PROVIDER NOTIFICATION OF POLICY CRITERIA CHANGE					
POLICY TITLE	**POLICY NUMBER**	**CRITERIA CHANGE**	**MATERIAL AMENDEMENT**	**EFFECTIVE DATE**	**LINK TO FULL POLICY**

Cryoablation of Neoplastic Conditions	2000041	Policy/coverage statement reformatted. Restricted criteria for cryosurgical ablation of renal tumor updated. Restricted criteria for suspected neoplastic renal tumor added.
		
		Cryosurgical ablation of renal tumors meets member benefit certificate Primary Coverage Criteria to treat localized renal cell carcinoma or suspected neoplastic renal tumor when:
		
		• The tumor is 3.0 cm or less OR
		• The tumor is 3.0 to 4.0 cm in size AND meets the following criteria:
		  • It is necessary to preserve kidney function in individuals with significantly impaired renal function OR
		  • The individual is not considered a surgical candidate.
		Note: Renal mass biopsy must be performed prior to or at the time of the ablation to provide pathologic diagnosis and guide subsequent surveillance.
			No	01/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2000041

Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors	2001011	Policy/coverage statement reformatted. Restricted criteria for renal cell carcinoma or suspected neoplastic renal tumor updated.
		
		Radiofrequency ablation in individuals with renal cell carcinoma or suspected neoplastic renal tumor meets Primary Coverage Criteria when:
		
		• The tumor is 3.0 cm or less; OR
		• The tumor is 3.0 to 4.0 cm or less AND meets the following criteria:
		  • it is necessary to preserve kidney function in individuals with significantly impaired renal function OR
		  • The individual is not considered a surgical candidate
		Note: Renal mass biopsy must be performed prior to or at the time of the ablation to provide pathologic diagnosis and guide subsequent surveillance.
			No	1/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2001011

Non-Implantable Insulin Infusion Devices, Hybrid Insulin Infusion Devices, and Continuous Glucose Monitoring Devices	2001009	Description, rationale, and references added. Policy/coverage statement reformatted. Restricted coverage added for implantable CGM devices. The use of implantable CGM devices for management of type 1 or type 2 diabetes Primary Coverage Criteria when **ALL** criteria below have been met: • The individual is 18 years of age or older; **AND** • The individual meets the criteria listed above for a non-implanted continuous interstitial glucose monitoring device for type 1 **or** type 2 diabetes.	No	1/15/2026	https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2001009