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 “Log in to medical tools and resources” button.

Medical Policy Committee

New Medical Policy and Criteria: Effective October 1, 2016


• Hip: Total Joint Replacement (Medicare Only): New medical policy based on CMS Local Coverage Decision LCD 36576.

• Knee: Total Joint Arthroplasty (Medicare Only): New medical policy based on CMS Local Coverage Decision LCD 36577.

• Prolotherapy: Policy split from the Back: Prolotherapy and intradiscal injection policy and reformatted. Policy expanded to all areas of the body. Mental Health Parity Disclaimer inserted.

Revised Medical Policy and Criteria: Effective October 1, 2016

• Back: Percutaneous Thermal Intradiscal Treatment for Low Back Pain: Policy reformatted. There was no change to the policy criteria. Mental Health Parity Disclaimer added to the policy.

• Definition: Mobility Assistive Equipment (MAE): Definition policy based on CMS NCD 280.3. No changes to the policy.

• Diabetes: Blood Glucose Monitors and Supplies: Policy reformatted. Mental Health Parity statement inserted. Policy is based on Medicare LCD L33822. Pharmacy link inserted for coverage on the number of glucose test strips.

• Fecal Bacteriotherapy: Coding clarified to indicate PMT capsules should be billed with J7999.
• **Gloves, Sterile and Non-sterile**: Policy reformatted. Mental Health Parity statement inserted. No other changes.

• **Heating Pads and Heat Lamps (Medicare Only)**: Policy reformatted. Mental Health Parity statement inserted. No other changes.

• **Hernia Repair: Human Acellular Dermal Matrix**: Policy expanded to address all human matrix skin substitutes for hernia repair and not just FlexHD. Removed Medicare coverage criteria as no current CMS guideline could be identified which supported continued coverage. Policy now indicates human acellular matrix skin substitutes are considered E/I for all lines of business. Codes which were not specific to hernia repair were removed from the policy.

• **High Frequency Chest Wall Oscillation Devices**: Policy criteria reformatted. Mental Health Disparity disclaimer added to the policy. Evidence section added.

• **Joint Resurfacing**: Reformatted policy. Added statement: “This medical policy does not address hip resurfacing which may be considered medically necessary.” An additional note was added to direct users to a separate medical policy for MAKOplasty robotic assisted partial knee resurfacing when applicable. These statements were added to clarify the policy intent. No other changes.

• **Knee Arthroscopy**: Removed prior authorization.

• **Nerve Conduction Studies**: New Medicare coverage for automated nerve conduction studies (NCS) added to policy to allow as medically necessary for one service per arm when there is a high pretest or prior probability for the diagnosis of Carpal Tunnel Syndrome. In addition, new medical necessity criteria regarding non-automated NCS added to the policy for the clinical diagnosis of peripheral nervous system disorders. Policy reformatted. Mental Health Parity Disclaimer added.


• **Seat Lift Mechanisms**: Policy reformatted. Mental Health Parity statement inserted. No other changes.

• **Standing Frames**: Title change. Policy reformatted. Mental Health Parity statement inserted. No other changes.

• **Vectra DA Test for Rheumatoid Arthritis**: Policy reformatted. Policy criteria added for Medicare coverage for indications r/t rheumatoid arthritis. Mental Health Parity Disclaimer added to the policy.

• **Wireless Capsule Endoscopy**: Policy reformatted. Policy title updated. Arterial venous abnormality (AVA) added to criterion III as a covered indication. Mental Health Parity Disclaimer added to the policy.

• **Wounds: Non-contact Ultrasound Treatment**: Policy reformatted. Mental Health Parity statement inserted. No other changes.
**Revised Medical Policy and Criteria:** Effective December 1, 2016

- **Transgender Services:** Policy updated to align further with WPATH guidelines. Effective 12/01/2016. The following changes to the criteria were made:
  - Now require a referral from 2 mental health professionals for all genital surgeries, except breast/chest surgery.
  - Patients must now undergo 1 year of continuous hormonal therapy prior to lower body genital construction procedures.
  - Mammoplasty may only be performed when 12 months of continuous hormone therapy have failed to result in breast tissue growth or there is a medical contraindication to hormonal therapy.
  - Electrolysis was added as medically necessary when performed for surgical site preparation only. This change is supported by WPATH guidelines.
  - Removed requirements for referral by a mental health professional and hormone therapy prior to mastectomy

**No Changes to Medical Policy and Criteria:**

- **Definition: Urgent Care (Out of Area):** No changes to the policy.

- **Organic Acid Testing and Nutritional Panels:** Policy reformatted, otherwise no other changes.

**Retired Policies:** Effective October 1, 2016

- **Back: Prolotherapy and Intradiscal Injections for the Treatment of Musculoskeletal Pain:**
  Prolotherapy and intradiscal injections are now addressed in separate policies.

- **Blood Pressure Monitors**

- **Blood Pressure Monitoring Ambulatory (ABPM) in Adults and Pediatrics**

- **Computerized Neuropsychological Testing:** Combined with the general Computerized Neuropsychological medical policy.