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 for dates of service Oct. 1, 2015 and after

- Gastrointestinal Ecology and Gastrointestinal Comprehensive Profiles: Comprehensive GI profiles or GI ecology screens are considered not medically necessary.
- Organic Acid Testing and Nutritional Panels: Screening for organic acid disorders may be considered medically necessary in symptomatic newborns and infants up to 1 year of age. See medical policy for coverage and non-coverage guidelines.

Revised Medical Policy and Criteria: Effective for dates of service Oct. 31, 2014 and after

- Breast Prosthetics and Mastectomy Bras, External: External breast prosthesis garment, with mastectomy form (L8015) is covered for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis.

Revised Medical Policy: Effective for dates of service Aug. 1, 2015 and after

- Drug: Lucentis and Drug: Eylea (Aflibercept); ICD-10-CM codes added to medical policy.

Revised Medical Policy: Effective for dates of service Oct. 1, 2015 and after

- Back: Radiofrequency Ablation for Persistent Facet Pain: See medical policy for diagnostic facet joint injections for coverage guidelines that were replaced in policy.
- Eye: Blepharoplasty, Eyelid Surgery, and Brow Lift: policy title changed from “Blepharoplasty, Eyelid Surgery and Brow Lift”. No other changes to policy.
- Compression: Home Intermittent Pneumatic Compression Devices (PCDS) for DVT Prevention: The correct coding (E0675, E0676) was identified through Noridian PDAC Medicare Pricing, Data Analysis, and Coding. See policy for coverage criteria.
- Urinary Dysfunction—Incontinence: prior authorization is required for Radiofrequency Tissue Remodeling (Renessa); and Botulinum Toxin Types A and B. All language
regarding posterior tibial nerve stimulation has been removed from this policy. See policy for coverage criteria.

**Retired Medical Policy: Effective for dates of service June 1, 2015 and after**

- Fecal Calprotectin Assay for Management of Crohn’s Disease: Fecal Calprotectin Assay CPT code 83993 is now covered.
- Sensory Integration Therapy

**NEW TECHNOLOGY MEDICAL POLICY:**

**New Medical Policy and Criteria: Effective for dates of service Oct. 1, 2015 and after**

- Acessa System for RFA of Uterine Fibroids: non-coverage policy as utility and efficacy has not been established.
- Vectra DA Test for Rheumatoid Arthritis: Non-coverage policy. The use of this drug is investigational and experimental.

**Revised Medical Policy and Criteria: Effective for dates of service Oct. 1, 2015 and after**

- Back: Cervical and Thoracic Spine Surgery: Epidural steroid injections are no longer required as conservative care prior to surgery. See policy for coverage criteria.
- Back: Instrumentation/Stabilization Devices: X-Stop are no longer covered as current literature does not demonstrate efficacy; no coverage for Superion® Interspinous Spacer.
- Back: Lumbar Spine Surgery: Epidural steroid injections are no longer required as conservative care prior to surgery. See policy for coverage criteria.
- Breast Cancer: BRCA 1 and BRCA2 Genetic Counseling and Testing, CK2, Gene Mutation Analysis; Bracanalyis Rearrangement Test (BART); BROCA 1 Test and BreastNext, Oncouve®, BREVAgen: BART coverage for Medicare Members: See policy for coverage criteria.
- Cardiac Risk Screens: Prior authorization required. Coding changes, new codes added, and language clarified. See policy for coverage criteria.
- Genetic Studies and Counseling: Policy reformatted. Addition of RenalNext NGS panel for renal cell carcinoma as non-covered as experimental and investigational for lack clinical utility. Warfarin and Amplichip removed from policy. See policy for coverage criteria.
- Helmet Therapy for Cranial Remodeling: Added information about cephalic index. See policy for coverage criteria.
- Lyme Disease: Clarified language surrounding administration of antibiotics. See policy for coverage criteria.
- Pharmacogenetic Testing: Changes to coverage for GeneSight Psychotropic Testing for Medicare Members. Amplichip and Warfarin testing added to policy. See policy for coverage criteria.

- Prostate Transurethral Needle Ablation (TUNA); Microwave Thermotherapy (TUMT): Prior authorization requirement removed from policy. See policy for coverage criteria.

- Sclerotherapy Coil Embolization – Ovarian Vein: non-coverage policy – coding changes.

- Sleep Apnea: Treatments and Testing: Snoroplasty added as non-covered; language clarification for oral appliances; added Watch-Pat™200 for home testing for sleep apnea. See coverage policy for criteria.

- Transcutaneous Electrical Nerve Stimulators (TENS) and Related Supplies: Language clarification, clarification of uses for TENS, and coding added. See policy for coverage criteria.

- Urinary Dysfunction: Vesicoureteral Reflux Treatments: Title change from Deflux Injectable Gel for the Treatment of Vesicoureteral Reflux in Children, added Macroplastique as additional treatment for vesicoureteral reflux, no coverage for use in urinary incontinence. See policy for coverage criteria.

Retired Medical Policy: Effective for dates of service Aug. 1, 2015 and after

- Eye: Glaucoma Surgery iStent

- Multiple Sclerosis: gMS DX test Blood Test for Diagnosing