Medical Policy and Criteria
Premera Blue Cross Medicare Advantage reviews all medical policies and criteria annually. The following policies are updated and available on the secure provider Premera Medicare Advantage website at premera.com/wa/provider/medicare-advantage/—simply click on the Get Started button.

New Medical Policy and Criteria: Effective April 1, 2015
- Vitamin B\textsubscript{12} Deficiency: Vitamin B\textsubscript{12} injections may be considered medically necessary in the treatment of documented vitamin B\textsubscript{12} deficiency as evidence by laboratory tests (e.g., low serum B\textsubscript{12}, abnormal schilling test) and related to specific conditions and diagnoses. See medical policy for specific coverage criteria.
- Cardiac: Cardiac Risk Screens: replaces Cardiac: Corus Coronary Artery Disease (CAD) and Other Risk Screens. This is a non-coverage policy for specific bundled cardiovascular risk screens. See policy for criteria for specific coverage guidelines.
- Drug: ILUVIEN\textsuperscript{®} (Fluocinolone Acetonide); prior authorization required. Intra-vitreal implant for Diabetic Macular Edema: covered. See policy for coverage criteria.

Revised Medical Policy and Criteria: Effective April 1, 2015
- Back: Epidural Steroid Injections, Cervical and Lumbar; prior authorization required.
- Back: Radiofrequency Ablation for Persistent Facet Pain: C2-3 facet joints may now be done in staged procedure. Prior authorization required. See policy for coverage criteria.
- Breast Cancer: BRCA 1 and BRCA 2 Genetic Counseling and Testing; Checkpoint Kinase 2 (CHEK2) Gene Mutation Analysis; BRAC Analysis Rearrangement Test (BART); BROCA1 Test; BreastNext\textsuperscript{™}; Oncovue\textsuperscript{®}; BREVAGen\textsuperscript{™}. Prior authorization required. Added language to follow National Comprehensive Cancer Network guidelines. See policy for coverage criteria. The BRAC Analysis Rearrangement Test (BART) is covered.
- Breast Cancer: MAMMAPRINT Genetic Assay; BLUEPRINT Molecular Subtyping Profile: The MAMMAPRINT genetic assay for breast cancer is covered. The BLUEPRINT molecular subtyping profile is not covered due to the lack of any proven clinical benefit. CPT code 81519 (new code for 2015) was added to medical policy.
- Electrical Nerve Stimulators (TENS) and Related Supplies: Calmare Device added to policy as non-covered. Considered experimental and investigational.
- Genetic Studies and Counseling: Prior authorization required. Revised language added for clarification. See policy for coverage criteria.
- Hyperhydrosis Surgical Treatment and Iontophoresis: prior authorization required. CPT 97033 was deleted from this policy. See policy for coverage criteria.
• Knee: Cartilagenous Defects of the Knee: prior authorization required. The addition of biocartilage allograft has been added to the medical policy. See policy for coverage criteria.
• Liver Tumor Treatment: Cryosurgery, Radiofrequency Ablation, Ethanol Ablation, Transcatheter Arterial Chemoembolization, Microsphere Radiation and Transarterial Emolization: Prior authorization required. Title change, added new 2015 CPT codes. See policy for coverage criteria.
• Obesity: Bariatric Surgery; prior authorization required. Coverage criteria have been revised to meet CMS guidelines, see medical policy for coverage criteria.
• Therapeutic and Opioid Drug Monitoring: See medical policy for new 2015 CPT/HCPCS codes, and revised coverage criteria.
• Therapeutic and Opioid Drug Monitoring Transcutaneous Therapeutic and Opioid Drug Monitoring: See medical policy for new 2015 CPT/HCPCS codes, and revised coverage criteria.
• Varicose Veins Prior authorization required. CPT code 36469 was deleted from medical policy and prior authorization list due to 2015 code changes.

**Retired Medical Policy: Effective Jan. 1, 2015**

• Cardiac: Corus CAD and other risk screens (see Cardiac: Cardiac Risk Screens: replaces Cardiac: Corus CAD and Other Risk Screens).
• Shoulder: arthroscopy surgical, no longer monitoring utilization