PREMERA | BLUE CROSS

Medicare Advantage plans
Medical policy and criteria

MEDICAL POLICY UPDATE

Premera Blue Cross Medicare Advantage reviews all medical policies and criteria annually. The following updates are available on the Premera Medicare Advantage provider website at premera.com/wa/provider/medicare-advantage/. Simply click on *View medical and pharmacy policy updates* located on the right side of the Medicare Advantage provider landing page.

NEW MEDICAL POLICIES EFFECTIVE APRIL 1, 2020

Policy	Description/Background
Bronchial Thermoplasty for the Treatment of Asthma	Bronchial thermoplasty is the controlled delivery of radiofrequency energy to heat tissues in the distal airways. Bronchial thermoplasty is based on the premise that patients with asthma have an increased amount of smooth muscle in the airway and that contraction of this smooth muscle is a major cause of airway constriction. Medical Policy Statement: The safety and effectiveness of bronchial thermoplasty for the treatment of asthma have not been established. Further studies are needed to evaluate the clinical utility, safety and long- term health implications of this procedure. Bronchial thermoplasty for the treatment of asthma is experimental/investigational. We've added the following codes to the prior authorization list: 31660, 31661. Detailed CMS Policy Documents: NCD: There is no national coverage determination on bronchial thermoplasty. LCD: There is no local coverage determination on bronchial thermoplasty.

Cataract Removal Surgery	A cataract is an opacity, or cloudiness, of the normally clear lens of the eye. It is a common cause of visual impairment, particularly in the elderly population. The cloudiness and loss of transparency are due to the clustering of proteins within the lens. Medical Policy Statement: The safety and efficacy of cataract removal surgery, with or without intraocular lens (IOL) implantation, have been established. It is considered an effective treatment when clinical criteria are met. We've added the following codes to the prior authorization list: 66820, 66821, 66830, 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984. Detailed CMS Policy Documents: NCD for Phacoemulsification Procedure - Cataract Extraction (80.10): Longstanding NCD; effective date of this version has not been posted. LCD for cataract surgery in adults for services performed on or after 10/01/2019 (L37027)
Continuous Passive Motion Machine (CPM)	Continuous passive motion (CPM) devices are utilized to keep a joint in motion without patient assistance. CPM is being evaluated for treatment and postsurgical rehabilitation of the upper and lower limb joints and for a variety of musculoskeletal conditions. Medical Policy Statement: The safety and effectiveness of the continuous passive motion machine have been established. It may be considered a useful therapeutic option when indicated. We've added the following codes to the prior authorization list: E0935, E0936. Detailed CMS Policy Documents: NCD: Medicare National Coverage Determinations-Durable Medical Equipment Reference List (280.1) Manual 100-3, effective on or after 5/5/2005. LCD: There is no local coverage determination.
Hyperbaric Oxygen Therapy, Systemic and Topical	Hyperbaric oxygen therapy (HBOT) is a technique for delivering higher pressures of oxygen to tissue. Two methods of administration are available: systemic and topical. Medical Policy Statement: The safety and effectiveness of systemic hyperbaric oxygen therapy have been established for some conditions. It may be considered a useful therapeutic option when indicated for specified conditions.

	Topical hyperbaric oxygen therapy is experimental/ investigational. It has not been scientifically demonstrated to improve patient clinical outcomes. We've added the following codes to the prior authorization list: 99183, G0277, A4575, E0446. Detailed CMS Policy Documents: NCD: 20.29 – Hyperbaric Oxygen Therapy; effective Date: 4/3/17; implementation Dates: 12/18/17. LCD: There is no local coverage determination regarding hyperbaric oxygen therapy.
Orthopedic Applications of Platelet-Rich Plasma	Platelet-rich plasma (PRP) can be prepared from samples of centrifuged autologous blood. Exposure to a solution of thrombin and calcium chloride degranulates platelets, releasing the various growth factors. The polymerization of fibrin from fibrinogen creates a platelet gel, which can then be used as an adjunct to surgery with the intent of promoting hemostasis and accelerating healing. Medical Policy Statement: Use of platelet-rich plasma is considered experimental/investigational for all orthopedic indications. It has not been scientifically demonstrated to improve patient clinical outcomes. We've added the following codes to the prior authorization list: 0232T. Detailed CMS Policy Documents: NCD: There is no national coverage determination. In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers. LCD: There is no local coverage determination.
Air Ambulance Services	Air ambulance transport services utilizing specially designed and equipped airplanes or helicopters are important in providing rapid medical care and transport of ill or injured patients. Medical Policy Statement: The safety and effectiveness of air ambulance services have been established. For medical necessity to be established, the attending/ordering physician must determine that the patient's condition requires air ambulance transport, and that any alternative form of transport (ground ambulance, commercial transport) would be clinically inappropriate or detrimental to the health or outcome of the patient.

	We've added the following codes to the prior authorization list: A0430, A0431, A0435, A0436, A0420, S9960, S9961. Detailed CMS Policy Documents: NCD: Medicare Benefit Policy Manual, Chapter 10, Section 10.4 – Air Ambulance Services. Rev. 103; Issued: 02-20-09; effective Date: 05-05-09; implementation Date: 03-20-09). Medically appropriate air ambulance transportation is a covered service regardless of the State or region in which it is rendered. However, contractors approve claims only if the beneficiary's medical condition is such that transportation by either basic or advanced life-support ground ambulance is not appropriate. LCD: There is no local coverage determination.

PHARMACY PART B CODES ADDED TO THE PRIOR AUTHORIZATION LIST EFFECTIVE APRIL 1, 2020

JCode	Drug Name
J3245	Ilumya
J3304	Zilretta
J3397	Mepsevii
J1301	Radicava
J0584	Crysvita
J0565	Zinplava
J3111	Evenity
J0222	Onpattro
J9119	Libtayo
J9269	Elzonris
J1303	Ultomiris
J0179	Beovu