# BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

## April 2025 Medical Policy Updates

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan frequently revise the medical policies we use to make clinical determinations for a member's coverage. Here are medical policies that have been updated or newly added. A revision history for each policy is included. Please visit the Medical Policies pages of www.SouthCarolinaBlues.com and www.BlueChoiceSC.com regularly to stay informed of these changes and to read any policy in its entirety.

| Policy Number | Policy Name | Recent Changes |
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| CAM 176 | Telehealth | Interim review to add statement Physical Therapy, Occupational Therapy, and Speech Therapy via telehealth are not reimbursed services. Also removing Physical Therapist, Occupational Therapist, and Speech Therapist from approved clinician list. No other changes. |
| CAM 80130 | Hematopoietic Cell Transplantation for Chronic Myeloid Leukemia | Annual review, no change to policy intent. Updating rationale. |
| CAM 20231 | Myocardial Strain Imaging | Annual review, no change to policy intent. Updating Summary of evidence, table #3, rationale and reference. |
| CAM 20173 | Actigraphy | Annual review, no change to policy intent. |
| CAM 20133 | Home Spirometry | Annual review. No change to policy intent. |
| CAM 20130 | Biofeedback as a Treatment of Chronic Pain | Annual review, no change to policy intent. Updating table #5, rationale and references. |
| CAM 701126 | Image-Guided Minimally Invasive Lumbar Decompression (IG-MLD) for Spinal Stenosis | Annual review, no change to policy intent. Updating Description, summary of evidence, rationale and references. |
| CAM 387 | Applied Behavioral Analysis Services | Interim review. Minor revisions made. Updated policy guidelines, providers qualifications, definitions, references and coding section. |
| CAM 381 | Breast Cancer Radiation Oncology | Annual review, no change to policy intent. |
| CAM 80146 | Intensity-Modulated Radiotherapy of the Lung | Annual review, no change to policy intent. Updating Summary of evidence and background. |
| CAM 701170 | Laser Interstitial Thermal Therapy for Neurological Conditions | Interim review, removing investigation coverage stance and adding coverage criteria for treatment of epilepsy, brain tumors, and radiation necrosis. Updating rationale. |

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| CAM 722 | Radiopharmaceutical Tumor Localization (SPECT), Single Area | Interim review, no change to policy intent. Adding code 78072. No other changes. |
| CAM 253 | Surgical Treatments for Lymphedema and Lipedema | Interim review, adding coverage statements "suction assisted lipectomy of the trunk is considered cosmetic therefore NOT MEDICALLY NECESSARY" and "addition of skin excisions as adjunct treatment to lipectomy are considered NOT MEDICALLY NECESSARY". Also adding codes 15834, 15835, 18538. No other changes |
| CAM 80301 | Functional Neuromuscular Electrical Stimulation, Robotic-Assisted Rehabilitation and Robotic-Assisted Orthotics | Annual review, no change to policy intent. Updating table #1, rationale and reference. |
| CAM 80135 | Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors | Annual review, no change to policy intent. Updating additional info, rationale and references. |
| CAM 60125 | Minimally Invasive Approaches to Vertebral Fractures and Osteolytic Lesions of the Spine | Annual review, no change to policy intent. |
| CAM 765 | CTA Coronary Arteries (CCTA) | Annual review, policy updated for formatting, clarity and consistency including adding AUC score. Also updating rationale and references. |
| CAM 384 | Colorectal Cancer Screening | Annual review, adding guardant shield test to criteria #4. Also updating table of terminology, rationale, guidelines/recommendations, and references. Adding CPT code 0573U. |
| CAM 271 | Testing for Diagnosis of Helicobacter Pylori | Annual review, updating entire policy for clarity and consistency. Removing coverage criteria as it is addressed in new coverage criteria #5 "For all individuals who have tested positive for H. pylori, urea breath testing or stool antigen testing to measure the success of eradication of H. pylori infection, with testing perormed at least four weeks post treatment, MEETS COVERAGE CRITERIA". Updating coverage criteria #6. Adding new note 2 and 2. Also updating description, rationale, guidelines/recommendations, and references. |
| CAM 168 | Genetic Testing for Polyposis Syndromes | Annual review, update criteria #3. Also updating description, notes, table of terminology, rationale, guidelines/recommendations, regulatory status, and references. |
| CAM 135 | Thyroid Disease Testing | Annual review, updating criteria #1 and criteria #4 with examples of thyroid antibodies. Also updating description, table of terminology, rationale, guidelines/recommendations, and references. |

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| CAM 128 | Biomarker Testing for Autoimmune Rheumatic Disease | Annual review, editing allowed frequency of testing in coverage criteria 1,2,3. Adding new coverage criteria #10 "for testing not discussed above is considered not medically necessary". Adding ailse DX disease activity index and Early Sjogren's Syndrome Profile to new coverage criteria #13. Also updating description, table of terminology, guidelines/recommendations, and coding descriptions. |