired due to no utilization and will no longer be reviewed.
11.01.045 Proteomics-Based Testing for Evaluation of Ovarian Masses	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important Changes: ■ 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.
11.01.077 (C) Human Microbiome Analysis	<ul style="list-style-type: none"> ■ Effective Date: 12/1/2025 ■ Important Changes: <ul style="list-style-type: none"> • This policy is retired due to the tests manufactured by the company no longer being available.